Managing medicines for adults receiving social care in the community

Consultation on draft guideline - Stakeholder comments table

17/10/2016 to 11/11/2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

	Stakeholder	Document	Page No	Line No	**Comments** Please insert each new comment in a new row	**Developer's response** Please respond to each comment
242	Age UK	Short	General	General	Age UK welcomes this guideline as an opportunity to clarify the key steps health and social care professionals can take to help older people with social care support in their own home to manage their medications. A growing number of older people live with multiple long-term conditions and complex needs, and are prescribed a larger number of medicines. They may face practical challenges in managing their medications, especially if they are taking multiple medicines (also called polypharmacy) and may require additional support to do so. We believe much more can be done to enable older people and their carers to improve their experience of, and outcomes from, managing their own medications, including avoiding harm and hospital admissions caused by inappropriate use of medications.	Thank you for your comment.
243	Age UK	Short	General	General	Many of the guideline's recommendations seem to point towards taking positive steps to discuss the person's needs and preferences, taking into account their personal circumstances (particularly on page 4). While the recommendations are most welcome, they do not sit comfortably with the experience many older people have with health and care professionals. Indeed, in research we published with Ipsos MORI (*Understanding the lives of people living with frailty*, 2014) one participant described a medication she was repeatedly prescribed despite telling her GP it didn't work for her. Others we spoke to (*Frailty: Language and Perceptions*, Britain Thinks/Age UK/BGS,2015) described no effort being taken to engage them in decisions, with the result being that they would just do what the doctor told them. These seem to highlight big gaps in how we would want health and care professionals to communicate with older people about their care, including managing their medicines, and discuss their own needs and preferences. Professionals must be trained and supported to communicate sensitively and productively with service users, grounded in the principles of shared decision-making, and working to achieve this should be included as a recommendation – either as a stand-alone recommendation or an additional recommendation within the section on 'Training and competency' on page 19.	Thank you for your comment. The Committee strongly recognised the need for a person-centred approach. Please see also recommendations for shared-decision making in the NICE guideline on medicines optimisation. The Committee also recognised the importance of training and assessment of competency for health and social care practitioners. This is not part of NICE's remit, but we agree that staff training should address the issues highlighted.
244	Age UK	Short	4	9	In light of the above comment, we would suggest amending the sentence 'Many people want to actively participate in their own care' to make it more compelling, as follows: '*Most* people want to actively participate in their own care'.	Thank you for your comment. The current wording is consistent with the NICE guideline on **medicines optimisation** (NG5) and has not been amended. Evidence on shared-decision making indicates that some people do want health professionals to make decisions for them, although people should be given the opportunity to have as much involvement as they would like. The Committee strongly supported a person-centred approach and that helping people to manage their own medicines is preferred.
245	Age UK	Short	4	9-10	We are concerned the phrase 'Enabling and supporting people to manage their medicines is *usually preferred* […]' is not strong enough to convey the importance of health and care professionals taking every step to empower older people to look after their own health and wellbeing. We know that older people often do not feel supported to self-care, particularly those with multiple long-term conditions, including frailty. Our research has found cases where, for example, older people are being asked to do their own blood tests but are not feeling confident/physically able to do so. Among people over 75, 80% with diabetes are not trained to manage their condition; 73% with osteoarthritis are not supported to prevent it getting worse; and access to talking therapies is significantly lower compared to other age groups (Age UK and Exeter Medical School, *Health care quality for an active later life*, 2012).Therefore, supported self-management still remains an untapped resource within our health and social care system, and guidelines must ensure all health and care professionals work towards enabling older people to be in control of their own health and wellbeing. As such, we would suggest replacing '*usually preferred*' with '*an essential part of this*' so that the sentence reads as 'Enabling and supporting people to manage their medicines is *an essential part of this […]*' and thus refers back to the first sentence on involving people in their own care, as self-management is closely linked to patient involvement and shared decision-making.	Thank you for your comment. This wording has been amended to reflect the Committee's strong support for a person-centred approach that allows people to actively participate in their own care. 'Enabling and supporting people to manage their medicines is an essential part of this'.
246	Age UK	Short	11	19-30	The guideline should recognise more explicitly the negative impacts of *inappropriate polypharmacy* and the role that home care workers can play in identifying it and reporting it to the prescriber. A large body of	Thank you for your comment. The Committee recognised the problem of inappropriate polypharmacy, which is

					recent work has shown that the number of older people on multiple medications has accelerated over the past decade. Work commissioned by Age UK and carried out by Exeter Medical School showed that between 2003/4 and 2011/12, people aged 65+ on no medications halved to around 15% while those on five or more doubled to around 30%. The proportion prescribed ten or more drugs increased sharply from 16.4% to 24.6% (Melzer, D., et al, Much more medicine for the oldest old: trends in UK electronic clinical records, *Age and Ageing 2014*). Polypharmacy can be linked to increased prescribing and monitoring errors. For example, the 2012 PRACtICe Study by the General Medical Council found that 30.1% of people receiving five or more medications and 47% of people receiving 10 or more had prescribing or monitoring errors in the 12-month study period (*Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICe Study*, University of Nottingham/GMC, 2012). More specifically, for older people, alongside the risk of drug interactions and side-effects, there are additional risks linked to age-related physiological changes. There is strong evidence to suggest that prescribing more than 8-10 medications provides little therapeutic benefit and is more likely to be causing harm. Older people receiving social care support in the community are likely to be living with multiple long-term conditions and therefore on multiple medications. Through their regular contact with them, home care workers have a key role in raising any concerns around inappropriate polypharmacy. As a result, we would suggest adding a bullet point recommendation 1.6.4 around 'possible inappropriate polypharmacy'.	highlighted in the recommendations on assessing a person's medicines support needs. No evidence in relation to polypharmacy that was specific to the guideline population (adults receiving social care in the community) was identified. Please see also the NICE guidelines on medicines optimisation and multimorbidity. The Committee did not agree that care workers would be in a position to identify inappropriate polypharmacy.
247	Age UK	Short	14-15	20-28 1-21	We are concerned that Section 1.8 – and in particular recommendation 1.8.2 (page 15, lines 1-18) – does not fully illustrate the seriousness of a decision to administer medicine without the consent of the adult, and the fact that it presents a potentially serious interference with the right to respect for private life under Article 8 of the European Convention of Human Rights (ECHR). Specifically, we see the use of 'should' within this recommendation as problematic. Compliance with the Mental Capacity Act is not optional in this matter, therefore both mentions of 'should' on lines 1 and 3 should be changed to 'must'. A failure to comply with the principles of the Mental Capacity Act, in particular the elements around acting in a person's best interests within section 4 of the Act, could lead to a breach of Article 8 ECHR rights and mean that those administering the medication would not have the protection from liability usually afforded by Section 5 of the Mental Capacity Act.	Thank you for your comment. Cover**t administration was further discussed by the Committee in detail and the recommendations have been amended. Further consideration of the circumstances and principles are given in the full guideline.** In addition, a recommendation has been added **that care workers must not give, or make the decision to give, medicines by covert administration, unless there is clear authorisation and instructions to do this in the care plan, in line with the Mental Capacity Act 2005 (recommendation 1.8.2).** The term 'must' is used in the guideline if there is a legal duty to apply a recommendation.
248	Age UK	Short	15	1-21	In addition, and in relation to question 4 of this consultation, we believe the possibility that the use of treatment without consent (covert administration) could contribute to a deprivation of liberty (DOL) in a community setting must be fully considered. As previous court cases have found, DOLs can occur in the community. Although this particular case applied to a care home, District Judge Bellamy noted the following in AG v BMBC & Anor [2016]: *"… I accept that treatment without consent, covert medication in this case, is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the [Mental Capacity] Act and a consideration of the principle of less restriction and how that is to be achieved".* As such, we would like the guideline to fully reflect the legal parameters of any decision to give medicines to people covertly, including the fact that it may constitute a DOL, and to encourage home care providers to fully consider these aspects within their own guidelines.	Thank you for your comment. Covert administration was further discussed by the Committee in detail and the recommendations have been amended. Further consideration of the circumstances and principles are given in the full guideline. It is stated that covert administration by care workers must only take place in the context of existing legal and good practice frameworks.
249	Age UK	Short	14-15	20-28 1-21	In addition to the points raised above, we believe the guideline recommendations should be stronger in their requirement to apply the Mental Capacity Act, due to the very specific nature of a mental capacity act assessment. Someone may be able to consent to taking medication, for example, but lack the mental capacity to make a decision about what form of medicine (liquid, powder, tablet) works for them. They may not like the taste and texture of a tablet and spit it out and home care workers may see this as a refusal of the medication and decide to administer the medicine covertly, rather than looking for an alternative, less restrictive practice around the form of medication given. Conversely, other people may	Thank you for your comment. Covert administration was further discussed by the Committee in detail. The recommendations have been amended to reflect the need for a joint approach across health and social care to ensure that covert administration only takes place in the context of existing legal and good practice frameworks. Further

					have the mental capacity to express a preference about the form of the medicine but not the type of medicine. We would therefore recommend that the guideline sets out very clearly the need to ensure that the Mental Capacity Act is applied to *all* aspects of decisions around taking medication (e.g. why people take it, how people take it, when people take it, etc) to fully ensure that 'best interest' and least restrictive options are implemented.	consideration of the circumstances and principles are given in the full guideline.
250	Age UK	Short	14	22	Given the seriousness of covert administration, including the potential impacts on a person's human rights as well as the legal implications for those providing social care support, we believe that NICE should take steps to clarify what is intended by those 'exceptional circumstances' under which giving medicines to people covertly may be necessary, for example setting out the principles that must be applied, with some examples of exceptional circumstances.	Thank you for your comment. Covert administration was further discussed by the Committee in detail and the recommendations have been amended. Further consideration of the circumstances and principles are given in the full guideline.
115	Betsi Cadwaladr University Health Board	Short	1	6	(18 years and over)	Thank you for your comment. This wording has been added for clarification.
116	Betsi Cadwaladr University Health Board	Short	8	27, 28, 29	*Follow up any verbal changes with written confirmation to the home care provider as soon as possible* – NMC standards for medicines management (2010) state that a new prescription signed by the prescriber who sent the fax or email confirming the changes must be written within a maximum of 24 hours or 72 hours maximum on BH & Weekends	Thank you for your comment. The Committee were not able to specify a timeframe, but agreed that it was important that verbal changes are followed up as soon as possible. They were aware of the NMC standards, however, most often the care provider and care workers are not responsible for the collection of either prescriptions or prescribed items from the GP or pharmacy.
117	Betsi Cadwaladr University Health Board	Short	9	8,9,10	*ensuring the person requesting the change repeats the request to another person (for example, the person and/or a family member or carer*). This recommendation will be a challenging change in practice if the carer is on their own with a person who has cognitive decline or fluctuating mental capacity?	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended to reflect that another person may not always be available. The intention of the Committee was to ensure that there are robust processes in place for handling verbal changes to a person's medicines remotely, to protect both the person receiving care and the care worker. The Committee agreed that the recommendation reflects good practice.
118	Betsi Cadwaladr University Health Board	Short	12	28	NICE Managing medicines in care homes March 2014 refer to the 'Persons right to refuse' - to maintain consistency with all NICE documentation	Thank you for your comment. The Committee was aware of the wording used in the NICE guideline on managing medicines in care homes (SC1). The wording for this guideline was discussed and agreed by the Committee and has not been changed. The Committee strongly recognised the need for a person-centred approach. The person has the right to decline to take their medicines and the Committee felt that the term 'refuse' had a negative connotation in this setting.
119	Betsi Cadwaladr University Health Board	Short	15	13	pharmacist or GP should write how to give on the MAR chart and /or bottle	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records in detail. They were aware that not all pharmacies, dispensing doctors or other care providers have the necessary facilities or resources to produce them.
120	Betsi Cadwaladr University Health Board	Short	17	17	The information should clarify what medicinal product may be administered, and for what indication it may be administered, and time limitation before referral to a GP.	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over the counter medicines in this setting. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines

