PrescQIPP Community Interest Company

NHS

NHS Surrey Heartlands ICB

Prescribing, ordering and receiving medicines in care homes

The effective management of medicines in care homes requires robust systems to be in place as well as good communication between the care home provider, residents, prescribers, community pharmacies and GP practices.

This bulletin focuses on the prescribing, ordering and receiving of medicines in care homes, (both residential and nursing care homes). It includes guidance on prescribing and medication review within care homes, the use of electronic medication administration records (eMAR), using the multidisciplinary team effectively, reducing waste and good practice with controlled drugs.

This bulletin is aimed at all healthcare professionals involved in the prescribing and supply of medicines as well as all care home staff responsible for managing medicines.

It should be read alongside the following PrescQIPP resources:

279. Enhanced health in care homes – medicines optimisation. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-279-care-homes-medicine-optimisation/

278. Transfer of Care Around Medicines. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-278-transfer-of-care-around-medicines/.

66. Bulk Prescribing. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-66-care-homes-bulk-prescribing/.

87. Medication and Falls. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-87-care-homes-medication-and-falls/.

72. Homely Remedies. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-72-care-homes-homely-remedies/.

Recommendations for care home providers

- Care home providers should have an up-to-date care home medicines policy that includes written processes covering all aspects related to the prescribing, ordering, receiving, administration and disposal of medicines.
- Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying dispenser.
- Care home providers should ensure that at least two members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff.
- Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

Recommendations for care home providers

- Variable dose and 'when required' medicines can result in a stockpile of medicines and lead to medicines waste if they are ordered every time but not used regularly. It is important that stocks of these medicines are reconciled regularly and ordering adjusted to take this into account, to avoid excessive ordering.
- Where any changes to medications are made, care home staff (registered nurses and social care practitioners working in care homes) should update records of medicines administration to contain accurate information about these changes. This should be done as soon as possible (usually within 24 hours).
- If a change to a resident's medication is made by telephone, this must be supported in writing (e.g. by secure email) before the next dose or first dose is given. Care home staff should also ask that the healthcare professional using remote prescribing changes the prescription.
- An interim prescription or mid-cycle request can be used to ensure there is sufficient medication to complete the current cycle, synchronise to the 28-day cycle and to avoid waste. This may be a request for quantities of medication to complete the cycle as well as a further 28 days' supply to allow a supply for the next medication cycle to be prepared by the community pharmacy or dispending practice at the same time.
- Care home providers should ensure that medicines administration records (paper-based or electronic) include all the required information.
- Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.
- Care home staff must record medicines administration appropriately, including the date and time, on the relevant medicines administration record, as soon as possible.
- For medicines with a separate administration record, care home staff responsible for administering medicines should add a cross reference (for example, 'see warfarin administration record') to the resident's medicines administration record.
- Electronic medicines administration record (eMAR) may be useful, utilising an electronic tablet device instead of sheets of paper, to highlight which medicines are due at that particular time and alert the care home staff if any medicines are missed. This can aid accurate medicines administration, avoid errors and save time.
- Each care home should be supported by a multidisciplinary team (MDT) in its aligned primary care network (PCN) and members of this MDT will deliver the weekly home round. They will be responsible for the development and maintenance of personalised care and support plans (PCSPs) for care home residents and will make every reasonable effort to support delivery of these plans.
- Providers of adult care homes must comply with the Misuse of Drugs Act 1971 and associated regulations when storing controlled drugs.
- Care homes must have a policy or standard operating procedure which details how controlled drugs are managed within the service. This should cover the ordering, receipt, storing, administering, recording and disposal of controlled drugs and what to do if there's a discrepancy (including contact details of anyone who you need to inform).

Recommendations for primary care prescribers

- GP practices should ensure that they have a clear written process for prescribing and issuing prescriptions for their patients who live in care homes.
- Healthcare professionals prescribing variable dose or 'when required' medicines should:
  - Note in the resident's care record the instructions for when and how to take or use the medicine and note any monitoring, such as the effect they expect the medicine to have.
  - Include dosage instructions and reason for the medicine on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label.
  - Prescribe the amount likely to be needed (for example, for 28 days or the expected length of treatment).
  - Liaise with care home staff to see how often the resident has had the medicine and how well it has worked so that any amendments to quantity or dose can be made or medication stopped if not being effective.
- Telephone, video link or online prescribing (remote prescribing) should only be used in exceptional circumstances, e.g. during COVID-19 and should follow appropriate guidance on assessing capacity and obtaining informed consent from residents.
- Healthcare professionals prescribing remotely should:
  - Be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing.
  - Ensure that care home staff understand any instructions given and send written confirmation of the instructions to the care home as soon as possible.
- If a change to a resident's medication is made by telephone, this must be supported in writing (by secure email or fax) before the next dose or first dose is given. The prescription should also be changed. NB. The use of fax machines is being phased out in primary care for NHS and patient communications.
- When changes to medicines are made, wherever possible, the change should be implemented at the next cycle, rather than during a cycle, if the change is not urgent. This will help to avoid waste.
- All information included on the medicines administration record must be up-to-date and accurate. Support should be provided to the care home to facilitate this, as appropriate.
- Where a medicine is administered by a visiting health professional, a record should be kept on the resident's medicines administration record.
- Primary care prescribers should take part in the MDT delivering the weekly home round supporting care homes in their PCN.
- Arrangements should be made for patients who are residents in care homes to have medication reviews as set out in the residents' care plans. A named healthcare professional who is responsible for medication reviews for each resident should be designated.
- Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (the MDT).
- It is good practice for every person admitted to a care home to receive a structured medication review (SMR) alongside their comprehensive geriatric (CGA)-based assessment.

