Caring for Care Homes

NHS

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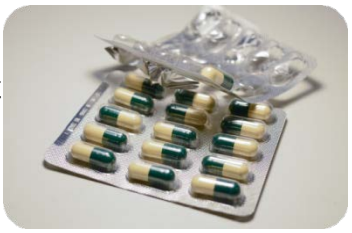
Accurately listing a residents medicines



It is essential that the resident's previous medication list is compared with their current medication list every time a resident is transferred from one healthcare setting to another, to check for discrepancies and to ensure that these are communicated to the resident and relevant clinicians.

It is important to identify the most accurate list of a resident's medicines, including the name of the medicine, the dose, frequency and route. This should be compared to the current list you are working from.

Why should medicines be accurately listed?

The Institute of Health Improvement estimates that as many as 50% of all medication errors are due to poor communication when residents transfer from one care setting to another. Residents recently discharged from hospital are known to be a particularly vulnerable group. 30-70% of residents experience an error with medications during transfer between settings.

What could go wrong if a resident's medication is not accurately listed?

- The resident might receive the wrong dose, strength, or formulation of their medicine
- The resident may not receive their medicine at all
- There could be delays to a resident's treatment while issues are resolved
- Greater risk of drug interactions and adverse effects
- Additional staff time spent on resolving issues
- The pharmacy could order in the wrong medication for the resident

Who is the best person to accurately list a resident's medication?

Medicine reconciliation can be carried out by any member of staff, as long as they are competent and have the information they need to carry out the task. It is important to establish who has responsibility for the process.

Who else should be involved in accurately listing a resident's medication?

- The resident and/or their family members or carers
- The pharmacist
- Other health and social care practitioners involved in managing medicines for the resident

What can be done by care homes to ensure the process of listing a resident's medication is being carried out in an accurate and timely manner?

- Care homes should have a policy in place to ensure that this process is carried out by a competent person. The policy should ensure timeliness and have a safe and robust process for addressing discrepancies.
- An 'up to date' copy of the resident's repeat list must be kept in a safe place in case of emergency admission.

Care homes should follow the three steps below to make sure their process is robust.

1. Collecting: This step involves taking a medication history and collecting other relevant information about the resident's medicines. The most up to date reliable source should be used, crossed checked and verified. Any discrepancies must be recorded, and a reason established for variation. A range of sources can be used including:

- A computer print-out from a GP clinical records system.
- The tear-off side of a resident's repeat prescription request.
- Verbal information from the resident, their family or a carer.
- Medical notes from a resident's previous admission to hospital (e.g. discharge summary).
- Medicine containers or repeat prescription supplies available at the time of the

reconciliation.
- Remember to check for drugs not prescribed by the GP, e.g. hospital outpatient, mental health drugs.

2. Checking: This step involves ensuring the medicines and doses prescribed following the basic reconciliation process are correct. These may not be identical to those documented during the collecting process, as the GP may have made some intentional changes. Any discrepancies will need to be resolved in the final step of this process. **Check that nothing has changed,** e.g. new adverse effects, the resident's ability to swallow tablets.

3. Communicating: This is the final step in this process where changes to the resident's prescription are documented and dated and communicated to the next person responsible for the medicines management care of that resident. **Be extra observant for any of the following:**

- Medications that have stopped
- Medications that have started
- Changes in medication strength
- Changes in medication dose
- Changes in medication frequency
- Specific details on length of treatment
- Specific details on increasing or decreasing regimes
- Known allergies, including those newly recorded
- Take special precautions with brands and generics (e.g. Losec® and omeprazole are the same drug)
- If a discharge summary appears incomplete, inaccurate or ambiguous, action must be taken immediately to seek clarification to avoid potential harm to the resident.

The following information should be available on the day a resident transfers into or from a care home:

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

Ensure that the details of the person completing the list of resident's medicines (name, job title) and the date are recorded. It is everyone's responsibility to make sure that where involved, they have 'collected, checked and communicated' any changes made.

Remember: NICE Managing Medicines in Care Homes - 6 R's of administration.

Right Resident	Right Medicines	Right Route	Right Dose	Right Time	Right to Refuse

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Using the Medication Administration Record (MAR)

Medication Administration Records may be on paper or electronic. For the purposes of this document, 'MAR' refers to both pMAR and eMAR unless specified	Paper Medication Administration Record	pMAR
	Electronic Medication Administration Record	eMAR

A Medication Administration Record (MAR) is the record of medications that have been administered to a resident. This includes both prescribed and purchased medicines.
The care home staff member signs each time a medication or device is administered to a resident. It is a **legal** document. Staff administering medication in the care home setting should be suitably trained and competent to do so. This should be documented and recorded by a manager.

Important: If the instructions or information on a MAR are not absolutely clear, immediately contact the pharmacy or GP surgery to get further clarification. Do not administer the medication until clarification has been sought.

General guidance on MARs

1. Care workers who give medication must have a MAR for the resident which details :
   - The full name and date of birth of the resident
   - Details of the medication the resident is taking, including the name, formulation and strength
   - The dose, times of administration and how the medication is taken or used (including route of administration)
   - When the medication should be reviewed, monitored or stopped (as appropriate)
   - Any special information, e.g., whether the medication should be taken with food
   - Any allergies: these should be cross-referenced with the resident's profile.
2. The information on the MAR should be supplemented by the resident's care plan. The care plan should include personal preferences, or specific support a person may need to take their medication.
3. The MAR must be completed when an individual dose is administered to a resident. This must be carried out for each resident when the medication is administered and not left until a later time, for example, at the end of a medicines round.
4. If a medication is not administered the reason must be recorded; there should not be any 'blank' entries or gaps. Use the omission codes as detailed on the MAR to describe when and why the medication was not given, and where appropriate provide additional information.
5. It is best practice that the administration of controlled drugs (CD) is recorded on the MAR by the person administering the medication and the witness. This is in addition to those records that are made in the controlled drugs register.
6. The MAR should be used to record medication which is carried over from a previous month. Ensure the quantities are checked before carrying over. Liaise with the pharmacy to ensure all current medications are listed, including those not ordered this cycle but still being taken. Ensure that discontinued medication is removed.
7. Ensure the quantities received are accurately noted on the MAR when booking in medication. If the amount stated on the MAR does not match the amount received, the quantity received should be re-checked, and then queried and changed as appropriate.

8. If an item is missing from the MAR and/or not received in the delivery, do not assume it has been discontinued. Check with the prescriber and re-order if necessary.
9. If an unexpected item has been added to the MAR and has been delivered, do not assume that this was intentional. Check with the prescriber before administering.
10. The MAR chart should be used to record when any non-prescribed medication is administered to a resident, e.g., a homely remedy or an over-the-counter medicine

Residents who self-administer

1. If a resident self-administers medication the MAR needs to state this, or a code recorded to reflect this.
2. The decision for a resident to self-administer should be regularly reviewed and risk assessed.
3. The resident does not have to complete a MAR.
4. The resident's care plan should make it clear where medication is stored and when it is handed over to the resident. For example, some residents may keep the whole pack in their room and others may be supplied with a single dose. The MAR does not have to be signed by staff as they are not administering the medication. However, a record of having supplied the medication to the resident must be kept; this could be on the MAR or in the care plan.