						support that is provided by care providers. Details of the process are for local consideration and determination.
121	Betsi Cadwaladr University Health Board	Short	17	8	Pre printed MAR chart to become compulsory not just a consideration	Thank you for your comment. The Committee were mindful that there is no legal requirement for medicines administration records (MARs) to be provided. The Committee was aware that not all pharmacies, dispensing doctors or other care providers have the necessary facilities or resources to produce MAR charts.
122	Betsi Cadwaladr University Health Board	Short	20	14 &15	***Home care provider 14*** *A provider organisation, registered with the Care Quality Commission as a home* – could CSSIW be included to make the document eligible to Wales too, in order to avoid confusion?	Thank you for your comment. NICE guidelines are written in the context of health and social care in England. Decisions on how our guidance applies in Wales, Scotland and Northern Ireland are made by the devolved administrations (please see the NICE website for further details).
123	Betsi Cadwaladr University Health Board	Short	22	16	(18 years and over)	Thank you for your comment. This wording has been added for clarification.
124	Betsi Cadwaladr University Health Board	Full	11	31	the 'Health Education England' website link wont open it stated that there is a problem with this website's security certificate	Thank you for your comment. NICE could not replicate this issue as the hyperlink directs to the correct landing page.
125	Betsi Cadwaladr University Health Board	Full	11	38 39	include CSSIW	Thank you for your comment. NICE guidelines are written in the context of health and social care in England. Decisions on how the guidance applies in Wales, Scotland and Northern Ireland are made by the devolved administrations (please see the NICE website for further details).
126	Betsi Cadwaladr University Health Board	Full	30	26 - 28	*Follow up any verbal changes with written confirmation to the home care provider as soon as possible* – NMC standards for medicines management (2010) state that a new prescription signed by the prescriber who sent the fax or email confirming the changes must be written within a maximum of 24 hours or 72 hours maximum on BH & Weekends	Thank you for your comment. The Committee were not able to specify a timeframe, but agreed that it was important that verbal changes are followed up as soon as possible. They were aware of the NMC standards, however, most often the care provider and care workers are not responsible for the collection of either prescriptions or prescribed items from the GP or pharmacy.
127	Betsi Cadwaladr University Health Board	Full	31	38	*ensuring the person requesting the change repeats the request to another person (for example, the person and/or a family member or carer*). This recommendation will be a challenging change in practice if the carer is on their own with a person who has cognitive decline or fluctuating mental capacity	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to add 'whenever possible' to address the point raised.
128	Betsi Cadwaladr University Health Board	full	31	16-19	Would like to see MAR sheets become compulsory	Thank you for your comment. The Committee recognised the importance of medicines administration records, but regulatory requirements for their use are outside the scope of this guideline.
129	Betsi Cadwaladr University Health Board	Full	34	14	NICE Managing medicines in care homes March 2014 refer to the 'Persons right to refuse' - to maintain consistency with all NICE documentation	Thank you for your comment. The Committee was aware of the wording used in the NICE guideline on managing medicines in care homes (SC1). The wording for this guideline was discussed and agreed by the Committee and has not been changed. The Committee strongly recognised the need for a person-centred approach. The person has the right to decline to take their medicines and the Committee felt that the term 'refuse' had a negative connotation in this setting.
130	Betsi Cadwaladr University Health Board	full	35	41 42	clearly instruction of how the covert medication is given must be written up on the MAR chart	Thank you for your comment. The Committee recognised that clear authorisation and instructions for covert administration should be provided for care workers, but implementation is for commissioners and providers to consider and determine locally. The Committee were

						mindful that there is no legal requirement for the medicines administration records to be provided.
131	Betsi Cadwaladr University Health Board	Full	36	7	Add 'and on the MAR chart' at the end of the sentence	Thank you for your comment. The Committee were mindful that there is no requirement for medication administration records to be provided.
132	Betsi Cadwaladr University Health Board	Full	37	4	It is 'essential' for them to provide MAR sheets	Thank you for your comment. The Committee were aware that not all pharmacies, dispensing doctors or other care providers have the necessary facilities or resources to produce medicines administration records
133	Betsi Cadwaladr University Health Board	full	44	41,42,43,44	This is also a recommendation within the NICE Managing medicines in care homes March 2014 document	Thank you for your comment.
134	Betsi Cadwaladr University Health Board	Full	40 and throughout document	19	Appendices not attached – (C.1).not included within document	Thank you for your comment. The appendices were available to download from NICE website during the consultation period.
135	Betsi Cadwaladr University Health Board	Full	52	39	Theguideline needs a space between words	Thank you for your comment. This text has been amended.
136	Betsi Cadwaladr University Health Board	Full	64	Paragraph 7	***Paragraph 7 – if a tablet is dropped on the floor no replacement if in an MDS***	Thank you for your comment. The text has been reworded following further discussion by the Committee.
137	Betsi Cadwaladr University Health Board	Full	70	19	Theguideline needs a space between words	Thank you for your comment. The text has been reworded following further discussion by the Committee.
138	Betsi Cadwaladr University Health Board	Full	76	32	Spelling error chid should be child	Thank you for your comment. The text has been reworded following further discussion by the Committee.
139	Betsi Cadwaladr University Health Board	Full	77	44	RPS state that in home care 'if it has been agreed with the patient and it is the home care plan, doses can be left out for that individual to take at a later time.'- leaving doses out is not recommended/ safe practice by the NMC standards for Medicines management (2010)	Thank you for your comment. Please note this is evidence from the literature which was discussed by the Committee and used to inform its recommendations. These are not NICE's recommendations. The Committee were aware of the NMC standards (2010 as amended 2015) on medicines management for registered nurses, however standard 14 (preparing medication in advance) only applies to substances for injection.
140	Betsi Cadwaladr University Health Board	Full	78	28	Over the counter medicines should not be administered by home care workers as they would not necessarily understand the contraindications precautions etc with a persons prescribed medication - to prevent errors	Thank you for your comment. The Committee agreed that adults receiving social care in the community who require support to manage their medicines should have equal access to over-the-counter medicines if they so choose, in line with the Equality Act 2010.
141	Betsi Cadwaladr University Health Board	Full	83	Paragraph 7	Reference on the NMC Standards for medicines incorrect date should be 2010 not 2008	Thank you for your comment. This text has been amended.
142	Betsi Cadwaladr University Health Board	Full	108	1st paragraph	Code of Practice on confidential personal information link not accessible .	Thank you for your comment. The hyperlink has been updated.
143	Betsi Cadwaladr University Health Board	Full	111		The Committee also concluded that prescribers should follow-up any verbal changes to a person's medicines with written confirmation as soon as possible. Written confirmation should be sent by an agreed method of communication, for example a secure fax or e mail. NMC standards for medicines management (2010) state that a new prescription signed by the prescriber who sent the fax or email confirming the changes must be written within a maximum of 24 hours or 72 hours maximum on BH & Weekends	Thank you for your comment. The Committee were not able to specify a timeframe, but agreed that it was important that verbal changes are followed up as soon as possible. They were aware of the NMC standards, however, most often the care provider and care workers are not responsible for the collection of either prescriptions or prescribed items from the GP or pharmacy.
144	Betsi Cadwaladr University Health Board	Full	112	all	The MAR chart should be written up by the pharmacist or dispensing GP to prevent care home worker transcribing as it would not be in their area of competence and could be a risk for potential errors causing harm	Thank you for your comment. The Committee agreed that this would be exceptional, and a printed medicines administration record (MAR) would be preferred. However, the Committee was also mindful that there is no legal requirement for the supplying pharmacist or dispensing doctor to provide MAR charts. The Committee agreed that

						robust processes would need to be in place and care workers would need to be trained and assessed as competent when using or providing MAR charts..
145	Betsi Cadwaladr University Health Board	Short	3	general	What medicines a home care workers are able to administer As need to consider that further information/consideration is required for enhanced medicines e.g. insulin etc...	Thank you for your comment. The Committee agreed that the principles of safe administration apply regardless of whether the medicines are 'high-risk' or time-sensitive.
146	Betsi Cadwaladr University Health Board	short	8	general	Add bullet point :- • home care providers	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline. However, recommendation 20 in the final published guideline is directed at social care providers, so they are not included in the bulleted list.
147	Betsi Cadwaladr University Health Board	short	8	25	Need to consider who is able to take his information and that the are suitably trained and competent for this task	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended. The Committee agreed that this reflects good practice. Please see also the section on training and competency.
148	Betsi Cadwaladr University Health Board	Short	9	2	Whom is responsible for this task and that the are suitably trained and competent for this task	Thank you for your comment. Please note that this recommendation refers to processes that care providers should have in place. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
149	Betsi Cadwaladr University Health Board	Short	11	GENERAL	Add bullet point • Ensure medicine prescribed/dispensed is correct	Thank you for your comment. This is included within the recommendation on care workers ordering a person's medicines.
150	Betsi Cadwaladr University Health Board	Short	12	29	Add /refuse after decline to place in line with NICE care home doc	Thank you for your comment. The Committee was aware of the wording used in the NICE guideline on managing medicines in care homes (SC1). The wording for this guideline was discussed and agreed by the Committee and has not been changed. The Committee strongly recognised the need for a person-centred approach. The person has the right to decline to take their medicines and the Committee felt that the term 'refuse' had a negative connotation in this setting.
151	Betsi Cadwaladr University Health Board	Short	13	General	For when required add that the reason/need for administration i.e. headache, hip pain etc...	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended.
152	Betsi Cadwaladr University Health Board	Short	13	General	Add bullet point:- They are satisfied all aspects of the '6 Rights' are met	Thank you for your comment. The recommendation has been amended to include the 6 R's.
153	Betsi Cadwaladr University Health Board	Short	17	General	Should it be that home care workers only in exceptional circumstances should they collect medicines themselves/risk assessment	Thank you for your comment. The guideline states that 'responsibility for transporting, storing and disposing of medicines usually stays with the person and/or their family members or carers. However, if a care provider is responsible, effective medicines management systems need to be in place. The Committee did not feel that it was exceptional for a care worker to help with collecting medicines, but the support needed should be identified as part of the medicines assessment (see recommendations