Recommendations for primary care prescribers

- Health and social care practitioners should agree how often each resident should have a multidisciplinary medication review. This should be based on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review. The interval between medication reviews should be no more than one year and are best tied into regular care and support planning reviews.

Recommendations for community pharmacists

- The supplying dispenser should not take responsibility for ordering medicines from the GP practice. This should be done by the care home provider.
- Full dosage instructions (including indication, the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) should be included on the medicine's label for care home residents so that staff know how they are to be used. 'When required' alone is insufficient.
- An interim prescription or mid-cycle request (to ensure there is sufficient medication to complete the current cycle, synchronise to the 28-day cycle and to avoid waste) should be supplied when requested, where appropriate.
- Supplying pharmacies should produce medicines administration records for care home residents wherever possible.
- All information included on the medicines administration record must be up-to-date and accurate and reflect all medicines currently prescribed. Support should be provided to the care home to facilitate this, as appropriate.

National Guidance

NICE published a Social Care Guideline in 2014 that covers good practice for managing medicines in care homes.[1] This includes advice on processes for prescribing and handling medicines and it sets out how care and services relating to medicines should be provided to people living in care homes.[1]

Policy and record keeping

In terms of medicines policy, care home providers should have a care home medicines policy that includes written processes covering all aspects related to the prescribing, ordering, receiving, administration and disposal of medicines.[1] Health and social care practitioners should work together to make sure that everyone involved in a resident's care knows when medicines have been started, stopped or changed. Care Home staff including registered nurses and social care practitioners should update records of medicines administration to contain accurate information about any changes to medicines.[1]

Ordering Medicines

Care home providers should retain responsibility for ordering medicines from the GP practice (with consent) and should not delegate this to the local or supplying community pharmacy or dispensing practice.[1]

Proxy access to the patient's online ordering system via their GP practice may be granted to the care home with consent if this is available.[2] Further information on proxy access for care homes is available at: https://www.england.nhs.uk/ourwork/clinical-policy/ordering-medication-using-proxy-access/

Ordering medicines is an important part of the work of staff in a care home. Medicines belong to individual people living in care homes and must not be shared between residents, even if two of them are

taking the same medicines. It is important that a care home does not run out of a person's medicines and therefore care home providers should ensure that at least two members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff.[1]

GP practices should have a clear written process for prescribing and issuing prescriptions for their patients who live in care homes.[1]

This process should cover:[1]

- Issuing prescriptions according to the patient medical records.
- Recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (the use of the term 'as directed' should be avoided).
- Recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible
- Providing any extra details that the resident and/or care home staff may need about how the medicine should be taken.
- Any tests needed for monitoring.
- Prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future.
- Monitoring and reviewing 'when required' and variable dose medicines.
- Issuing prescriptions when the medicines order is received from the care home.

Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the original order to make sure that all medicines ordered have been prescribed and supplied correctly and that all records are kept up to date.[1]

Prescribing variable dose and 'when required' medicines

When prescribing variable dose and 'when required' medicine(s) it is important that the care home staff administering the medicine know when it is needed and how it should be used. In order to assist with this, the healthcare professional prescribing the medicine should:[1]

- Note in the resident's care record the instructions for:
  - When and how to take or use the medicine (for example, 'when low back pain is troublesome take one tablet')
  - Any monitoring, such as the effect they expect the medicine to have.
- Include dosage instructions on the prescription (including the indication for use, the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label.
- Prescribe the amount likely to be needed (for example, for 28 days or the expected length of treatment).
- Liaise with care home staff to see how often the resident has had the medicine and how well it has worked so that any amendments to quantity or dose can be made or medication stopped if it is not effective.
- Follow local processes for anticipatory medicines to ensure residents in care homes have the same access to anticipatory medicines as those who do not live in care homes.