How to keep a MAR chart up to date

1. The responsibility for providing and using MAR charts is with the care provider, not the dispensing GP or community pharmacy.
2. Under the General Medical Services contract (GMS), the GP is not obliged to amend a MAR. However, when a GP is visiting a resident, they may choose to amend the MAR to reflect any changes they have made to the medication.
3. Poor records are a potential cause of preventable drug errors. It is best practice to use printed or eMARs. However, there will be occasions when hand-written MARs are necessary, for example, when new items are prescribed mid-cycle, on discharge from hospital or when Topical Medication Application Records (TMARs) are in use. Handwritten amendments should be kept to a minimum because of the risk of:
   - Incorrectly transcribing the details from another document.
   - Handwriting which may be difficult to read or may be misinterpreted.
   - Where handwriting is necessary, ensure there is a robust system in place for the new pMAR to be checked for accuracy by a second trained member of staff before it is used.
4. Only staff that are trained and accredited should amend a MAR. The care home should have a system in place to check the source and accuracy of any changes. The information for any amendments should be taken from written information whenever possible and a cross reference to the resident's care plan made, including the name of the prescriber who made the change.
5. When making handwritten entries the pMAR should be **amended**, ensuring the original details can still be read for completeness and audit purposes:
   - Write clearly and in black ink.
   - Write **'Stopped'** or **'Amended'** against the name of the original item, sign and date this comment and cross through any remaining days on the current pMAR.
   - On a new line, write full details of the new or amended item including name of the drug, dose and quantity. Date and sign the entry. Ensure a second check and signature.
6. Where a new pMAR is issued for a new medication it must be filed immediately with the current pMAR, to avoid it being overlooked or misplaced.
7. When a medication is **discontinued** it should be removed from the MAR:
   - Confirm with the resident's GP and document in the resident's care plan.
   - Write **'Stopped'** clearly against the name of the item and cross through any remaining days on the current MAR. Sign and date the amendment, ensure a second check and signature.
   - Ensure that you inform the pharmacy, so the item is removed from future MARs.

8. When medication is administered by a community nurse or other external healthcare professional (HCP), it is important for the care home staff to make a record on the MAR so that it is clear that the medication has been given. On the pMAR use the code for 'see back of chart'. On the reverse, record full details of the medication that has been administered and by whom; the visiting HCP will complete their own MAR.
9. Record on the MAR if a resident is admitted to hospital. It is very important to send a copy of the current MAR to the hospital with the resident.

'When required' (PRN) medication

1. Medicines prescribed for use 'when required' might not be ordered every month.
2. Liaise with the pharmacy to ensure all current medicines are printed on the MAR, including those not ordered that month.
3. Ensure that any supplementary information is on (or with) the MAR or in the resident's care plan.

Extra information for people using eMARs

1. Login details must never be shared.
2. The person who is logged into the eMAR must be the person administering the medication to the resident.
3. Where care homes are using eMARs, we recommend that only eMARs are used and not a mix of paper and electronic records, to reduce the risk of a patient having both versions and medication being missed.
4. Amendments should be made according to the system's protocols. Procedures must always be cross-referenced.

MAR chart audit

Complete the MAR chart audit every **one** to **two** months to identify whether your MARs meet the required standards. MARs form an essential element in determining whether people who use social care have been given medication as the prescriber instructed. Consider:

✓ Is the resident's name clearly identified?	✓ pMAR: Is the printing or handwriting legible and in ink?
✓ Are there gaps in the records? If so, investigate these further	✓ Does the MAR show the date, including the year?
✓ Is there a guide to explain the codes used for any medication which has not been given, as well as any additional information where appropriate?	✓ Can the reader clearly identify exactly what has been given on specified dates, for example if the dose administered was one or two tablets?
✓ Can you cross reference records for controlled drugs on both the MAR and in the CD register?	✓ Is there sufficient information to enable care workers to give 'when required' (PRN) medication safely?
✓ Are staff additions/amendments cross referenced with daily notes/ the resident's care plan?	✓ Can you confirm that the records are valid, for example by checking whether the number of signatures recorded for the administration of an antibiotic are consistent with the quantity left?
✓ Does the chart look 'in use', is there an indication that it was completed at each medication administration?	

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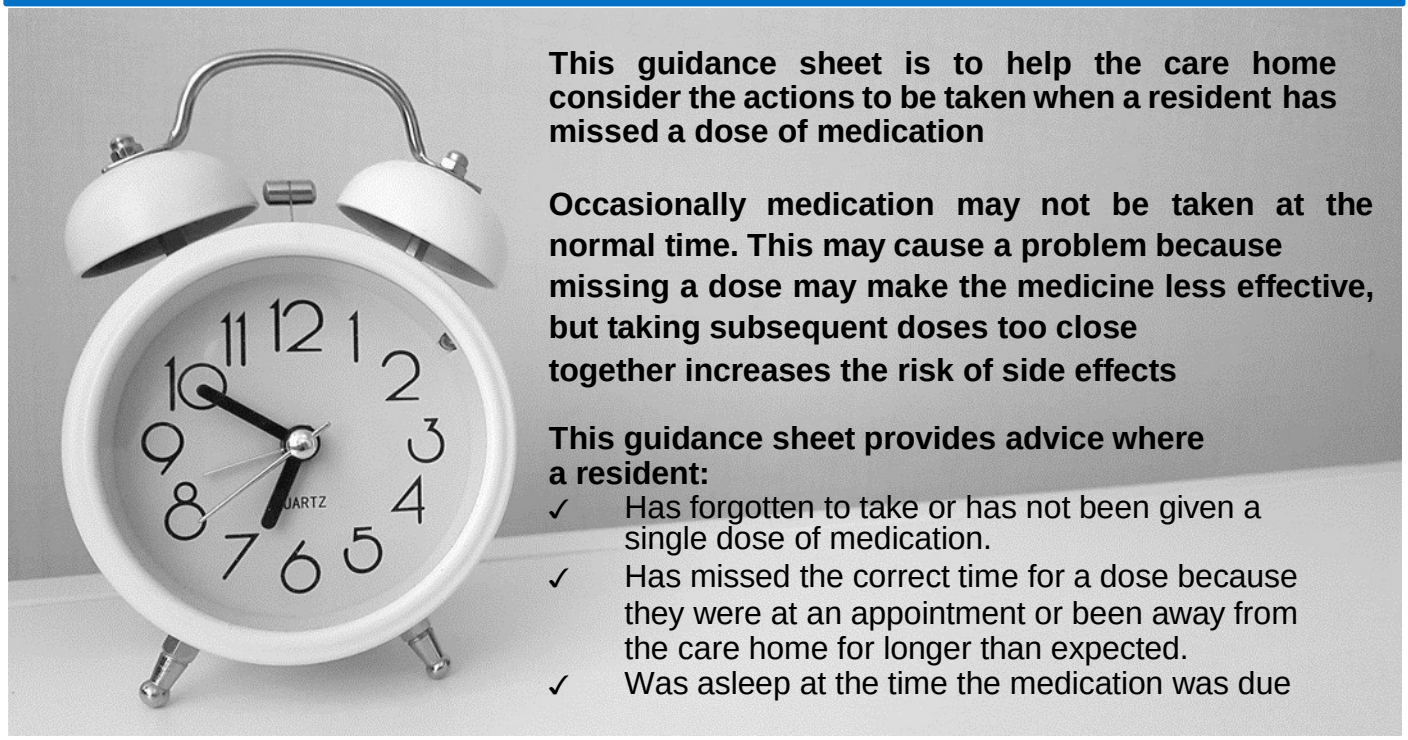
Missed Doses of Medication



This guidance sheet is to help the care home consider the actions to be taken when a resident has missed a dose of medication

Occasionally medication may not be taken at the normal time. This may cause a problem because missing a dose may make the medicine less effective, but taking subsequent doses too close together increases the risk of side effects

This guidance sheet provides advice where a resident:

- ✓ Has forgotten to take or has not been given a single dose of medication.
- ✓ Has missed the correct time for a dose because they were at an appointment or been away from the care home for longer than expected.
- ✓ Was asleep at the time the medication was due

This guidance **does not** cover a resident who:

- ✓ Does not wish to take their medication
- ✓ Has vomited their medication
- ✓ Regularly misses doses of their medication

There is no situation where the next dose should be doubled if one is missed. This could be harmful.