						on assessing and reviewing a person's medicines support needs).
154	Betsi Cadwaladr University Health Board	Short	17	General	Insert a section on receipt of medicines	Thank you for your comment. This issue is covered within recommendation 1.9.5 in the final short version – recording what medicines have been supplied and checking for any discrepancies between what was ordered and what was supplied.
155	Betsi Cadwaladr University Health Board	Short	General	General	The above points need to be considered for full document as well	Thank you for your comment. Any amendments made to the short version of the guideline are replicated in the full guideline.
156	Betsi Cadwaladr University Health Board	Full	29	31	Consider the need to discuss with multidisciplinary team	Thank you for your comment. The recommendation has not been changed as this point is covered by recommendations 10 and 12 in the full published guideline. The Committee recognised that discussions and decisions about a person's medicines support needs would need to involve a range of people, and therefore the recommendation has not been directed at a specific person or care provider. This will be for commissioners and providers to consider and determine locally.
157	Betsi Cadwaladr University Health Board	Full	29	39	Add if concerns are raised	Thank you for your comment. This wording has been added following further discussion by the Committee.
158	Betsi Cadwaladr University Health Board	Full	32	11	Check/advice from prescriber/health professional	Thank you for your comment. The intention of this recommendation is to ensure a record is made of whether each specific medicine has been taken or declined, when a care provider is responsible for supporting the person with their medicines. Other recommendations in the guideline highlight when to seek advice or contact a health professional.
159	Betsi Cadwaladr University Health Board	Full	37	55	If they do not agree to supply where would they get them from should it not be mandated that this is produced by them	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. The Committee were mindful that there is no requirement for MAR charts to be provided. They were aware that not all pharmacies, dispensing doctors or other care providers have the necessary facilities or resources to produce MAR charts. The Committee agreed that the recommendations reflect good practice.
160	Betsi Cadwaladr University Health Board	Full	37	57	Should not provide advice on OTC medicines	Thank you for your comment. This comment applies to all medicines and is covered in recommendation 31 of the published full guideline.
161	Betsi Cadwaladr University Health Board	Full	77	45	Add should be risk assessed	Thank you for your comment. Please note this is evidence from the literature which was discussed by the Committee discussed and used to inform its recommendations. These are not NICE's recommendations.
162	Care Quality Commission	Short	1	4	Question1: Can staff working at general practices be explicitly mentioned here? This is because they have been given responsibilities in the document around recording of medicines information (page 6).	Thank you for your comment. This wording has been amended following further discussion by the Committee to include health professionals and their 'support staff'.
163	Care Quality Commission	Short	10	7	Question 1: If a medicine is self-administered, does the provider have to document all the details relating to that medicine, and state that the client is responsible for taking it? Could there be some additional clarity to this within the document?	Thank you for your comment. This was discussed by the Committee and the recommendation has been amended. Care workers should record any medicines support given for each individual medicine on every occasion. The term 'medicines support' is defined in the guideline.

164	Care Quality Commission	Full	31	16	Printed MAR sheets: Whilst this is a positive change it may cause problems, particularly if the medicines supplier refuses to provide them. If not provided by the supplier the onus will be on the care provider to produce their own printed sheets. We note that there is a handwritten guidance section – could this be made more explicit, particularly in terms of processes for checking the accuracy of entries?	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. However, the Committee were also mindful that there is no requirement for the supplying pharmacist or dispensing doctor to provide MAR charts. The Committee agreed that robust processes would need to be in place and the recommendations have been amended to reflect their discussions.
165	Care Quality Commission	Full	33	10	This is a positive addition towards quality improvement.	Thank you for your comment.
166	Care Quality Commission	Full	33	18	This is a positive addition towards quality improvement.	Thank you for your comment.
167	Care Quality Commission	Full	36	41	This is a positive addition towards quality improvement.	Thank you for your comment.
168	Care Quality Commission	Full	37	4	The term “should consider” reduces the robustness of section 24.	Thank you for your comment. The Committee were aware that not all pharmacies, dispensing doctors or other care providers have the necessary facilities or resources to produce medicines administration records.
169	Care Quality Commission	Short	General	General	The document does not make it clear whether the information that should be recorded for medicines that are given, and medicines that the clients are physically assisted to take should be the same. Could this be made clearer?	Thank you for your comment. ‘When required medicines were discussed further by the Committee and the recommendation has been amended. All medicines support provided by the care worker must be recorded. Medicines support is defined in the guideline.
170	Care Quality Commission	Full	General	General	Clear, shared documentation of everyone’s responsibilities and expectations is key to making sure that people are well looked after in their own homes.	Thank you for your comment. The importance of joint working is highlighted in the guideline. See also the NICE guideline on home care.
191	City and County Healthcare Limited	Full Full Full	32	16,17,18,19	Home care workers should use a printed medicines administration record to record any medicines that they give to a person. This record should ideally be provided by a community pharmacist or the dispensing doctor (see also recommendation 56 on supplying medicines). We have concerns about this as the number of pharmacies involved could be considerable each with a different document type. Some service users have multiple pharmacists. The Mar charts would not then include over the counter medicines. The keys may be different. Medicines change frequently would a new record be supplied how would providers be able to control the right use of the right record. How would care staff know which one is the latest? This has been trialled on many occasions and leads to greater issues. Unless the whole country goes to a single system training across different towns or boroughs would need to be different and what would happen when care staff cross these borders. This would be a huge investment from all pharmacy organisations including independent operations.	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to include care providers. Implementation is for commissioners and providers to consider and determine locally.
192	City and County Healthcare Limited	full	35	17 18 19	Health and social care practitioners should ensure that an up-to-date patient information leaflet for each prescribed medicine is kept in the person’s home. This includes medicines supplied in monitored dosage systems. This is not currently done and I cannot see that this would ever be practical to do so.	Thank you for your comment. The Committee agreed that as patient information leaflets are already supplied by law with original packs (and must also be supplied with monitored dosage systems) to the patient, there is minimal burden in retaining one for each medicine in the patients care plan. In addition, having access to the additional information contained in the leaflet is likely to be helpful to care workers. An additional recommendation has been added after consultation to reflect the requirement for supplying pharmacists and dispensing doctors to supply a

						patient information leaflet for all medicines supplied, including those supplied in monitored dosage systems.
193	City and County Healthcare Limited	Full	36	5 6	Home care workers should not give medicines to a person covertly unless authorisation and instructions of how this should be carried out are clearly documented in the person's home care plan. There needs to be written documented evidence supplied to the home care provider of the decision made in best interest meetings. agreement for covert administration would be detailed on the care plan with instruction of how this is to be done.	Thank you for your comment. The recommendations have been amended to reflect the need for a joint approach across health and social care to ensure that covert administration only takes place in the context of existing legal and good practice frameworks.
181	Derby City Council	Short Version	5	14	There is no mention of the community pharmacist initially assessing the persons needs prior to social care input for example simply changing the lid of the loose tablet bottle or print a larger label may enable a person to continue to self-medicate and negate the need for social care support	Thank you for your comment. Please note that the assessment for social care support with medicines may well be undertaken before a person sees a community pharmacist (for example, by a hospital social worker who would then refer to a pharmacist).
182	Derby City Council	Short version	10	3	We have concerns that it is not just having a printed MAR sheet but the quality of that MAR sheet produced by the Community Pharmacist. Some have just been photocopied month after month, , others don not have enough lines for PRN doses etc. Here in Derbyshire we have developed a set of standards to make all parties aware of their duties responsibilities in relation to MAR sheets, as an example what is expected of the GP, The Pharmacist, Hospital Pharmacy and Home care provider, including hand written MAR sheets. I can send a copy of the document.	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. They were aware that there are a number of different types of pre-printed MARs currently in use. However they found no evidence on the safety or effectiveness of different types. Advice should be sought from the regulator if commissioners have concerns about the practice of care providers.
183	Derby City Council	Short version	13	15	We are concerned about the guidance that the carer should rely on guidance given by the family on how the directing variable dose medications are to be given.	Thank you for your comment. The Committee recognised that although the care worker attending a person's home may vary on a day to day basis, family members or carers are often more involved and provide continuity of care. The Committee strongly recognised the need for a person-centred approach.
184	Derby City Council	Short version	14	17,18,19	Who is responsible for informing the care agency which of the medications are time sensitive (this is often not included in the directions on the label) And how will this be communicated to the care provider	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended. This is now covered in recommendation 1.3.4 of the published short version of the guideline (or recommendation 11 in the final published full guideline)
185	Derby City Council	Short version	14	20	We agree with what the process includes, we have produced a template document and process that covers this from all parties and are happy to share this with you all. It was agreed with SDCCG Prescribing group, included in the Derby City Council medication policy and sits on the CCG intranet	Thank you for your comment. Examples of good practice can be submitted for NICE endorsement (endorsement@nice.org.uk).
186	Derby City Council	Short Version	16	25 - 28	The Disability Discrimination Act has been replaced by the Equalities Act 2010 which includes protected characteristics that may need support – disability being one of these, language could be another.	Thank you for your comment. This wording has been amended to refer to the Equality Act 2010.
187	Derby City Council	Short version	17	12 - 20	Do points 1.9.10 and 1.9.11 contradict each other as one point is saying robust process to obtain OTC medication requested by the person and then the next point says the carer should not obtain OTC medication based on symptoms described?	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over the counter medicines in this setting. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
188	Derby City Council	Short version	17	19	We disagree and think that the prescriber must authorise the OTC medications prior to administration.	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single