Variable dose and 'when required' medicines can result in a stockpile of medicines and lead to medicines waste if they are ordered every time but not used regularly. It is important that stocks of these medicines are reconciled regularly and ordering adjusted to take this into account, to avoid excessive ordering.

Remote prescribing

Healthcare professionals prescribing medicines should use telephone, video link or online prescribing (remote prescribing) only in exceptional circumstances, e.g. during COVID-19 and when doing so should:

- Follow guidance set out by the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC) on assessing capacity and obtaining informed consent from residents.[1] The GMC outline ten high level key principles when UK registered healthcare professionals providing remote consultations and prescribing remotely to UK based patients. These include: making patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification checks; understanding how to identify vulnerable patients and take appropriate steps to protect them; and obtaining informed consent and follow relevant mental capacity law and codes of practice.[3]
- Be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing.[1]
- Ensure that care home staff understand any instructions.[1]
- Send written confirmation of the instructions to the care home as soon as possible.[1]

Making changes to medicines

When any changes to medicines are made, wherever possible for example if the change is not urgent, the change should be implemented at the next cycle rather than during a cycle.[2] This will help to avoid waste.[2]

If a change to a resident's medication is made by telephone, this must be supported in writing (by secure email or fax) before the next dose or first dose is given. Care home staff should also ask that the healthcare professional using remote prescribing changes the prescription.[1] NB. The use of fax machines is being phased out in primary care for NHS and patient communications.[4]

Where any changes are made, care home staff (registered nurses and social care practitioners working in care homes) should update records of medicines administration to contain accurate information about these changes.[1] This should be done as soon as possible (usually within 24 hours).[1]

Interim prescriptions (mid-cycle requests)

Most care homes operate a 28 day medication cycle. An interim prescription or mid-cycle request can be used to ensure there is sufficient medication to complete the current cycle, synchronise to the 28 day cycle and to avoid waste.[2]

Mid-cycle requests for unusual quantities may be requested for the following reasons:[2]

- To synchronise medicines to the 28-day cycle.
- For new residents.
- When a new medication is prescribed for the first time, including from hospital or a community provider.
- For medicines which have been dropped, spilled or refused by the resident.
- Where additional quantities are required due to increased usage (e.g. analgesics) or dose increases.

Interim prescriptions should be requested with the next order unless urgent. Care Home staff may request quantities of medication to complete the cycle as well as a further 28 days' supply. This will allow a supply for the next medication cycle to be prepared by the community pharmacy or dispensing practice at the same time.[2]

Medicines administration record (MAR)

Supplying pharmacies should produce medicines administration records, either paper-based or electronic, wherever possible.[1]

Medicine administration records should:[1]

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

Care home providers should ensure that medicines administration records (paper-based or electronic) include:[1]

- The full name, date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident.
- Details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration). Any special instructions for use should also be included.
- Known allergies and reactions to medicines or their ingredients, and the type of reaction experienced.
- When the medicine should be reviewed or monitored (as appropriate).
- Any support the resident may need to carry on taking the medicine (adherence support).
- Any special instructions about how the medicine should be taken (such as before, with or after food).

Care home providers should also ensure that a new, hand-written medicines administration record (MAR) is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home.[1] The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.[1]

All information included on the medicines administration record must be up-to-date and accurate.[1] Care home staff may need support from the healthcare professional prescribing the medicines and the supplying dispenser to do this.[1]

Care home staff must record medicines administration, including the date and time, on the relevant medicines administration record, as soon as possible and ensure that they:[1]

- Make the record only when the resident has taken their prescribed medicine.
- Complete the administration before moving on to the next resident.
- Recognise that mistakes are less likely if one member of staff records administration on the medicines administration record rather than two staff recording.
- Record 'when required' medicines only when they have been given, noting the dose given and the amount left (where possible), to make sure that there is enough in stock and to reduce waste.
- Record when and why medicines have not been given.
- Correct written mistakes with a single line through the mistake followed by the correction and a signature, date and time (correction fluid should not be used).

Where a medicine is administered by a visiting healthcare professional, a record should be kept on the resident's medicines administration record.[1]

For medicines with a separate administration record, care home staff responsible for administering medicines should add a cross reference (for example, 'see warfarin administration record') to the resident's medicines administration record.[1]

Electronic medicines administration record (eMAR)

Several systems are available which provide electronic medicines administration records which are alternatives to paper based MAR charts.

eMAR has a number of features to help improve different areas of medication administration including documentation, reporting, time management, and restocking of medication inventory including:[6]

- Alerts – to ensure that no dosage is missed out.
- Audits – care workers can prepare extensive month-end reporting using eMAR.
- Notes – care workers can prepare notes and record them securely.
- Pharmacy integration – restocking medication inventory is integrated with the supplying pharmacy.

eMAR also utilises an electronic MAR instead of sheets of paper, to highlight which medicines are due at that particular time and alert the care home staff if any medicines are missed. The aim is that this can aid accurate medicines administration and avoid errors.