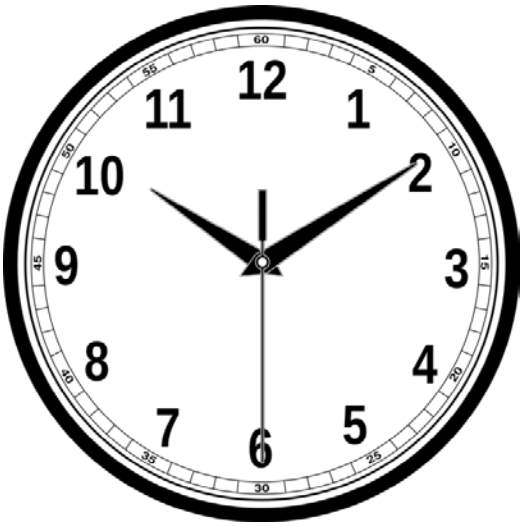
Action to take following a missed dose:

- First, look at the Patient Information Leaflet (PIL) supplied with the medicine. PILs usually contain specific advice about missed doses. Where you do not have a paper copy, the majority can be viewed online in the electronic Medicines Compendium: www.medicines.org.uk/emc.
- The Medicines Healthcare and Products Regulatory Agency (MHRA) website lists all PILs for medicines licensed in the UK at www.gov.uk/pil-spc. Only use the rest of this guidance sheet if you cannot find a PIL, or if the advice in the PIL does not adequately cover the situation you are dealing with.
- As a general rule, for all oral medicines it is usually acceptable to take a single dose up to 2 hours late. In these circumstances, any warnings about taking before or after meals can usually be ignored as it is more important to take the dose.
- If the dose is more than 2 hours late, for medicines taken once or twice each day, the resident can usually take the dose as soon as they remember, as long as the next dose is not due within a few hours. The resident should then continue as normal. The definition of a “few hours” will vary with each situation. Seek further advice if you are not sure what this means in the situation you are dealing with.

- If the dose is more than 2 hours late for medicines taken more frequently than twice a day, it is usually advised to omit the missed dose, wait until the next dose is due, then continue as normal. For example, this advice would apply to an antibiotic or painkiller taken four times per day.
- If you are unable to find the information you need and you are in doubt, always contact the pharmacist or GP for advice, particularly if more than one day of treatment has been missed. Record any advice you are given.
- Record on the MAR chart where a medication was missed and the reason. If it was given at a different time, ensure this is clearly documented so that the appropriate time interval can be maintained between subsequent dosing.

Specific medication:

Epilepsy medicines: it is important for residents with epilepsy to take their anticonvulsant medicines regularly. Missing a dose could trigger a convulsion. For medicines taken once a day the dose should be taken as soon as they remember unless, the next dose is due within a few hours.



For medicines taken twice a day, the dose should be taken only if within six hours of when the dose was due.
In both cases the next dose should be taken at the normal time. If taking more than twice a day wait until the next dose is due. Residents who miss doses should avoid activities where having a convulsion could be dangerous.

Warfarin: warfarin should be taken as a single dose at the same time each day. There is conflicting advice on how to manage missed doses and advice offered in the manufacturers' Patient Information Leaflet (PIL) varies.

Our advice (based on specialist opinion) is that a missed dose may be taken if it is up to 12 hours late, but if more than 12 hours late, patients should not take it and take their next dose at the normal time.

If a dose is not taken, make a note in the warfarin booklet and remember to tell the doctor at the next blood test appointment.

If you are worried, contact the anticoagulant clinic or the GP for advice on any increased monitoring requirements.

Direct Oral Anticoagulants (DOACs), Non-vitamin K antagonist other oral anticoagulants: Missing or delaying doses of this group of drugs can lead to a reduction in anticoagulant effect. Contact the pharmacist or healthcare professional for advice about taking the next dose. Ensure the GP is informed about the missed doses.

Examples of DOAC's: Apixaban, rivaroxaban, edoxaban and dabigatran

Insulin: patients with diabetes (type 1 or type 2) will be at risk of hyperglycemia and possibly ketoacidosis if they miss insulin doses.
It is advisable to ask for specific instructions in advance from their diabetes nurse/clinic or GP for this scenario. Residents should have their blood sugar checked, and you may also need to test their urine for ketones, particularly if they have any symptoms. If in any doubt always seek advice from the resident's GP or diabetes nurse.

Methotrexate once weekly: If a dose is missed, it can be taken as soon as it is remembered, if this is within two days. However, if the dose has been missed for more than two days then a GP's advice should be sought. A double dose should not be taken to make up for a missed dose.

Immune therapy and cancer drugs: You should seek the advice of a GP in respect of a missed dose of transplant rejection or cancer medicine.

Bisphosphonates (e.g. alendronic acid, risedronate): Bisphosphonates have strict dosing instructions and must be taken first thing in the For weekly bisphosphonates (alendronic acid or risedronate), the tablet should be taken on the first morning after you realise the dose had been missed and then resume taking it on the original day of the week. If the dose has been missed for more than two days then a GP's advice should be sought. Do not take two tablets on one day. For monthly dosing (e.g. ibandronic acid), if the next dose is MORE than 7 days away, take the missed dose the morning you remember, then resume your normal schedule. If the dose is LESS than 6 days away, wait until the next scheduled dose.

Medicines for Parkinson's disease: stopping antiparkinsonian medicines suddenly can lead to loss of control of symptoms. Care plans should show how people with Parkinson's disease will receive their medicines at the prescribed intervals. If a dose is missed, the MAR must show this. Staff should be able to explain what action they took, and the person's GP should be contacted.

Other Points:

- It is important to review each individual case and identify the reason for the missed dose.
- Is the resident's routine (e.g. asleep prior to night time medication round) leading to a dose being missed regularly? If so, ask the GP to review the medication.
- Are there other reasons where the resident's routine is not conducive to their drug regime? If so, consider asking the GP to review the resident and their medication.
- Was there an issue with the home's policies or procedures that contributed to the missed dose?

Refused medication:

Residents should never be forced to take medicines against their will and no medicine should be used as a means of punishment or social control. Most refusals are attributable to physical problems or to fears and anxieties that can be resolved by expressions of care and concern. Seek advice from the community pharmacist or GP in the event of refusal due to inability to swallow a solid dose. Alternative forms of medicines may be available which may be easier for the resident.

If a medicine is refused, this should be recorded on the MAR and the GP informed in a timely manner. For medicines where compliance with the dosage and frequency are critical to the resident's wellbeing, the GP should be contacted after the first dose is refused (e.g. epilepsy medication). Any advice given by the GP should be documented.

Adapted from: UKMi Medicines Q&As: What should patients do if they miss a dose of their medicine? 2017. Accessed: 25th July 2019.

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Administration Dilemmas

It is very important that medicines are taken exactly as instructed to ensure that they work as intended. If instructions are not accurately followed, the medication may interact with another medication, and may cause side effects or even cause the condition to deteriorate. The advice below will help you to understand the importance of these warnings.

Medicines and Food

- **Before food or on an empty stomach**
  Some medicines should be taken before food or on an empty stomach. This means an hour before, or two hours after, eating food. If these instructions are not accurately followed and there is food in the stomach, the medicine will not be absorbed into the bloodstream and may not work properly.

- **Take with or after food**
  Some medicines should be taken with food or immediately after eating. The main reasons why medicines may need to be taken with or after food are:
  Some medicines may cause nausea or vomiting.
  Some medicines are irritants and may cause symptoms of indigestion.
  Medicines to treat conditions in the mouth or throat may need to be taken after eating as they can get washed away quickly during food consumption and the medicine may not work.
  Some medicines are absorbed better if there is food in the stomach.

It is therefore very important that care home staff are aware of these warnings and that administration times are altered accordingly.