						recommendation that incorporates all aspects of managing over the counter medicines in this setting. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination. Please note that there is no legal requirement for adults receiving social care in the community to need prescriber approval for over-the-counter medicines. The Committee supports the right of people receiving social care to have equitable access to these medicines.
189	Derby City Council	Short version	19	6	Reference to the Care Certificate 2015 Standard 13.5 Skills for Care 2013 QCF Unit 80	Thank you for your comment. The Committee recognised the importance of training and assessment of competency for health and social care practitioners, but this is not part of NICE's remit. The purpose of the guideline recommendations was to outline the principles of good practice. Please see the full guideline for references to the Care Certificate.
190	Derby City Council	Short version	21	25	Consulted the Care Act 2014 we would expect the drive or overarching principle to reflect person centred care and the well-being principles in relation to how they impact on medication to include in 1.2.4	Thank you for your comment. The Committee strongly recognised the need for a person-centred approach. Please note the short version of the guideline does not contain all the information pertinent to its context. Please see the full guideline.
6	EsKe Ltd t/a Care Wyvern	Short	3	3 - 15	In the domiciliary care environment medication is a high risk area. The medication element of calls is often "tagged on" to calls as the task is not specifically funded by the social care budget and not at all by the health budget. The calls are often assessed by social services to include as many tasks as possible in a specified time frame, more often than not 30 minutes duration. The carers do receive medication training continually throughout their employment, including quarterly medication observations, however, the staff often have to make snap decision regarding a clients medication, with limited health professional advice. If carers are working in the evenings the dispensing pharmacy is not open and calling 111 takes so long to get a reply, especially within the 30 minute window carers have allocated to each client. To accurately carry out the all the verbal and physical checks on the person and the medication to be administered, assisted with or prompted Care Wyvern recommends at least 10 – 15 minutes be allocated to the medication task. This would go a long way in recognising the skill of home carers, emphasise the importance of coherent medication administration in the medication therapy of our clients and reduce the risk of mistakes being made because of shortness of time.	Thank you for your comment. NICE has made recommendations on the contracting of home care and the amount of time needed for each visit. Please see the NICE guideline on home care.
7	EsKe Ltd t/a Care Wyvern	Short	6	1	1.2.7 Medication reviews rarely happen. GP's do not regularly pass on any review information to the care provider, therefore leaving domiciliary care out of the loop.	Thank you for your comment. Please note that this recommendation is about the medicines support (which is defined in the guideline) provided by care providers. This is not medication review which is covered in the NICE guideline on medicines optimisation.
8	EsKe Ltd t/a Care Wyvern	Short	8	19	1.4.4 In practice domiciliary care providers do not get notified of changes in medicines, especially in writing. This is a problem, operationally and practically, when dealing with Warfarin, or other similar therapies, in the community.	Thank you for your comment. The Committee recognised that effective communication about medicines and joint working between health and social care is essential, which is reflected in the recommendations.
9	EsKe Ltd t/a Care Wyvern	Short	10	3	1.5.3 Pharmacy printed Medication Administration Records (MAR) sheets are not suitable for the domiciliary environment. On a Pharmacy printed MAR you can fill the time compliance once e.g. AM medication is given at 08:00. This may be the case for the first days of the week, however later in the week the call may be delivered at 07:30 or 08:30. The change in times is not able to be recorded on this style of MAR sheet. A more flexible one in needed.	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. They were aware that there are a number of different types of pre-printed medicines administration record currently in use. However they found no evidence on the safety or effectiveness of different types.

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

10	EsKe Ltd t/a Care Wyvern	Short	10	13	1.5.4 Not always aware of any stop of review date in the domiciliary setting.	Thank you for your comment. The Committee agreed that these should be included, when possible.
11	EsKe Ltd t/a Care Wyvern	Short	13	16	1.7.2 Labels do not state when dose should be taken.	Thank you for your comment. The Committee was aware that there is advice for pharmacists on labelling in the British National Formulary. This recommendation has been amended following further discussion by the Committee.
12	EsKe Ltd t/a Care Wyvern	Short	13	17	1.7.2 Labels do not state the minimum time between doses. This would be invaluable in the community setting.	Thank you for your comment. The Committee was aware that there is advice for pharmacists on labelling in the British National Formulary. This recommendation has been amended following further discussion by the Committee.
13	EsKe Ltd t/a Care Wyvern	Short	14	13	1.7.8 Patient leaflets do not always accompany Measured Dose System (MDS) boxes from Pharmacists.	Thank you for your comment. When medicines are dispensed into a monitored dosage system, it is a legal requirement that a patient information leaflet (PIL) is supplied for every dispensed medicinal product included. An additional recommendation has been added after consultation to reflect the requirement for supplying pharmacists and dispensing doctors to supply a patient information leaflet for all medicines supplied, including those supplied in monitored dosage systems. Please also see the Royal Pharmaceutical Society publication Improving patient outcomes – the better use of multi-compartment compliance aids.
14	EsKe Ltd t/a Care Wyvern	Short	17	8	1.9.9 Pharmacy printed MAR sheets are not suitable for the domiciliary environment. On a Pharmacy printed MAR you can fill the time compliance once e.g. AM medication is given at 08:00. This may be the case for the first days of the week, however later in the week the call may be delivered at 07:30 or 08:30. The change in times is not able to be recorded on this style of MAR sheet. A more flexible one in needed.	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. They were aware that there are a number of different types of pre-printed MARs currently in use. However they found no evidence on the safety or effectiveness of different types. Therefore, details of the process are for local consideration and determination.
15	EsKe Ltd t/a Care Wyvern	Short	18	16	1.10.4 Clearer guidance is needed; • Defining what a control drug is. • Who has responsibility for administering these drugs in the community. • How and where the medications should be stored. • The correct type of recording for this class of drugs in the home.	Thank you for your comment. Please see the NICE guideline on controlled drugs.
16	EsKe Ltd t/a Care Wyvern	Short	22	4	Care Wyvern would concur with this context. With multiple medications extra time needs to be allocated to the task. This is not recognised when allocation of funding is assessed. Home carers and home care providers often take on the bulk of these responsibilities with little of no recognition.	Thank you for your comment.
17	EsKe Ltd t/a Care Wyvern	Short	22	10	Care Wyvern would concur with this context. Many carers feel the responsibility of medication administration is a heavy one as they understand the implications and risks of the task. Care Wyvern has had experience of employees leaving care because they simply to not wish to take on the responsibility of administering medication because of the very limited health care supervision and/or support, thus helping to exasperating the current recruitment issues with in social care	Thank you for your comment. The Committee were very mindful of this issue when considering the evidence and took this into account when making their recommendations. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Advice should sought from the regulator if commissioners have concerns about the practice of care providers.
5	First4healthtraining.com Ltd	Full	General	General	There is one aspect that seems to have been overlooked. The bulk of the staff I train (we are accredited by the RPS) who provide home care administer from medicines collected and delivered to the client's home by a relative, the bulk are not collected by the home care company. I cannot see anywhere where it	Thank you for your comment. If a relative is collecting and delivering a person's medicines, they are responsible for

					says these medicines should be checked and only administered from the original pharmacy labeled packaging and that each medicine should be signed and accounted for separately. It only mentions checking the medicines when collected by the home care provider and nowhere does it say that each medicine must be signed for separately.	checking the medicines are received correctly and the recommendation will not apply in this situation.
194	Harrogate and Rural District CCG	Full	31	5	There is a superscript 1 next to medicines on this line but it doesn't seem to refer to anything.	Thank you for your comment. The footnote is shown at the bottom of the above page: 'Take into account the 5 rules set out in the Health and Social Care Information Centre's A guide to confidentiality in health and social care (2013) when sharing information.'
195	Harrogate and Rural District CCG	Full	31	17-19	The home care worker is often not present when the person transfers settings to hospital. It is difficult to see how they can ensure that the relevant information is transferred with the person. Should there be a corresponding requirement that the new service should contact the home care provider for information. Section 9.5 evidence to recommendations on transfer of medicines acknowledges the challenges in home care. This does not appear to be reflected in the wording of the recommendations.	Thank you for your comment. The NICE guideline on Medicines optimisation to which this guideline refers the reader does not recommend transfer of information with the person, but ideally within 24 hours of the person being transferred (recommendation 1.2.2). This is to take account of the challenges discussed.
196	Harrogate and Rural District CCG	Full	31	22	It is difficult to see how this recommendation can be met. A new prescription cannot be issued for a medication which has been stopped and it is not likely to be issued if the person had sufficient supplies of a medication when the dose is changed. Would it be appropriate to include "or otherwise provide the information in writing"?	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to reflect your comment. The recommendation bullet now states 'providing written instructions of the change or issuing a new prescription'.
197	Harrogate and Rural District CCG	Full	31	20-21	There is no indication here that the prescriber should inform the home care provider if home care workers are administering medication where feasible (assuming they are aware that home provider is administering medication).	Thank you for your comment. The recommendations state that care providers should notify the practice when they start providing medicines support, and that practices should keep a record so that a GP is aware that this is the case.
198	Harrogate and Rural District CCG	Full	29	16-18	Is this only referring to non-clinical issues with medication? It would be expected that clinical issues would be referred to a relevant healthcare professional.	Thank you for your comment. The Committee agreed that a named person to contact about medicines should be agreed, to ensure continuity and consistency of care. This should be the person themselves, or another named contact (a carer, family member or care coordinator). This is stated in the recommendations.
199	Harrogate and Rural District CCG	Full	31	26-30	This is a welcome recommendation. It should help prevent miscommunications. It may be challenging in that currently GPs etc are not always aware that there is a "home care provider"	Thank you for your comment. The Committee recognised that this was often the case in current practice, and made recommendations which should help to address this issue (see recommendations on joint working between health and social care).
200	Harrogate and Rural District CCG	Full	110	Paragraph 3	This appears to imply that home care workers can take instructions on medication changes from the person or relative/carer. This would be likely to leave home care workers vulnerable to being involved in a medication error due to unintentional (or intentional) misinformation from the person or relative/carer and does not appear to be consistent with recommendation 20.	Thank you for your comment. This wording relates to when a prescriber makes changes to a person medicines when a family member, carer or care worker is not present, and the person is not able to communicate this change. The recommendation states that the person or named contact needs to be informed. The text has been amended to ensure that this is explicit: The Committee was aware from experience that problems can occur when changes to prescriptions are made by the prescriber when people involved in the person's care are not present and are not informed. For example, the person receiving care may be unable to pass on information regarding the change (for example, due to poor memory or fluctuating capacity) to their family members or carers or a care worker.