Similar software is available from other software providers and the following questions should be considered when choosing the most appropriate system:

- Are there potential difficulties adding acute prescriptions from another dispenser who didn't create the original eMAR?
- If care home staff only have read only access to the eMAR, can this cause delays in updating the information relating to medication changes or administering patients own drugs on admission?
- If manual entry is possible, are there are risks of transcribing errors?
- Does the system support third party access (with appropriate governance), to allow other healthcare professionals to access the information?
- Is it possible to select specific times for medicines to be administered or are there only limited options available?
- Does the system allow enough flexibility for 'when required' medicines, including sufficient information to be recorded including the specific dose given?
- Does the system allow enough flexibility for medicines prescribed for a defined course?

Adequate training should be provided to staff who will be using eMAR by the software provider.

Medication review

GPs should ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans.[1] They should also work with other health professionals to identify a named health professional who is responsible for medication reviews for each resident.[1]

Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (MDT).[1]

Health and social care practitioners should agree how often each resident should have a multidisciplinary medication review.[1] They should base this on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review.[1] The frequency of planned medication reviews should be recorded in the resident's care plan.[1]

The interval between medication reviews should be no more than one year and are best tied into regular care and support planning reviews.[1,7]

It is good practice for every person admitted to a care home to receive a structured medication review (SMR) alongside their comprehensive geriatric (CGA)-based assessment.[8]

Best practice includes:[4]

- In a structured medicine review, each medication should be reviewed according to national care homes, structured medication review guidance, and any relevant local prescribing guidance issued by the area prescribing committee.
- Care home providers should be supported to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.
- Agreeing what medicines the person will take after the structured medication review and making sure they can use the medicines as prescribed.

Using the multidisciplinary team (MDT) effectively

The delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs) is included in the Network Contract Directed Enhanced Service (DES) for 2021/2022.

Under the requirements of this DES, the PCN must deliver a weekly 'home round' for the PCN patients who are living in the PCN's aligned care homes and:[7]

- Must prioritise residents for review according to need based on MDT clinical judgement and care home advice (a PCN is not required to deliver a weekly review for all residents).
- Must have consistency of staff in the MDT, save in exceptional circumstances.
- Must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement.
- May use digital technology to support the weekly home round and facilitate the medical input.
- Must aim for a personalised care and support plan (PCSP) to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale).
- Develop plans with the patient and/or their carer.
- Base plans on the principles and domains of a CGA including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life care needs where appropriate.
- Draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and make all reasonable efforts to support delivery of the plan.

Good practice with controlled drugs

Providers of adult care homes must comply with the Misuse of Drugs Act 1971 and associated regulations when storing controlled drugs.[9]

Care homes with nursing can hold stocks of controlled drugs in schedules 3, 4 and 5 without a Home Office licence.[10] This may be the case if several people are receiving end of life care.[10] A controlled drugs licence is needed to hold stocks of controlled drugs in schedule 2 if less than 50% of the care home's funding comes from public funds or charitable donations.[10]

Care homes without nursing must not hold stocks of controlled drugs and can only hold controlled drugs prescribed and dispensed for an individual person.[10]

Care homes must have a policy or standard operating procedure which details how controlled drugs are managed.[10] This should cover the ordering, storing, administering, recording and disposal of controlled drugs and what to do if there's a discrepancy (including contact details of anyone who you need to inform) Staff must make sure ordering processes are robust enough so that people do not run out of these medicines.[10]

It is recommended that care homes keep a running balance of the stock levels of each controlled drug preparation. This makes it much easier to spot and track discrepancies.

For good practice, two staff members should witness and sign when:

- Receiving controlled drugs stock
- Checking stock balances
- Administering controlled drugs and disposing of controlled drugs.[6]

Both staff members involved in the process should be trained and competent to do so.[10]

Appropriate records should be made of controlled drugs that have been administered to residents.[1] The care home staff responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. The staff member administering the controlled drug should also sign the medicines administration record (MAR).[1]

Detailed records should be kept when administering topical controlled drugs, for example, patches.[10] These records should include the site of application and the frequency of rotation of the site.[10]

Any movement of a schedule 2 controlled drug must be recorded in a controlled drugs register, which must:[10]

- Be bound (this may be in the form of a separate bound booklet for each preparation).
- Have separate sections for each class of controlled drugs - within this each formulation and strength should be recorded on a separate page.
- Have the name, form and strength of the drug specified at the top of each page.

Summary

The effective management of medicines in care homes through robust systems and effective communication between everyone involved has the potential to improve patient care and reduce potential medicines-related harms. It also presents the opportunity to streamline processes and reduce waste.

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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-291-prescribing-ordering-and-receiving-medicines-in-care-homes/
Implementation tools	

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