Crushing tablets or opening capsules

Care homes should never attempt to crush a tablet or open a capsule without seeking advice from a relevant healthcare practitioner and ensuring that the prescriber is made aware that this will be happening. How to administer the medication should be clearly recorded in the patient's medication plan. A person administering crushed tablets or opened capsules to a resident, without directions from the prescriber and without making the appropriate checks, could be held liable for any harm caused.

Situations do arise where a resident is unable to swallow or has a percutaneous endoscopic gastrostomy tube (PEG). In these cases, the prescriber will decide the best possible action to be taken. Options may include:

- Temporarily or permanently stopping a medication
- Replacing a medicine with an alternative
- Investigating if a different formulation such as a liquid or a chewable tablet is available
- Crushing tablets or opening capsules may be advised (the resident must be aware of this at administration)

There are some tablets or capsules that must never be crushed or opened. These include:

- **Modified release preparations**
  crushing will affect how the drug is released
- **Enteric coated**
  the special coating no longer provides protection
- **Hormone, steroid, antibiotic or chemotherapy medicines**
  due to risk of inhalation by the person crushing

In the majority of cases a liquid medicine will be available. However, these are often unlicensed products and will need to be specially manufactured. This can be very expensive (usually over £100 a bottle) and often products do not have a long shelf life, so it is important that the most appropriate formulation is considered.

Alcohol

Alcohol can interact with prescription medicines to produce unexpected results such as drowsiness, dizziness, weakness, and decreased coordination. This can increase the risk of falls. Alcohol may also increase or decrease the effectiveness of a medication by changing the way it is processed by the liver.

Missed doses

Missing a dose of medication may make the medicine less effective but taking doses too close together could increase the risk of side effects.

Delayed doses

If a dose is delayed by a short period of time then it may still be appropriate to administer the dose having checked with a relevant healthcare practitioner .

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‘When Required’/PRN Medication

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’ or PRN medicines is included in the care home medicines policy.

Clear and specific instructions

It is important care homes are provided with clear and precise instructions to ensure ‘when required’ or 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 PRN medicines should be recorded in the resident’s care plan including:

- A clear treatment and outcome plan (consider using attached template).
- What the medication is being used for.
- When and how to record usage on the MAR chart.
- Symptoms to look out for and when to offer.
- Whether the 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, and in which order they should be tried (e.g. *“paracetamol first, then codeine if pain not resolved…”).*

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 or 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 and night 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).
- 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 cycle 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 disposed of as detailed in your policy; depending on your circumstances, this means returning them to the pharmacy for destruction, or using a licensed waste disposal company.
- Care homes should ensure the 'Homely Remedy' list is utilised, as it is not always necessary to request a prescription for treatments requiring less than 48 hours.

Administration

A system should be in place to highlight to care home staff 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.
- Offer the medication to the person when they are experiencing symptoms. Do not limit the offers to the medicines rounds, or the time of the medication round printed on the MAR.
- Make a record of the exact time and the amount of medicine given.
- Staff should be fully aware of the quantity to be given, the interval between doses and the maximum daily quantity allowed.
- 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.
- If staff are unsure of the quantity to administer, contact the GP for clarification.
- Consideration should be given to residents who may not have the capacity to refuse medication offered.
- Provide decision-making aids such as 'the universal pain assessment chart' to assist residents in describing their current symptoms.

Medication Administration Record (MAR)

MAR charts should provide a clear and accurate audit trail of PRN medicines. The resident's care plan should detail when and what to record on the MAR chart. For example, glyceryl trinitrate spray is used variably, for chest pain in angina. You might record this only when needed. Another example is pain relief that you assess at each medicines round. You might record this each time you assess it, or you might only record this when it's given. The following details should be recorded:

- Number of tablets or dose administered, especially where there is a varying dose (e.g. 1- 2 tablets).
- Date and exact time of administration, enabling care home staff to decide if the appropriate time period has passed before administering the next dose.
- Where possible, the amount of PRN medicine remaining, to make sure there is enough in stock and to reduce waste.
- The administration of all medication should be recorded on the MAR chart immediately to prevent an incident or accidental overdose from occurring.

Monitoring

When a PRN medication is in use, the resident should be monitored and reviewed regularly to ensure it is still appropriate. Observations can be recorded on the 'When Required (PRN) Medication Outcome Record'. 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 resident's Patient Information Leaflet (PIL).
- 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.

‘When Required’ (PRN) Medication Plan

The following information must be referred to when offering or administering PRN medication (prescribed or over the counter) for the individual concerned. This information must be held in the MAR folder, at the back of each resident’s MAR sheets for reference. The expected response to therapy should be stated in the resident’s clinical notes.

Resident name:

Date of birth:

Name of medication and form:

When to record on MAR chart:

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 an 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 and when, expected outcome etc.*

Any additional comments/information:

Date:

Name of person completing this information:

Review date:

Date review completed and name:

‘When Required’ (PRN) Medication Outcome Record

When a PRN medication is in use, the resident should be monitored and reviewed regularly to ensure that the medication is still providing the most appropriate treatment. Observations, for example, any side effects, change in resident’s condition, noticeable benefits or frequency of requests for more, should be recorded in the chart below. This can be used for reference when medication is being reviewed by the GP or when a new PRN medication is started.

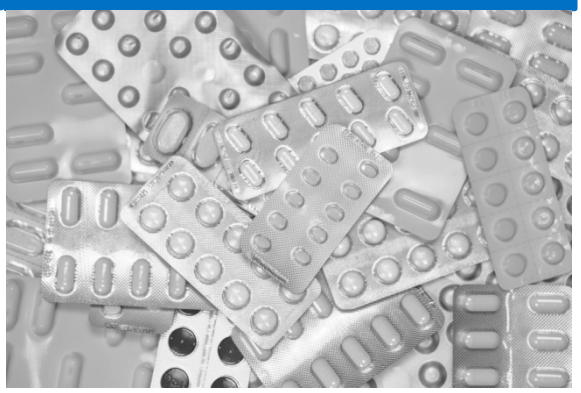
Name of medication	Dose	Indication

Date	Time of administration	Dose	Reason medication given	Time monitored	Outcome
e.g. 01/01/2018	*e.g. 08:00*	*e.g. 2 x 500g tablets*	*e.g. Back pain*	*e.g. 12:30*	*e.g. Improved, but some discomfort. Still in bed, will mobilise.*

Caring for CareHomes

NHS

Storage and expiry dates



Medicines should be stored in a way that means they are safe and will be effective when administered. All medicines have expiry and storage requirements that are specified by the manufacturer.

The **expiry date** of a drug is the point in time when a medication is no longer within an acceptable condition to be considered effective.

All medicines will have **storage** requirements that are specified by the manufacturer and are included on their Patient Information Leaflet (PIL). It is important these requirements are met to ensure that the medicines remain effective and safe to use.

Key points for storage

- Keep all medication in the original container in which they were dispensed.
- Keep medicines in original outer packaging, to protect from sunlight.
- Medicines should be stored in a cool (below 25°C) dry place unless refrigeration is required (between 2°C and 8°C
- Store all medication as recommended by the manufacturer.
- It is recommended good practice to check and record the temperature of storage locations at least once a week, and more frequently if high or low temperature is suspected.
- If you suspect that a medication has been stored outside of the specified temperature range, contact your community pharmacist as soon as possible for advice.
- Medications stored under the responsibility of staff must be stored in a locked designated room or area only accessible to authorised care home staff. This also includes access to the keys or keycode.
- Residents who have their own medication and self-administer should store the medication as identified in their risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Medicines can be kept on their person if this does not place other residents at risk.

Storing medication

- It is important to note and act on any specific storage instructions, e.g. fridge items, controlled drugs.
- Emergency medicines should be stored safely and securely, though in a manner that means they can be accessed quickly when needed.
- Rotate stock so the earliest expiry is at the front and therefore will be used first.
- Surplus stock should be stored in a cupboard big enough to allow individual residents' medication to be grouped together.
- Set up a monthly reminder or system to check all expiry dates.
- Any external medication should be kept in a separate locked cupboard or shelf, or in the resident's own room (in a securely locked place).