						Care workers taking verbal instructions of a change to medicines is covered in recommendation 19 in the final full guideline.
201	Harrogate and Rural District CCG	Full	31	38-39	Is it possible to add a “whenever possible” to this. In home care there may not be a second person available at the time. Also a comment that the home care worker should request confirmation in writing as soon as possible.	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to reflect your comment.
202	Harrogate and Rural District CCG	Full	32	16-19	This recommendation provides a challenge as home care providers do not generally work with one pharmacy or dispensing GP. It is likely that the home worker will have to negotiate several different styles of MAR chart if they are supplied by pharmacies or dispensing GPs. Neither the pharmacy or dispensing GP are required to supply MAR charts for the benefit of care staff (although I am aware that many do) so there is also an issue of cost.	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to reflect your comment. The Committee were mindful that there is no legal requirement for the supplying pharmacist or dispensing doctor to provide medicines administration records (MARs).
203	Harrogate and Rural District CCG	Full	32	16	This specifies a printed MAR chart. This seems to imply that if the home care provider is supplying their own MAR charts that these too must be printed. Could an option for handwriting the MAR charts for providers be included? There is not usually the ability to print a MAR chart at the person’s own home if the chart is prepared there.	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to reflect your comment. The recommendation now includes the provision of medicines administration records by care providers and states that this should ideally be a printed record.
204	Harrogate and Rural District CCG	Full	34	28	“what dose should be taken” should be specified on any medication that is to be taken for home care workers to be able to administer safely- not just time sensitive and PRN medication.	Thank you for your comment. This is covered within the main stem of the recommendation. However, the Committee agreed that information on time sensitive medicines and when required medicines needed to be explicitly stated and the recommendation has been changed to make this clearer.
205	Harrogate and Rural District CCG	Full	34	28-29	Would it not be possible to for the prescriber to specify the circumstances which would indicate which dose of a variable dose should be given also?	Thank you for your comment. The recommendation recognises that prescribers may prescribe variable doses, but usually the amount required would depend upon what the person needed (for example, 1 or 2 paracetamol for pain relief). The Committee were aware that in cases where a variable dose is prescribed and no such information can be obtained then this can cause uncertainty for care workers over the correct dose to given.
206	Harrogate and Rural District CCG	Full	34	36	Should this sentence include “for prescribed medication”. Otherwise it appears to exclude over the counter medication. For these there will be no dispensing label and no actual prescriber.	Thank you for your comment. This recommendation has been reworded to address the issue highlighted in relation to over the counter medicines, following further discussion by the Committee.
207	Harrogate and Rural District CCG	Full	35	4	The use of “**or** check the written record” may imply that care staff do not have to do this before administering a medication. Would the use of “and” rather than “or” be more appropriate?	Thank you for your comment. This section has been reworded following further discussion by the Committee.
208	Harrogate and Rural District CCG	Full	35	8-12	This does not appear to cover non prescribed medication which could technically be purchased anywhere not just supplied by a healthcare professional. Would “home care workers should give medication from the containers as originally dispensed or purchased” work?	Thank you for your comment. The recommendation has been amended to reflect your comment.
209	Harrogate and Rural District CCG	Full	35	6-7	Could “unless stated otherwise in the care plan” be added. Some people do not like to be asked every time.	Thank you for your comment. This section has been reworded to reflect this comment, following further discussion by the Committee.
210	Harrogate and Rural District CCG	Full	35	16	Should this read “see recommendation 31”?	Thank you for your comment. This recommendation cross reference has been changed. There is now a cross-reference to recommendation 30 in the final full guideline on reporting concerns about medicines.
211	Harrogate and Rural District CCG	Full	36	20-22	Should the task of ordering medication be delegated to the pharmacy at all? The home care worker ordering at the person’s home will be able to check available supplies but the pharmacy will not. Would	Thank you for your comment. The recommendation has been amended to reflect your suggested text.

					"unless specifically requested to do by the person" be appropriate? In this case it would be the person who is delegating the ordering not the home care worker.	
212	Harrogate and Rural District CCG	Full	36	22	"this is agreed by the person and/or their family members or carers." This implies that family/carers can agree on behalf of the person however they may not have legal authority to do so e.g. relevant lasting power of attorney. If the person lacks capacity and there is no one with legal authority to make the decision then a best interest decision following the principles and procedures of the Mental Capacity Act would need to be recorded to show valid consideration of consent. If the person has capacity then only their consent would be appropriate.	Thank you for your comment. The Committee agreed that a care worker should report any concern regarding a person's ability to make a decision to the care provider. This is covered in recommendation 30 in the final full guideline.
213	Harrogate and Rural District CCG	Full	36	39	It is not always possible for pharmacies or dispensing GPs to supply medication in its **original** packaging for various reasons, eg, the tablets come in a pack of 100 and the prescription is for 28. Would "traditional packaging" work?	Thank you for your comment. The wording has now been clarified and the recommendation hyperlinks to a glossary entry which explains what is meant by the term 'original packaging'.
214	Harrogate and Rural District CCG	Full	36	40 and 43	I believe the Disability Discrimination Act was repealed by the Equality Act 2010 in October 2010.	Thank you for your comment. This section has been reworded to reflect your comment following further discussion by the Committee.
215	Harrogate and Rural District CCG	Full	36-37	41-3	This recommendation does not take into account that repacking of medicines into a monitored dosage system is at the professional discretion of the healthcare professional filling it. Some medicines cannot be put in a MDS even if it would otherwise be a reasonable adjustment. I agree that it should only be used to support the needs of the person and only after assessment by a relevant healthcare professional supplying the medication.	Thank you for your comment. The Committee considered the risks and benefits of original packaging compared with monitored dose systems in detail when making their recommendations. The Committee were aware of the many disadvantages to using monitored dosage systems, including that pharmacies are not reimbursed for their use. The Committee recommendations make provision for the use of monitored dosage systems, when an assessment has been carried out, in line with legislation and when a specific need has been identified to support medicines adherence. It does not state that this must be provided by pharmacists.
216	Harrogate and Rural District CCG	Full	37	2	For comments about "involve the person and/or their family or carers" see comment 20	Thank you for your comment.
217	Harrogate and Rural District CCG	Full	37	14-16	I agree that home care workers should not be making decisions about appropriate medications based on symptoms. However, this paragraph seems to imply that they are not able to ask the advice of a healthcare professional on behalf of the person at the person's request and follow the healthcare professional's recommendation. Was this the intention? If not please could this be clarified.	Thank you for your comment. The Committee agreed that as care workers are not trained to diagnose illness it would be outside the scope of their practice to interpret symptoms described to them and then relay what was said to a healthcare professional. If the person cannot make a determination which over-the-counter medicine they want then the care worker should ask the person to contact the health professional directly. This is covered in the recommendations.
218	Harrogate and Rural District CCG	Full	37	38-40	NICE guideline NG46 refers to healthcare professionals giving this advice to people prescribed CDs. Is it necessary to single out CDs? I am aware that home care workers may not actually be aware of which medications are also CDs and the considerations for safe storage will be the same in the person's home as any other medication.	Thank you for your comment. The Committee acknowledged the need for safe storage of medicines in other recommendations, but agreed that it would be useful to refer to the NICE guideline on controlled drugs as this also applies to this population.
219	Harrogate and Rural District CCG	Full	37	42	"agree with the person and/or their family.." please see comment 20.	Thank you for your comment.
220	Harrogate and Rural District CCG	Full	38	7	Please see comment 20 - "this is agreed by the person and/or their family members or carers." This implies that family/carers can agree on behalf of the person however they may not have legal authority to do so e.g. relevant lasting power of attorney.	Thank you for your comment. The Committee agreed that a care worker should raise any concern regarding a person's ability to make a decision to the care provider. This is covered in recommendation 30 in the final full guideline.

					If the person lacks capacity and there is no one with legal authority to make the decision then a best interest decision following the principles and procedures of the Mental Capacity Act would need to be recorded to show valid consideration of consent. If the person has capacity then only their consent would be appropriate.	
221	Harrogate and Rural District CCG	Full	38	8	We advise **all** medication requiring disposal to be returned to a pharmacy/dispensing GP for disposal.	Thank you for your comment. Please note that whilst the Committee agree that it is best practice to dispose of medicines at a pharmacy, the recommendation recognises that a person receiving care is able to dispose of unwanted medicines either as household waste or at a pharmacy. The recommendation is aimed at care providers who are disposing of waste on behalf of that person.
222	Harrogate and Rural District CCG	Full	38	10	Is there a need for special arrangements for disposing of CDs for home care workers as they would be returned to a pharmacy as other medicines would. Records are required for the return of all medication in social care settings.	Thank you for your comment. Please see the NICE guideline on controlled drugs [NG46] which has recommendations on safely destroying and disposing of controlled drugs.
223	Harrogate and Rural District CCG	Full	38	25	Would it be appropriate to review training needs and assess competence annually?	Thank you for your comment. The Committee did not identify any evidence on the frequency of review, but agreed that the recommendation reflects good practice.
224	Harrogate and Rural District CCG	Full	44	35-36	Should this be one sentence?	Thank you for your comment. The broken sentence has been amended.
225	Harrogate and Rural District CCG	Full	44	37-39	Could this be widened to include other clients not only people with mental health needs?	Thank you for your comment. The evidence presented here specifically relates to mental health crisis teams. The recommendations made by the Committee apply to all adults receiving social care in the community.
226	Harrogate and Rural District CCG	Full	45	30	“Additionally any identified risks related should be assessed”. Should this read “related risks”?	Thank you for your comment. This text has been amended.
227	Harrogate and Rural District CCG	Full	58	1-3	It is difficult to see how the community pharmacist can achieve this. It is not possible to ensure that a pharmacy holds a supply of every person’s medication at all times and the community pharmacy (or indeed the GP) cannot know what medication is available at every person’s home in order to ensure supplies are there at all times. This information is only available to the person or their nominated representative with access to the medication at the home. Responsibility for ordering medication should stay with the person (or their representative) who can check what is needed. Supplying medication without checking requirements is likely to lead to over stocks of medication at the person’s home with the associated risks and waste.	Thank you for your comment. Please note this is evidence from the literature which was discussed by the Committee and used to inform its recommendations. These are not NICE’s recommendations. Please see recommendation 50 in the full published guideline which outlines the legal requirements of care providers, when they are responsible for ordering a person’s medicines.
228	Harrogate and Rural District CCG	Full	59	19 &28	These refer to medicines cupboard(s) **or** room. This appears to imply that if there is a locked room then medicines cabinets are not required? Ie medicines can be stored on open shelves in a locked room if medication storage is central. Is this the intention?	Thank you for your comment. Please note this is evidence from the literature which was discussed by the Committee and used to inform its recommendations. These are not NICE’s recommendations.
229	Harrogate and Rural District CCG	Full	60	2	This statement could be interpreted that the home care worker should label the medication as fridge item. Is the intention to indicate that home care workers should identify items requiring fridge storage by reference to the dispensing label or product packaging? If so could the wording be changed to reflect this?	Thank you for your comment. This text has been amended to clarify the statement. Please note this is evidence from the literature which was discussed by the Committee and used to inform its recommendations. These are not NICE’s recommendations.
230	Harrogate and Rural District CCG	Full	61	2, 3, 4	These two bullets would not be appropriate to this setting and are contradicted by the bullet immediately below. Is it possible to remove them?	Thank you for your comment. Please note this is evidence from the literature which was discussed by the Committee and used to inform its recommendations. These are not NICE’s recommendations.
231	Harrogate and Rural District CCG	Full	general	general	There appears to be no clear reference in the recommendations or associated evidence regarding home care workers **administering** over the counter medication although I am aware that the use of medicine in the guidance is intended to cover both prescribed and non prescribed medication. Would it be possible to consider a recommendation around this? For example, if administering non prescribed medication home care workers should ensure that it is safe to do so by asking the advice of a relevant healthcare	Thank you for your comment. The Committee discussed over-the-counter medicines further and have amended the recommendations to incorporate all aspects of managing over-the-counter medicines in this setting. The Committee concluded that the purpose of the recommendations was to