Expiry after opening

- Certain preparations have a shorter shelf life once they have been opened, e.g. Dipyridamole Modified Release (MR) capsules, some liquids, eye drops, ointments and creams.
- The date opened should be written on the label or container and the 'use by date' calculated. If appropriate this can be recorded on the separate Topical Medication Application Record Sheet.
- Your community pharmacy may be able supply 'date opened' labels to attach to these medicines.

Examples of different wording of expiry dates:

Wording on packaging	Definition
Use before end of January 2020	Discard 31st January 2020
Use by January 2020	Discard 31st January 2020
Discard after January 2020	Discard 31st January 2020
Expires January 2020	Discard 31st January 2020
Use within one month of opening	Self-explanatory
Discard 7 days after opening	Self-explanatory

Table of suggested expiry of products from date of opening

Formulation and packing	Suggested 'use by date' after opening, unless otherwise stated by manufacturer, and still within manufacturer's expiry date	Rationale
Tablets and capsules in Monitored Dosage System (MDS)	As per expiry date on label or eight weeks from date on dispensing label	Check with your pharmacist or dispensary if you have any questions about this
Tablets, capsules and liquids decanted into pharmacy bottle	Seek community pharmacy or dispensary advice if not stated on dispensing label	Dependent on stability of product
Part pack of tablets and capsules remaining in manufacturer's blister pack dispensed in pharmacy box or in original pack	Manufacturer's expiry on blister. If no expiry visible, contact community pharmacy or dispensary for advice	Closed container, contents not openly exposed to environment. If no visible expiry, there is a risk that product may have expired
Oral liquids in original container	Six months unless otherwise specified by manufacturer, remember to mark date of opening on container	Exposure of liquid to environment when dose is measured can introduce contamination
Eye, ear, nose drops and ointments	One month, unless otherwise stated by manufacturer	Manufacturer's recommendation
Inhalers	Manufacturer's expiry	Closed container, contents not openly exposed to environment
Insulin	Four weeks for insulin vials and pens unless otherwise stated	The sterile seal has been broken and may be stored outside the fridge

Important: Any product whose appearance suggests it may be unfit for use should be discarded irrespective of expiry date.
If there is any doubt, contact the community pharmacy or dispensary for advice. Be aware of the expiry date of PRN medications (when required), especially if they are not used frequently.

Monitored Dose Systems (MDS)

It is recommended that medicines dispensed in a MDS are discarded after 8 weeks, unless otherwise specified. Please note that not all medicines are suitable for inclusion in MDS, for example:

- There is stability data available which indicates that the medication is not suitable for inclusion in MDS, e.g. Sodium Valproate.
- Medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate
- Medicines that are sensitive to moisture, e.g. effervescent tablets
- Light sensitive medicines, e.g. chlorpromazine
- Medicines where the dose may vary depending on test results, e.g. warfarin
- When required (PRN) medicines that are not taken regularly

Effects of using expired stock

- The active drug becomes chemically unstable
- The effectiveness of the drug may change
- The breakdown of the drug may be toxic and harmful to the resident
- Increased risk of contamination

Disposing of medication

Medicines do not have to be (should not automatically be) discarded at the end of every monthly cycle. To prevent waste, before disposing of medicines, care home staff should check:

- Is the medicine still prescribed for the resident?
- Is it still within its' expiry date?
- If the container has been opened, is it still within its 'use by date'?

If the answer is 'yes' to all these questions, then the medication can continue to be used.

Caring for Care Homes

Controlled Drugs

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These are called Controlled Drugs (CDs). Unlike other prescribed medicines, CDs have additional safety and legal requirements for their prescribing, supply, receipt, storage, administration and disposal. These additional safety and legal requirements need to be acknowledged in the Care Home's Medicines Policy. The following points should be taken into consideration.

Receipt

- To allow for an audit trail, CDs should be signed for on receipt.
- If CDs are delivered, they should be clearly marked and separated from other medication by the supplier.
- CDs should be checked on receipt. If there is any discrepancy between the product and the label, or what was ordered, and the CD received, there should be a documented procedure for handling such an occurrence.
- Receipt of Schedule 2 CDs and those laid out in the Care Home's Medicines Policy should be recorded in the Controlled Drug Register (CDR).

Storage

- A CD cabinet must be made of steel, have a specified locking mechanism and be permanently fixed to a solid wall or floor with at least two rag-bolts (Safe Custody Regulations: www.legislation.gov.uk/uksi/1973/798/made).
- CD cabinets should only be used for the storage of CDs and no other medication or valuables should be stored in the cabinet
- If a CD is provided within a Monitored Dosage System (MDS), the MDS should be stored in the CD cabinet.
- Access to the CD cabinet should be controlled. The CD cabinet keys should be kept under the control of a designated person and there should be a clear audit trail of the holders of the keys.

Controlled Drugs Register (CDR)

- A CDR is a bound book with pages clearly numbered and should not be used for any other purpose. It must be kept in a secure place when not in use. Electronic CDRs are permitted, though are subject to specific legislation (www.opsi.gov.uk/si/si2005/20052864.htm).
- Administration of a CD by staff should be recorded on the Medicines Administration Record (MAR) and the CDR.
- The CDR should be used to record the receipt, administration, disposal and transfer (e.g. when a patient goes into hospital) of CDs and a running balance should be kept.
- As best practice, all entries in the CDR should be signed and then (where possible checked and countersigned by an appropriately trained witness.

- Errors must not be crossed out. Errors should be marked as “entered in error” signed, witnessed and dated. The correct entry should then be made using a new line.
- On receipt of a CD, the date, quantity and where it came from should be entered into the CDR and initialed by the receiving authorised member of staff, with a second person as a witness. The correct balance should be verified each time.
- Each drug, for each resident should be recorded on a separate page, with the name, form, dose and strength of the drug written clearly at the top of the page.
- Following administration of a CD, the resident’s name, plus time and dose given, should be recorded in the CDR and the running balance verified.
- When transferring the drug record to a new page in the CDR the amount remaining should be identified with ‘carried forward from page x’ written clearly on the new page.
- When CDs are sent for disposal (residential care home) a record must be made in the CDR and in the returns book. In the case of nursing homes CDs remain written in the register until destroyed.
- When CDs are returned to a person leaving the home a record must be made in the CDR.
- Routine checks of all CDs held, and the recorded running balances should be carried out
- by two authorised members of staff, on a regular basis (eg weekly). Any discrepancies should be reported to the manager immediately.
- It is a legal requirement to keep the CDR for two years from the last entry or 7 years if it contains records of destruction. It is good practice to retain the CDR for longer as cases can take several years to come to light and go to court.

Medication Administration Record (MAR)

- Following administration of a CD, the MAR chart must be signed by the authorised person administering the CD and by the person witnessing the administration, who must have the appropriate level of training.
- If the medication is administered by a visiting healthcare professional, the care home staff should ask them to complete the appropriate section of the CDR. The visiting healthcare professional will complete their own administration records. Care homes should keep a record of who is administering the medication (this could be on the MAR chart or in the care plan).

Service users managing their own medication

- A risk assessment should take place and be regularly reviewed for residents who wish to manage their own medication, in case a resident’s circumstances change.
- Where a resident is wholly responsible for their medicines (i.e. requesting and collecting the CDs personally), no record is required in the CDR.
- If staff are ordering and collecting on behalf of the resident then a record of the receipt from the pharmacy, the supply to the person and any disposal should be made. Individual doses do not need to be recorded.
- CDs should be stored in a locked, non-portable receptacle in the resident’s room.

Disposal – care homes with nursing

- The care home must have a valid T28 Exemption from the Environment Agency to allow denaturing to take place on the premises. To obtain a T28 Exemption online visit wasteexemptions.service.gov.uk or for more information contact enquiries@environment-agency.gov.uk or telephone: 03708 506 506.
- CDs should be denatured using a specially designed denaturing kit by a registered nurse in the presence of a witness, before being handed to the waste disposal company.
- A record of the disposal must be made in the CDR and must be signed and witnessed by the authorised members of staff undertaking the task.

Disposal – care homes without nursing

- CDs should be returned to a pharmacy or dispensing doctor for destruction.
- CDs to be returned to the pharmacy or dispensing doctor must be entered out of the CDR and a signing sheet or returns book prepared.
- The pharmacy should sign for the CDs on receipt and this record should be retained by the care home.

Discrepancies - supply

- Always enter the stock received in the CDR.
- Segregate the stock received in the CD cabinet until the discrepancy can be resolved.
- Contact the supplier of the CD to resolve the discrepancy.
- If stock is deemed unfit for use and is picked up by the supplier, obtain a signed receipt.

Discrepancies - running balance

- Check back over the CDR entries to ensure that there has not been a calculation error or missed entry.
- Check the MAR chart and records of medicine disposal.
- If the discrepancy can be identified, the outcome should be recorded and the CD register should be corrected, with a retrospective entry referencing how the discrepancy was resolved.
- If the discrepancy cannot be explained then the Care Quality Commission (CQC), the Area Team Controlled Drugs Accountable Officer and the Police should be informed.

CD incident reporting

There is a legal requirement for Care Homes to report all CD-related incidents in a timely manner to the local NHS England Accountable Officer for Controlled Drugs.

- From 1st October 2018, all CD incidents (including balance discrepancies) should be reported using the web-based system www.cdreporting.co.uk (registration required).

Although the immediate concern upon discovery of a CD incident is for service user safety, and this takes priority, incidents should be reported as soon as possible thereafter. There should be robust processes in place to identify, report and review incidents, errors and near misses.

Please see overleaf a table of the common Controlled Drugs, which has been taken from PrescQIPP Bulletin 75 (December 2014) and updated from Medicines Complete BNF (May 2019).

Acknowledgement to NHS Devon CCG

Common Controlled Drugs

Schedule 2 CDs		
Controlled drug	**Brand name**	**Legal requirements**
Morphine	MST Contlnus® Sevredol® Zomorph® MXL® Oramorph® concentrated oral solution 100mg/5ml (10mg/5ml strength is not a CD, however, some care homes may choose to store it in a CD cabinet and complete CD records)	Requires safe custody in a CD cabinet. Records need to be made in the CD Register.
Diamorphine	-	
Dexamphetamine	Amfexa®	
Pethidine	-	
Oxycodone	Shortec®, Longtec®, Oxycontin®,Oxynorm®	
Methadone	Physeptone®	
Methylphenidate	Ritalin®, Equasym®, Xenidate®, Concerta®	
Fentanyl	Durogesic DTrans®, Mezolar®, Matrifen®, Abstral®, Effentora®	
Tapentadol	Palexia®	
Schedule 3 CDs		
Buprenorphine	Subutex®, Temgesic® tablets	Safe custody in CD cabinet is required with some exceptions (common exemptions are phenobarbital, midazolam and tramadol, pregabalin and gabapentin). Schedule 3 CDs do not need to be recorded in the CD register, however, some homes may choose to make records for buprenorphine and temazepam.
	BuTrans®, Butec®, Bupeaze®, Transtec® patches	
Midazolam	Hypnovel® injection	
	Buccolam® oromucosal solution	
Temazepam	-	
Phenobarbital	-	
Tramadol	Zydol®, Marol®, Zamadol®	
Pregabalin	Lyrica®	
Gabapentin	Neurontin®	
Schedule 4 CDs		
Diazepam	-	Safe custody is not required nor is it a requirement to make records in the CD Register.
Clobazam	Frisium®	
Lorazepam	-	
Nitrazepam	Mogadon®	
Clonazepam	Rivotril®	
Chlordiazepoxide	Librium®	
Zaleplon	-	
Zolpidem	Stilnoct®	
Zopiclone	Zimovane LS® and Zimovane®	

This list is not exhaustive, therefore care home staff should seek advice, for example from the pharmacist or dispensing doctor, when unsure of the legal requirements for safety custody and recording of a CD.

Caring for Care Homes

How to record and review a significant incident

It is important that all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm are recorded and reviewed to understand and share the learning from them.

Why is it important to record safety incidents?

The recording and review of incidents provides valuable learning to make the NHS safer. Only a small percentage of incidents result in actual harm, but no harm and low harm incidents provide an opportunity to learn and develop strategies to minimise the risk of preventable harms.

What would be considered a safety incident?

A safety incident is any event (positive or negative) which is important or unusual and provides an opportunity to identify an area for learning, improvement or the sharing of good practice. Significant events could relate to clinical, organisational or communication issues or they might be a combination of these. This guidance sheet will focus on incidents related to medicines.

What would be considered a medication incident?

Definition of a medication error[1]: "A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident, or consumer". Please see over the page for examples of scenarios where medication errors can occur.

What actions should be taken after discovering an incident?

1. After discovering an incident, the priority is to ensure the resident is safe. This may require contacting the resident's GP or other healthcare professional.
2. When you are satisfied that the resident is safe consider the following:
   - Could the incident be a safeguarding issue? If so, report to safeguarding through your usual route
   - Did the incident result in a death, an injury, abuse or allegation of abuse, or was it reported to, or investigated by the police? If yes, report to Care Quality Commission and your Local Authority commissioners.
   - Did the incident involve a Controlled Drug? If yes, report to NHS England CD Accountable Officer using the online CD Reporting Tool at: **www.cdreporting.co.uk**
3. Complete details of the incident as soon as possible after the incident. This form should be retained in the care home.

How should I use the form?

1. Details of the incident should be completed as soon as possible.
2. Do not include the names of people involved, the report should be anonymous to allow sharing with the wider team.
3. You should then take time to reflect on what happened and identify what went well and what did not go well and to make appropriate changes to practice. This approach will enable you to concentrate on learning and improving systems and processes to manage risk more effectively.
4. Following a full evaluation, you should use the form to facilitate discussion and reflection at your team meetings to ensure that any learning is shared with the wider team.

The following list gives examples of scenarios where medication errors can occur. Near misses in any of the sections below should also be recorded and then reviewed when appropriate.
The definitions have been divided into sections according to the National Patient Safety Agency (NPSA) Safety in doses: medication safety incidences in the NHS (2007):

Prescribing Errors

- Resident prescribed the wrong medication, dose, route or rate
- Incomplete information e.g. no strength or route specified
- Medication omitted from prescription
- Medication prescribed to the wrong resident
- Transcription errors, this would include errors when hand-writing a Medication Administration Record (MAR) Chart
- Prescribing without taking into account the resident's clinical condition
- Prescribing without taking into account resident's clinical parameters e.g., weight

Pharmacy/Dispensing Doctor Dispensing Errors

- Resident dispensed the wrong medication or dose or route
- Medication dispensed to the wrong resident
- Resident dispensed an out-of-date medicine
- Medication is labelled incorrectly

Preparation and Administration Errors

- Resident administered the wrong medication, dose or route
- Resident administered an out-of-date medicine
- Medication administered to the wrong resident
- Medication omitted without a clinical rationale
- Medication incorrectly prepared
- Unauthorised administration e.g., disguised in food
- Medication administered late or early
- Medication deliberately not administered without good reason
- Administration of medication recorded incorrectly or not recorded

Monitoring Errors

- Resident known to be allergic to medication, but the medication was prescribed and/or dispensed and/or administered
- Failure to provide the resident with correct information regarding their medication e.g. when to take, what it is for, side effects
- Failure to monitor therapeutic levels
- Failure to monitor resident who is undertaking self-medication
- Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell – associated with medication administration

Other Errors

- Poor or inadequate communication
- Poor, inadequate or incorrect recording/documentation
- Inappropriate or inadequate disposal of medicines
- Inappropriate administration of medication to chemically manage a resident's behavior that has not been prescribed or giving additional doses to sedate resident
- Deviation from local policy and guidelines relating to medicines management

Caring for Care Homes

Parkinson's Disease

How common is Parkinson's disease and what causes it?