					professional. Non prescribed medication should only be administered in accordance with the directions from the manufacturer from the original packet as purchased.	set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
171	Kirklees Council	short	general	general	Overall, we welcome the guidance. We feel it clarifies that medicines management in the community is a shared responsibility between health and social care. **However we feel that this is an opportunity to state who is responsible in law for medicines in the community and the guidance does not clarify this issue.** We very much agree with the improved communications between the prescriber and the home care providers and the health care professionals' responsibility when delegating medication related tasks. We feel the guidance acknowledges that social care providers need the necessary support in order to deliver the safest service for service users.	Thank you for your comment. The Committee were unable to clarify this issue (but please see section 1.2 in the full guideline). This will be for commissioners and providers to consider and determine locally. The importance of joint working between health and social care is highlighted in the guideline. See also the NICE guideline on home care.
172	Kirklees Council	Short	17	1.9.9	We strongly agree with the recommendation for printed MARs and that pharmacies should consider providing these. Ideally we would prefer this to be a' should' rather than 'should consider' statement. We do not think it safe for social care workers to complete MAR's. Also pharmacists provide them in hospitals and care homes to more trained workers so why not in home care to less trained workers?	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. However, the Committee were also mindful that there is no requirement for the supplying pharmacist or dispensing doctor to provide MARs. The Committee agreed that robust processes would need to be in place and the recommendations have been amended to reflect their discussions.
173	Kirklees Council	Full	16	1.9.7	Whilst we agree that the use of MDS' is excessive, we **do** support the use of MDS where appropriate, for example where there are many medications. MDS should be accompanied by description of individual medications in these circumstances in order to comply with CQC recording requirements. We are somewhat concerned regarding the recommendation for all medication to be supplied in original packages (unless the pharmacist deems it appropriate under the DDA). This is very challenging for care workers ,particularly where there are many medications . There would be cost implications for supporting everyone with original packets in an already stretched social care system. Also staff turnover in these roles is high and there is potentially a knock on impact on training and resources.	Thank you for your comment. The Committee discussed the risks and benefits of original packaging compared with monitored dose systems in detail when making their recommendations. They were aware of guidance from the Royal Pharmaceutical Society (Improving patient outcomes through the better use of multi-compartment compliance aids) and felt this gave a balanced and accurate view of the risks and benefits of monitored dosage systems. The Committee concluded that monitored dosage systems should be used for the benefit of the person receiving care, rather than for the ease of carers or care workers. The Committee recommendations make provision for the use of monitored dosage systems, when an assessment has been carried out, in line with legislation and when a specific need has been identified to support medicines adherence. It does not state that all medication should be supplied in original packaging in all circumstances. The Committee also agreed that the person receiving care and/or their family members or carers and the care provider should be involved in decision-making and the person's needs and preferences should be taken into account. Furthermore, the Committee agreed there are resource implications for using monitored dosage systems, for example, training of pharmacy staff, additional time to fill and check individual compartments and pharmacies are not reimbursed for the costs of monitored dosage system packaging.
174	Kirklees Council	Short	7	1.3.4	It may be worth adding that a person's medication may be able to be prescribed less frequently eg, once a day versus 4 times a day which reduces the possibility of error and reduces the cost to health and social care even if the medication is more expensive.	Thank you for your comment. This issue is covered by the first bullet in the recommendation.
175	Kirklees Council	Short	8	1.4.4	An important contact to inform of changes needs to be the home care provider if they are involved. We suggest for bullet 21 '*or their named contact*' to add..'*for example the home care provider*'	Thank you for your comment. The named contact is likely to be the person themselves or a family member or carer.
176	Kirklees Council	Short	10	1.5.3	We suggest removing the word 'ideally' as we feel this should be done by a pharmacist for safety reasons	Thank you for your comment. The legal requirement under The Health and Social Care Act 2008 (Regulated Activities)

						Regulations 2014 Regulation 17 (2)(c) is for the registered person (the care provider) to maintain the record. The responsibility for this cannot be transferred, although the action of producing printed medicines administration records can be agreed between the social care provider and either a pharmacy or dispensing doctor.
177	Kirklees Council	Short	16	1.9.4	Bullet 11 states providers to allow sufficient time but should this include commissioners /Assessors commissioning enough time?	Thank you for your comment. NICE has made recommendations on the contracting of home care and the amount of time needed for each visit. Please see the NICE guideline on home care.
178	Kirklees Council	Short	16	1.9.5	This is placing a lot of responsibility on care workers. Is this really safe?	Thank you for your comment. The guideline states that the responsibility for ordering medicines usually stays with the person and/or their family members or carers. The Committee agreed that in some situations a care worker may provide support, if this support has been agreed and they have been trained and assessed as competent to do so.
179	Kirklees Council	Short	17	1.9.10 and 1.9.11	Appear to contradict each other. One says don't do it if a person asks and one says what to do if a person asks	Thank you for your comment. Over-the-counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over-the-counter medicines in this setting. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
180	Kirklees Council	Short	17	1.10	Storage/Transport and disposal- is it reasonable to expect home care workers to carry out these tasks? We feel it is more appropriate for pharmacists /health professionals responsibility.	Thank you for your comment. The Committee recognised that these were tasks that care workers may be asked to assist a person with, if this has been agreed as part of the assessment of medicines support needs.
81	NHS England	Short	1	5	We welcome this guideline in that it identifies the need for good practice in the wider range of community settings which are likely to house vulnerable older adults on complex medicines treatment plans and who will need additional support to ensure that they receive their medication appropriately and in a safe timely fashion. We do however question how in practice it will be utilised in the context of existing regulatory standards and professional guidance. At the very least the opening paragraph should, we suggest, set out a clearer rationale and be more specific on how the guidance is intended to be positioned with the existing guidance and standards which govern medicines administration in community settings. We suggest that any such guidance must be firmly aligned and cross referenced from the outset with existing regulatory guidance and professional standards to provide it with the best opportunity of being taken up in the way intended. See for example the standards set out at: http://www.cqc.org.uk/content/regulation-12-safe-care-and-treatment#guidance and the guidance at: http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf? Which covers considerably the ground covered in this guidance.	Thank you for your comment. The guideline is published in a number of different formats. The short version of the guideline contains recommendations and brief context only. The full guideline includes more detail on context, legal requirements and current professional and regulatory guidance (see sections 1.1 and 1.2 of the full guideline). The regulator (Care Quality Commission) was involved in the development of the guideline and the Committee were aware of relevant professional standards and national guidance when developing the recommendations.
82	NHS England	Short	4	11	It is suggested that a very clear definition of 'medicines support' be included in the guidance to avoid confusion over the meaning and use of this term. For example the following definition covers this well: **Medication support** is the prompting and/or assisting the client with self-medication and may involve: • reminding and/or prompting the client to take the medication	Thank you for your comment. Medicines support is defined in the guideline. The Committee agreed that terms such as 'prompting', 'reminding' and 'assisting' may be misinterpreted and agreed that these terms should not be used in the guideline.

					• assisting (if needed) with opening of medication containers for the client • and other assistance not involving medication administration. **If medication support is being provided the client retains all responsibility for their medications.** http://ww2.health.wa.gov.au/	
83	NHS England	Short	5	2	Suggest adding: '..taking into account the information with which they have been provided (written and verbal) and the person's intellectual and cognitive capacity to understand this information'	Thank you for your comment. The Committee agreed that this is a simple check on how much understanding a person has regarding their medicines. They agreed that the ability to assess cognitive capacity is beyond the level of knowledge and skill expected for this role. The guideline recommends that if the care worker has concerns about a person's cognitive ability they should seek advice.
84	NHS England	Short	5	3	Suggest adding '..taking into account physical (including dexterity) and sensory impairments (including vision)	Thank you for your comment. The Committee felt that this was already captured within the recommendation, and the example of problems reading medicines labels has been included.
85	NHS England	Short	5	5	Some medications require regular check on the quality of storage particular if required to be in a refrigerator, and on their expiry dates which are often ignored meaning that out of date or degraded medications are being consumed.	Thank you for comment. The process for managing out of date medicines is included in the guideline.
86	NHS England	Short	5	11	And how and where this information is documented for ease of accessibility: see comment below	Thank you for your comment. This is covered in the recommendations on joint working between health and social care.
87	NHS England	short	5	15	There are additional and emerging ways of storing this information for ease of retrieval, for example digital devices or wrist bands. We suggest these options be explored for adding into the guidance.	Thank you for your comment. The Committee did not find any evidence on the comparative effectiveness or cost-effectiveness of digital devices or wrist bands compared with a care plan.
88	NHS England	Short	5	19	It's not clear from this to what consent the guidance is referring: consent to record information? To receive medicines support? Or some other form of consent?	Thank you for your comment. This wording has been amended following further discussion by the Committee to clarify this means how consent for decisions about medicines will be sought. The term 'consent' is also included in the glossary in the full guideline.
89	NHS England	Short	8	3	Suggest linking to best practice in relation to advance care planning; for example http://www.goldstandardsframework.org.uk/advance-care-planning	Thank you for your comment. Examples of good practice can be submitted for NICE endorsement (endorsement@nice.org.uk).
90	NHS England	Short	8	11-15	This is an extremely difficult area of clinical practice which requires considerable knowledge and expertise. We question whether this statement is appropriate to include in guidance primarily aimed at social care professionals and community based practitioners who may not be adequately equipped to address such technically, legally and ethically complex areas of practice.	Thank you for your comment. This is a wider issue that does not just relate to the population included in the guideline. The recommendation is not directed at social care practitioners or community based practitioners. It is not possible to specify the person or organisation responsible, due to the complexity described. This will be for commissioners and providers to determine locally.
91	NHS England	Short	10	8	In line with other best practice the medicines administration record should contain at least two other identifiers such as NHS number and date of birth. This is particularly important if the document becomes part of documentation which transfers between health care settings (such as a hospital admission) to ensure that the record is not susceptible to being wrongly linked to another patient record.	Thank you for your comment. This wording has been amended to include the points raised, following further discussion by the Committee.
92	NHS England	Short	10	12	Mindful of the evolving healthcare commissioning and provider landscape we suggest that this also includes 'and/or other clinician directly responsible for the health care of the person'.	Thank you for your comment. This wording has not been changed as the Committee felt that it would not be appropriate or necessary to include a list of all clinicians directly responsible for a clinician's care on the medicines administration record (MAR). The main purpose of the MAR