It's thought around 1 in 350 people are affected by Parkinson's disease. Most people with Parkinson's start to develop symptoms when they are over 50, although around 1 in 20 people with the condition first experience symptoms when they are under 40. Men are slightly more likely to get Parkinson's disease than women.

Parkinson's disease is caused by a loss of nerve cells in a part of the brain called the substantia nigra. This leads to a reduction in a chemical called dopamine in the brain. Dopamine plays a vital role in regulating the movement of the body. A reduction in dopamine is responsible for many of the symptoms of Parkinson's disease. Exactly what causes the loss of nerve cells is unclear. Most experts think that a combination of genetic and environmental factors is responsible.

The effects of Parkinson's disease

The three main symptoms of Parkinson's disease are; tremors (an involuntary shaking of limbs), slow movement and stiff or rigid muscles.

A wide range of other symptoms are often experienced. Some of these include depression, constipation, problems sleeping, memory problems and tiredness. The range and severity of symptoms will vary from person to person. How symptoms affect a person can change from hour to hour and from day to day. Symptoms will also get worse when drugs prescribed for Parkinson's are wearing off and improve again after they are taken. Parkinson's disease is a progressive disease meaning the symptoms will increase over time. This may happen slowly in some people, but much more quickly in others.

Treating Parkinson's disease

Although there's currently no cure for Parkinson's disease, treatments are available to help reduce the main symptoms and maintain quality of life for as long as possible. These include supportive treatments, such as physiotherapy and occupational therapy, medication and, in some cases, brain surgery. People with Parkinson's disease (and their carers) are often experts in their condition. They should be asked about their needs and how they manage their symptoms. If you need more information about the medication a resident is taking then talk to their GP, Specialist, Parkinson's nurse, or pharmacist.

The importance of getting medicine on time in Parkinson's disease

For the vast majority of people with Parkinson's, medication is the only means of controlling their symptoms. If medication is not given in accordance to their routine, this may result in people:

- being unable to swallow (increasing the risk of aspiration)
- being unable to speak and/ or move (increasing their dependence on staff)
- at worst, developing Parkinsonism-hyperpyrexia syndrome (also called neuroleptic-like malignant syndrome), which can be fatal.

Parkinson's medication should not be abruptly withdrawn

People with Parkinson's may be very anxious about getting their drugs on time. The timing of medicines will vary from person to person and should not be altered to fit in with drug rounds.

How to improve medicine optimisation for your resident with Parkinson's disease

- A person with Parkinson's may have a medication diary; make sure you check it. Ask your resident, also their family or carers, how their symptoms change when they need medication.
- Where possible, encourage your resident to look after their own medicines. Support should be offered to allow this to happen.

- An alarm could be obtained if your resident has difficulty remembering when to take their next dose. An alarm may also be helpful for care staff doing the medication rounds.
- It is important to note that it is dangerous to stop medication suddenly. If your resident becomes unwell and cannot manage their medicines, then their GP or Specialist should be contacted as a priority.
- Swallowing problems can become an issue for many people with Parkinson's disease. If these develop then this should be discussed with their GP or Specialist.

Medicines for Parkinson's disease

The BNF's pages on Parkinson's disease, provide useful information on the medications that may be prescribed for your residents.

- There are a wide range of different strengths and formulations available of the various medicines prescribed for Parkinson's. These include standard tablets or capsules, slow release products, dispersible tablets and patches. Some residents may be taking more than one type or strength of these medicines, so it is very important to carefully check the labels to ensure the correct one is being given at the correct time.
- Follow the instructions on the pharmacy label carefully. Do not crush, dissolve, or break capsules or tablets unless specifically stated.
- Some residents may need to take their first dose of medication 30 minutes before they get out of bed to allow them to 'get going'.
- Side effects of medication vary between each person; be aware some people are more sensitive than others.
- Potential problems can include confusion/ hallucinations or compulsive behaviour such as gambling, hyper-sexuality, and risk-taking behaviours. If you notice any change to a resident's behaviour it is important to inform a GP or Parkinson's nurse as soon as possible.
- In some cases, medicines may be prescribed several times a day. The specific times for these should be marked on the resident's MAR chart. It is very important that these times are adhered to, even if they do not match 'normal' drug round times.
- Some residents may have been told by their specialist to take certain medicines (e.g. Madopar® or Sinemet®) 30 minutes before food. This is because these medicines may not work as well if these medicines were taken on a full stomach. It is important to establish if this is the case for your resident.
- Some residents may be prescribed rotigotine patches to help manage their condition. These have specific instructions for application and staff should be aware of these. The patches should be applied to dry, non-irritated skin on torso, thigh or upper arm, and removed after 24 hours. The replacement patch should be applied on a different area, and avoid using the same area for 14 days. It is important that a robust system is in place for recording patch application.
- People with Parkinson's disease are likely to be taking other medications to manage some of the other symptoms related to the effects of the disease. Medications commonly required can include laxatives, pain killers and anti-depressants.

Care planning for residents with Parkinson's disease

It may be helpful to list in the care plan any key points related to medication issues for residents with Parkinson's. Most patients with Parkinson's disease will have had some contact with a Parkinson's disease specialist nurse. These nurses have specialist experience, knowledge and skills that will help you to provide the best care for your resident with Parkinson's disease.

Caring for Care Homes

NHS

Medication and falls

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The impact of falls may include:

- Fractures of the hip, femur, humerus, wrist and rib
- Social/psychological consequences (loss of independence, loss of confidence, limited social and physical activity)
- Soft tissue injuries
- Haematoma
- Transient confusion
- Sudden ageing
- Hospitalisation and immobilisation
- Disability
- Death

Medication and falls: Key information for care home staff

In patients taking medicines known to contribute to falls, medication review can play an important part in falls prevention. The aim of the review should be to modify or withdraw the drug. If this is not possible, close monitoring is required.

Key points

- ✓ Residents who have fallen are at high risk for a repeat fall. The mortality risk from a fall at age 85 is about 1% per fall.
- ✓ Older people (65 years of age or older) may be more 'sensitive' to medications.
- ✓ Residents taking four or more prescription drugs are at an increased risk for falls, regardless of type of drug.
- ✓ Falls may be due to recent medication changes but are often caused by medicines that have been taken for a long time without appropriate review
- ✓ Orthostatic hypotension (sudden drop in blood pressure when they move from a lying down or sitting position to sitting or standing) is often caused by medication and leads to falls in older adults.
- ✓ Residents at high risk of falling (e.g. with recurrent, unexplained or injurious falls) should be considered for specialist referral and multidisciplinary intervention.

In theory any medicine that causes one of the following effects can increase the risk of falling

- **Sedation, drowsiness**
- **Hypoglycaemia**
- **Confusion**
- **Vestibular damage (Tinnitus deafness)**
- **Orthostatic hypotension**
- **Impaired postural stability**
- **Hypothermia**
- **Dehydration**
- **Visual impairment (blurred vision dry eyes)**
- **Drug induced Parkinsonism**

Acknowledgement to NHS Devon CCG

Remember

The more risk factors a resident has, the more likely they are to fall. Medication is only one risk factor; others include:

- ✓ Motor problems
- ✓ Physical problems e.g. not using mobility aids correctly
- ✓ Environmental problems e.g. poor footwear
- ✓ Cognitive problems e.g. poor memory resulting in trying to walk unaided
- ✓ Behavioral problems
- ✓ Cardiovascular problems
- ✓ Neurological problems

Care plans should take resident's falls risk into account. They should be risk-assessed and mitigating action taken to reduce the risk of falls.