						is to record medicines administration and there is no legal requirement for MARs to be provided. It may be more appropriate for the details of clinicians directly responsible for a person's care to be recorded in the care plan. This is covered in recommendation 1.2.5 of the published short version of the guideline.
93	NHS England	Short	10	15	We strongly recommend that the patients known allergy status is recorded prominently on the medicines administration record.	Thank you for your comment. This wording has been amended to include any known drug allergies, following further discussion by the Committee.
94	NHS England	Short	11	8	While the language of a 'fair blame' culture is beginning to achieve understanding within NHS services we would question how well this is understood among home care providers. We suggest that 'openness' or similar language may be better received in practice.	Thank you for your comment. The term 'fair-blame' is explained in the 'Terms used in this guideline' section of the short version and in the glossary of the full guideline. This wording is consistent with that used in the NICE guideline on medicines optimisation (NG5).
95	NHS England	Short	11	29	Suggest adding '..mental capacity to make decisions about their medical treatment'	Thank you for your comment. This suggested wording has been added to the recommendation for clarity, following further discussion by the Committee.
96	NHS England	Short	11	30	We suggest cross referencing this to guidance about falls risk management in community settings given the strong associations between falls, multi-morbidity, polypharmacy and medicines adverse effects and/or interactions.	Thank you for your comment. This suggestion in relation to falls has been incorporated into the guideline, following further discussion by the Committee. Please note that related guidelines are included in the full guideline (section 2.7).
97	NHS England	Short	13	4	Suggest adding statements about disposal of used or expired medications – particularly removal and disposal of patch medications.	Thank you for your comment. Please see the section on transporting, storing and disposing of medicines.
98	NHS England	Short	14	4	Suggest adding'…mental capacity to make decisions about their medical treatment '	Thank you for your comment. This suggested wording has been added to the recommendation for clarity, following further discussion by the Committee.
99	NHS England	Short	17	15	We question whether it is realistic to expect providers to be responsible and capable of assessing and ensuring the person is able to understand 'any risk' associated with OTC medicines; This requires the professional expertise and knowledge of appropriately trained health care professionals and can often be difficult to determine given the sometimes unpredictable nature of medicines interactions.	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over the counter medicines in this setting. The recommendation states that advice should be sought from a pharmacist or other health professional, who would be able to advise on the risks and benefits of treatment. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
100	NHS England	Short	19	20-23	See comment 9	Thank you for your comment.
76	Northern Devon Healthcare NHS Trust	**short** version	17	1	We are concerned about the risk of monitored dosage systems being over-used, as they can be viewed inappropriately as being a solution, which may not be appropriate without specialist assessment (see next comment below). Monitored dosage systems may add to risks of medication error rather than being a solution without appropriate expert assessment. We would like to see the word "Only" added to the first sentence, as the first word, so that the sentence reads "**Only** consider using a monitored dosage system only…."	Thank you for your comment. The wording of the recommendation has not been changed as this is consistent with NICE style on how recommendations are worded. Please see Developing NICE guidelines: the manual (section 9) for more information.
77	Northern Devon Healthcare NHS Trust	**short** version	17	2	We are concerned that the reference in the example cited "(for example, a community pharmacist)" is too specific and would suggest that this is broadened to state "(for example, a community, domiciliary care or hospital pharmacist)". This assessment may also be carried out by other healthcare professionals, such as occupational therapists, so the example could also include the term "competent healthcare professional", as it would	Thank you for your comment. The wording has been amended to 'pharmacist' following further discussion by the Committee. The recommendation states that the assessment is carried out by a health professional, and a

					be more important to ensure that an appropriate assessment is carried out in the context of the individual and the arrangements for on-going care, rather than who the assessment is carried out by.	pharmacist is given is an example because they commonly undertake these assessments.
78	Northern Devon Healthcare NHS Trust	**short** version	18	24-30	We are concerned that this paragraph may be mis-interpreted, and would like to see the sentence re-worded to say: "Medication dispensed for named patients are the property of that patient and may not be disposed of without their consent. In such circumstances, medicines for named patients should be returned to a community pharmacy for disposal, following safe procedures (e.g. use of sharps bins, pharmaceutical waste bins).	Thank you for your comment. The guideline states that responsibility for transporting, storing and disposing of medicines usually stays with the person and/or their family members or carers. However, the recommendation is directed at care providers, if it has been agreed that they will be responsible.
79	Northern Devon Healthcare NHS Trust	**short** version	18	24-30	Continued: When care home providers are responsible for disposing of any unwanted, damaged, out-of-date or part used medicines that have been purchased or bulk-ordered by them, they must have a robust process for disposal to meet current waste Regulations (The Controlled Waste [England and Wales] Regulations 2012), to include how the medicines will be disposed of (usually to a community pharmacy for disposal). If the medicine is the patient's own property, permission of the patient must be obtained and recorded prior to disposal."	Thank you for your comment. The guideline states that responsibility for transporting, storing and disposing of medicines usually stays with the person and/or their family members or carers. However, the recommendation is directed at care providers, if it has been agreed that they will be responsible.
80	Northern Devon Healthcare NHS Trust	**short** version	19	12	Bullet point to be changed to state: "Commission or procure appropriate training and support from an appropriately qualified trainer / healthcare professional." As the word 'receive' does not imply how the care home will arrange appropriate training and support.	Thank you for your comment. Wording was considered by the Committee and has not been changed. The Committee recognised the importance of training and assessment of competency for health and social care practitioners, but this is not part of NICE's remit. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
253	Parkinson's UK	Full	16	43	In section 2.2 remit information could have been included on whether the funding or commissioning body had any influence on the content of the guideline.	Thank you for your comment. As a non-departmental public body, we are accountable to our sponsor department, the Department of Health, but operationally we are independent of government. Our recommendations are made by independent Committees. Please see the NICE website for full details.
254	Parkinson's UK	Full	17	16	In section 2.3 where it states who developed the guideline, it says that details of declared interests and actions taken are recorded in Appendix A. However these details were not available. They should be included.	Thank you for your comment. The appendices were available to download from the NICE website during the consultation period.
255	Parkinson's UK	Full	18	General	An additional section describing facilitators and barriers to the implementation of the guideline should be added.	Thank you for your comment. Implementation is for commissioners and providers to consider and determine locally. A standard section on implementation is included at final publication.
256	Parkinson's UK	Full	18	General	An additional section should be added providing advice and/or tools for putting the recommendations into practice. This information may have been embedded in the sections titled 'Evidence to recommendations', but a distinct section would be helpful.	Thank you for your comment. Implementation is for commissioners and providers to consider and determine locally. A standard section on implementation is included at final publication.
257	Parkinson's UK	Full	18	General	An additional section should be added describing the resource implications of applying the recommendations. This information may have been embedded in the sections titled 'Evidence to	Thank you for your comment. The Committee considered the resource implications when reviewing the evidence and

					recommendations', but a distinct section would be helpful.	developing recommendations. Their discussions are included in the 'Linking evidence to recommendations' (LETR) table in the full guideline. Please see sections 5.5, 6.5, 7.5, 8.5, 9.5 and 10.5. This is the standard approach for all NICE guidelines.
258	Parkinson's UK	Full	18		An additional section should be added presenting monitoring and/or auditing criteria.	Thank you for your comment. The purpose of the guideline is to provide recommendations on the systems and process for managing medicines for adults receiving social care in the community. The suggested additional performance or audit criteria are outside the scope of this guideline.
259	Parkinson's UK	Full	21	25	In section 3.1.1 on 'review questions' there was no description in the methods, of a strategy or process for capturing the views and preferences of the target population. This information should be added.	Thank you for your comment. The literature search included looking for studies which included the outcomes of service user and carer reported outcomes (see Appendix C.2). Section 2 of the full guideline outlines how the guideline was developed.
260	Parkinson's UK	Full	23	15	In section 3.2.1 on literature searching Cumulative Index to Nursing and Allied Health (CINAHL) was not included among the databases searched. Relevant articles from nursing and allied health journals may have been missed as a result, unless these were covered by the included social science/ care/ policy/ services databases. If so, this was unclear. We recommend that the CINAHL is added to the searches that inform this section.	Thank you for your comment. It is very unlikely that CINAHL will retrieve any unique references. A NICE internal project found that only 0.33% (95% confidence interval: 0.01%-0.64%) of references per guideline were unique to CINAHL. No significant relationship was found between question type and unique CINAHL yield for drug-related questions. Therefore, as the main focus of the search was managing medicines it is very unlikely that anything unique would have been found. A judgement was made based on where it was most likely to retrieve unique evidence and it was felt that we should include social care databases which would contain unique references from this setting.
261	Parkinson's UK	Full	25	2	In section 3.3.3 on appraising the quality evidence there was no clear description of the precise criteria on which judgments of quality were made. Appendix F did show the AGREE II domain scores for each included guideline, but it was unclear whether scores represented: a) Crude scores derived from a single reviewer; b) Mean crude scores derived from a number of reviewers; c) Percentage scores derived from (obtained score - minimum possible)/(maximum possible - minimum possible) x 100. Nor was it clear how overall quality categories for guidelines (eg. moderate quality; very low quality) were derived. No comment was made on the worryingly low score for Domain 3 (rigour of development) for each included guideline. These comments should be include to help users of this NICE guideline to quickly determine the strength of evidence on which the recommendations are made, and could be made more explicit. If a single reviewer rated the quality of the guideline using the *Appraisal of Guidelines for Research and Evaluation (*AGREE II) instrument, the reliability of scores may have been compromised. This should be stated explicitly in the guideline if it is the case.	Thank you for your comment. The AGREE II was conducted by 2 reviewers (1 assessing and 1 checking) and represents the crude scores for each domain. A description of how the judgements on quality were made has been added to section 3.3.3. Appendix F shows the domain scores and the overall score. A cross reference to section 3.3.3 and appendix F has been added to each 'clinical evidence' section.
262	Parkinson's UK	Short	3	9-10	The bullet point states "*supporting people to take their medicines, including 'when required' time-sensitive and over-the-counter medicines*." We recommend that this sentence is added to by stating '*for example, people with Parkinson's*'.	Thank you for your comment. Many groups of people require treatment with when required and time-sensitive medicines. The term 'time-sensitive medicine' is explained in the 'Terms used in this guideline' section of the short version and in the glossary of the full guideline. Parkinson's disease medicines have been added to this definition as an example of a time-sensitive medicine.