Key actions

- ✓ Prompt medication review for any resident who has an acute fall, to identify and review any medicines that may be contributing to their risk of falls.
- ✓ If there are any changes to a resident's mobility, balance, coordination or alertness inform the GP as this increases their risk of falls.
- ✓ To avoid orthostatic hypotension, encourage the resident to:
  - › Avoid sudden postural change, especially when getting up in the morning.
  - › Increase their non–caffeinated fluid intake to more than 2 litres a day (about 3 litres if they weigh more than 75kg) where appropriate, some residents may be on a fluid restricted diet.
  - › Eat several small meals a day.
  - › Drink caffeine on rising and after meals.
  - › Lie propped up at night with a head up tilt of 15°- 20° (pillow height 20cm - 30cm).

Thank you to the **PrescQIPP** website for this information. Further information is available on www.prescqipp.info/

Acknowledgement to NHS Devon CCG

Caring for Care Homes

Inhaler Technique and Respiratory Conditions

When diagnosed with asthma, Chronic Obstructive Pulmonary Disease (COPD) or another respiratory condition, an inhaler may be prescribed. There are many different devices which are prescribed, and it is important the correct inhaler technique is used. The illustrations below show some examples of the different devices currently available:

Metered Dose Inhaler: Breathe in slowly and deeply

Easi-breathe®

Autohaler®

Respimat®

Metered dose inhaler (MDI)

Spacer devices, (used with some MDIs)

Dry Powder Inhaler: Breathe in strongly and deeply

Nexthaler®

Breezhaler®

Turbohaler®

Spiromax®

Genuair®

Easyhaler®

Ellipta®

Zonda®

Problems that residents may experience and what can be done about them

Some residents may have problems with their treatment. This may be due to the drug itself or the type of device that they are using. Commonly experienced problems include:

- Inability to co-ordinate activating an inhaler with inhaling at the right time, thereby 'missing' the dose.
- Sore throat or hoarseness can be caused by inhaled corticosteroids.
- Inhaling too quickly making the spacer device 'whistle'.
- Not loading the device correctly before use, particularly for dry powder inhalers.
- Inhalation strength not strong enough to bring the powder out of the device in dry powder inhalers.

For more information regarding problems which can be experienced with inhaler usage, please see **Appendix One** at the end of this Guidance Sheet.

You can use these resources to help your residents to improve their inhaler technique:

1. **Watch a video** on inhaler technique with a resident to help demonstrate the correct technique, to help get the best outcome possible from their inhalers. The 'Right Breathe' website also has many useful videos, which you can find here.

2. **Discuss** a COPD self-management plan or Asthma action plan with the resident's GP or respiratory nurse.

If you feel that your residents are experiencing difficulties with their inhalers, please seek advice from your community pharmacist, the resident's GP, respiratory nurse or practice pharmacist.

Acknowledgement to NHS Devon CCG

The difference between asthma and COPD

What is asthma? Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness and breathlessness. The severity of these symptoms varies from person to person. Asthma can be controlled well in the majority of people most of the time, although some people may have more recurrent problems.

What is COPD? Chronic Obstructive Pulmonary Disease (COPD) is the name for a collection of lung diseases including chronic bronchitis and emphysema. People with COPD have difficulty breathing in and out; this is known as airways obstruction. The breathing difficulties residents suffer from are caused by long-term damage to the lungs. this is not reversible. The most common cause of this damage is smoking. People with COPD who still smoke should be offered support with stopping.

Symptoms	Asthma	COPD
People under 35 years	Common (often starts in childhood)	Very few
Smoker or ex-smoker	Sometimes	Nearly all
Symptoms caused by an allergy	Sometimes	No
Chronic (long lasting) cough with lots of phlegm	Uncommon	Common
Breathlessness	Variable. Residents can be free of symptoms for long periods	Can be persistent, usually worsens over time
Symptoms causing night time waking	Often	Rarely
Noticeable variation in symptoms between day and night, or from day to day	Common	Uncommon

COPD rescue medication

Residents who have COPD may be prescribed a COPD rescue pack by their GP or respiratory nurse. It is important that care home staff who administer medication are aware of the purpose of these packs, and know when they should be used.

COPD rescue packs should only be started if the resident is having a flare up of their COPD. The individual resident's COPD management plan will detail the symptoms to look out for and the steps you should take. It also details when emergency medical attention is required. If the resident does not have a current COPD management plan, you should contact the resident's GP or respiratory nurse to ask if they could provide one.

COPD rescue packs contain a short course of medications, normally an antibiotic and a steroid. These medications will have been carefully selected for the specific resident and should never be borrowed for use by another resident. Normally COPD rescue packs will be packaged separately from regular medication, have a leaflet advising on how to use appropriately, and will be clearly marked with an expiry date. Care homes should ensure this medication is date checked along with other medications. Out of date medication should be replaced and disposed of as advised in your medication policy.

When the COPD rescue pack has been started, it is extremely important that the GP is contacted as soon as possible to inform them that the medication is in use. Also, a new prescription must be requested to replace the COPD rescue pack.

Acknowledgement to NHS Devon CCG

Appendix One: Problems and Solutions with Inhaler Usage

For videos on how each inhaler should be used correctly go to:

- Right Breathe Website

If you are unsure on which type of device an inhaler is, then please seek advice from your local community or practice pharmacist.

*****_The problems described may not be applicable to every device within the inhaler grouping._

Metered Dose Inhaler (MDI), including Autohalers® and Easibreathe®	
***Problem**	**Tip**
Resident has poor co-ordination and inhaler technique	Consider using a spacer device with the MDI (especially if using a steroid inhaler). Residents can inhale multiple breaths in through the spacer device, so correct timing is less important. (spacers cannot be used with an Autohaler or Easibreathe)
Sore throat/ mouth or hoarseness with steroid inhalers (caused by drug depositing at back of mouth, not in lungs)	
Failing to hold breath for long enough after inhaling	Remind resident about the importance of holding their breath for 10 seconds, or as long as is comfortable. If not possible consider using a spacer device.
Using multiple puffs without waiting in-between, and not shaking inhaler beforehand	Remind the resident to wait 30 seconds and shake inhaler between puffs. Consider using a spacer device.
Breathing in too quickly	Residents may assume they have to breathe in rapidly with this device. A slow and steady breath is required. If the resident cannot manage a slow breath in, a dry powder inhaler could be used instead or an MDI inhaler with a spacer device.
Spacer device makes a whistling noise (if a spacer is used)	Slow down the inhalation. A whistling noise means the inhalation is too fast.

Dry Powder Inhaler (DPI)	
***Problem**	**Tip**
Not breathing in strongly enough to deliver dose	Dry powder inhalers require considerable breath strength to use, if the resident's breathing is weak this could be difficult for the resident. If the inhaler mouthpiece looks gritty when this happens discuss with the GP/ respiratory nurse.
Dose not delivering properly	DPIs must be primed before use. Remind the resident to do this before each inhalation. The inhaler must be kept horizontal and level after loading a dose.
Inhaler has no more doses	Advise resident that there is often a dose counter which should be checked regularly, and a new inhaler should be used once it runs out.
Resident is getting symptoms of oral thrush or irritation in the mouth	This can be a side effect of inhaled corticosteroids. Check resident's inhaler technique and advise resident to rinse mouth after use.
Inhaler cover left open/ off after use	Remind resident to close or replace the cover after using the inhaler.
Resident turns inhaler upside down before inhaling, after loading a dose.	Retrain the resident and advise the resident to ensure the inhaler remains upright after the dose has been loaded.
Capsule placed in the mouthpiece (if the inhaler has capsules).	Do not place the capsule in the mouthpiece. Capsules must only be placed in the capsule chamber to avoid inhaling the capsule and choking.