263	Parkinson's UK	Short	4	2	The definition of 'competency' should be clarified. Does the guideline mean someone who lacks mental capacity, or limitations which would stop them taking their medication, such as inability to move their arms? Or both of these definitions? We recommend the guideline clarifies this and we believe it should contain both examples.	Thank you for your comment. This wording has been amended to 'assessment of competency' following further discussion by the Committee. It was felt that this term would be well understood in the context of training and competency. The mental capacity of the person receiving support is an unrelated issue. This term is explained in the glossary of the full guideline and has been added to the 'Terms used in the guideline' section of the short version.
264	Parkinson's UK	Short	4	24 - 29	We are pleased to see the inclusion of information instructing professionals to take into account the patient and families ability, and their views on taking medication themselves. It is vital that people with Parkinson's and their carers are enabled to take their own medication where possible. The timing of medication is so important people can get apprehensive if professional carers do not administer their tablets on time. Their condition can also seriously deteriorate if their medication is delayed.	Thank you for your comment.
265	Parkinson's UK	Short	4	24 - 29	Parkinson's UK agrees with recommendation 1.2.4. It is incredibly important that people with Parkinson's are enabled to manage their own medication where possible. Self management of medication can keep people more independent, reduce their symptoms and improve their wellbeing. At the beginning of 2016 Parkinson's UK completed some work on "outcomes" of self management. This looked at information from feedback forms completed by 675 participants who attended groups, telephone interviews and a focus group. Comments made by people with Parkinson's who have attended our self management programme include: "*I would recommend this course to everyone, even if they are shy or uncomfortable with public speaking, because with encouragement they will settle down and thoroughly enjoy the laughter and meeting brave people – and be inspired to carry on enjoying life.*" "*Beginning at a very negative point, after three weeks I am totally changed. My attitude is one of motivation now rather than lacklustre acceptance. Thank you, I wish we had three more weeks.*" "*The course is brilliant. I have got out of it things I had never considered. I have plans now which I believe will improve my husband's life and my life*." Outside of Parkinson's UK there is research into the benefits of self management for long term conditions. The recent NHS England funded "Realising the Value" programme created a guide on supporting self management based on the findings of the research projects http://www.nesta.org.uk/self-management-education This recommendation should add a bullet point stating that people should be referred to self management programmes where appropriate.	Thank you for your comment. The Committee found no evidence in relation to supported self-management that was specific to the guideline population (adults receiving social care in the community). Please see also the NICE guideline on medicines optimisation.
266	Parkinson's UK	Short	5	1	We support this recommendation that people with Parkinson's should be encouraged to discuss advanced care planning, and preferences for palliative care. The UK Parkinson's audit found that less than one third of people with markers of advanced Parkinson's had documented discussions about end of life care/Lasting Power of Attorney with their clinicians (239 clinical services took part): REF Parkinson's 2015 audit https://www.parkinsons.org.uk/sites/default/files/audit2015_summaryreport.pdf.	Thank you for your comment.

					Research also shows that half of Parkinson's patients are unable to make or communicate decisions in the last month of life - 68% had difficulty communicating and 47% were confused. (Fleming, A., Cook, K. F., Nelson, N. D., & Lai, E. C. (2005). A 2008-2011 UK study also showed that 90 per cent of patients with Parkinson's had not discussed their wishes with a health or legal professional or written them down. (Walker RW, End Stage Disease in Parkinson's, Presentation to Autumn 2013 British Geriatrics Society meeting).	
267	Parkinson's UK	Short	6	20- 22	Parkinson's UK strongly supports recommendation 1.3.4 stating that home care workers and other social care practitioners should seek advice about medicines from people with specialist experience. Many people with Parkinson's have a range of long term conditions on top of their Parkinson's, including dementia. As a result, the concoction of medication needed can be very complex, and some medicines can react badly when taken with others. '*Parkinson's disease has been increasingly recognised as having a multitude of non-motor symptoms including psychosis, cognitive impairment and dementia, mood disturbances, fatigue, apathy, and sleep disorders. Psychosis and dementia, in particular, greatly affect quality of life for both patients and caregivers and are associated with poor outcomes. Safe and effective treatment options for psychosis and dementia in PD are much needed. Antipsychotics with dopamine-blocking properties can worsen parkinsonian motor features and have been associated with increased morbidity and mortality in elderly, dementia patients. For treating PD psychosis, a first step would be eliminating confounding variables, such as delirium, infections, or toxic-metabolic imbalances, followed by simplifying parkinsonian medications as tolerated.*' From 'Treatment of Psychosis and Dementia in Parkinson's Disease Jennifer G. Goldman, MD. There is more evidence in Cognitive Impairment and Dementia in Parkinson's Disease: Practical Issues and Management Murat Emre, MD,1* Paul J. Ford, PhD,2 Bas¸ar Bilgic¸, MD,1 and Ergun Y. Uc¸, MD3,4.	Thank you for your comment.
268	Parkinson's UK	Short	7	7	Problems with medicines adherence could also be caused by cost barriers. Research completed by the Prescription charges Coalition in march 2014 found - Over one third of the total sample reported that the cost of their medication had prevented them from taking it as prescribed, reconfirming the significant impact that prescription charges have on medicine adherence and effective self-management - Three quarters of those who said that they were not taking their medication as prescribed because of the cost reported that this had affected their ability to work; for 70% of these, this had included time taken off work - Prescription charges have a detrimental impact on the working lives of people with long-term conditions at all income levels and of all ages, although this is greatest for those on the lowest incomes and for those who are younger. http://www.prescriptionchargescoalition.org.uk/the-evidence.html This recommendation should include information for professionals to signpost people to the low income scheme for prescriptions, and the pre-payment certificate for prescriptions.	Thank you for your comment. Please note that the issue of prescription charges is out of scope for this guideline.
269	Parkinson's UK	Short	8	1 - 10	We agree with recommendation 1.4.1. Please see our research and information to support this in comment 14.	Thank you for your comment.
270	Parkinson's UK	Short	12	10- 13	We support recommendation 1.6.7 and agree that people should be signposted to the Medicines and Healthcare products Regulatory Agency's yellow card scheme.	Thank you for your comment.
271	Parkinson's UK	Short	12	18-19	Parkinson's UK agrees with recommendation 1.7.	Thank you for your comment. The Committee found no evidence in relation to supported self-management that was

					There is research into the benefits of self management for long term conditions. The recent NHS England funded "Realising the Value" programme created a guide on supporting self management based on the findings of the research projects http://www.nesta.org.uk/self-management-education The guideline should include information about organisations, like Parkinson's UK who provide tailored self management courses to help people cope with specific conditions.	specific to the guideline population (adults receiving social care in the community). Please see also the NICE guideline on medicines optimisation.
272	Parkinson's UK	Short	13	8	We strongly agree that there should be robust processes in place to ensure that home care workers give patients with time-sensitive medication their medicine on time. This is crucial for people with Parkinson's who's condition can severely deteriorate if they do not get their medication on time. This bullet point should be expanded to give the example of '*people with Parkinson's*'.	Thank you for your comment. The term 'time-sensitive medicine' is explained in the 'Terms used in this guideline' section of the short version and in the glossary of the full guideline. Parkinson's disease medicines have been added to this definition as an example of a time-sensitive medicine.
273	Parkinson's UK	Short	13	10 - 19	We strongly support recommendation 1.7.2.	Thank you for your comment.
274	Parkinson's UK	Short	14	5- 6	We agree with recommendation 1.7.6 as leaving medicines open and out could result in someone with Parkinson's and dementia forgetting when they are supposed to take their medicine and overdosing.	Thank you for your comment.
275	Parkinson's UK	Short	14	17- 18	We strongly agree with recommendation 1.7.9 that home care providers should ensure that home care workers are able to prioritise their visits for people who need support with time sensitive medicines. Graham, who is blind, cared for his wife Maureen who lived with Parkinson's explains the importance of timely medication for people with Parkinson's: "*Maureen was unable to get her medication at the right times and her health went downhill rapidly. As well as developing problems swallowing, Maureen became rigid, which meant she wasn't able to have physiotherapy to help keep her moving. Sadly, Maureen has not fully recovered from the period where she did not get her medication on time. She can no longer stand or walk and now lives in a care home. I can't overstate the importance of staff being educated on how crucial it is for people with Parkinson's to get their medication on time."*	Thank you for your comment.
276	Parkinson's UK	Short	19	6	Section 1.11 should include signposting to organisations who can provide appropriate training. Parkinson's UK offers training to professionals on a range of topics to enable them to support people with Parkinson's manage their medication needs. We therefore recommend that this guideline encourages health and social care providers to utilize Parkinson's UK training opportunities to professionally develop their staff.	The Committee recognised the importance of training and assessment of competency for health and social care practitioners, but this is not part of NICE's remit.
232	Prescription Training	Short version	9 10	27 4	I think it would be clearer if we just stated that **regula**r prompts are recorded on the medicines chart. Otherwise there is a risk that some home care agencies continue to write 'prompted meds' in the daily record. We should know **which** medicines were prompted and when. Suggest differentiate regular vs occasional prompts. If prompting makes it into the care plan, it is usually a regular prompt that is needed. If a client needed a **regular** reminder, then I would also want the support worker to stay and watch the client take their medicine(s). If they are that forgetful…. I would also want the support worker to intervene if they thought that the client was about to take the wrong medicine (e.g. blister pack is upside down). For me, a regular prompt is akin to the support worker taking responsibility for ensuring that the medicines is taken (i.e. they are instigating the dose). Hence, to stay in line with previous guidelines (HMSC) and CQC professional advice (administration medicines in domiciliary care (2009)) this activity must be interpreted as administering medicines. Hence it should be recorded on a medicines chart. This would enable us to see which medicine was prompted and when. Although this could be seen as a grey area, with the thousands of dom. care staff we have trained, both they and we feel this advice (above) is pragmatic and realistic.	Thank you for your comment. Please note that although the use of MAR charts are recommended in the guideline, there is no legal requirement for care providers to use them (indeed some providers make records of care given in relation to medicines in the person's notes or care record). The need for a care worker to remind a person to take their medicines should be identified as part of the medicines assessment. This would be included in the guideline's definition of medicines support (see the recommendations on assessing a person's medicines support needs). The wording of the recommendation was considered by the Committee and has not been changed as the term 'medicines support' is defined in the guideline.

					Suggest change page 10, line 4 to "Home care workers should use a printed medicines administration record to record any medicines that they give to a person **or the support outlined in 1.5.2**	
233	Prescription Training	Short version	10	11	In practice, most dom care agencies have had to design their own medicines charts (with some exceptions like West Sussex and the Take as Directed Local Pharmaceutical Scheme I ran for Brighton and Hove PCT). Hence 1.5.4 has implications for dom care who design their own charts. I personally feel that insisting route of administration is included is not needed as having the formulation makes this obvious e.g. Tablet/capsule – where else would these be administered? Eye drop – as above Ear drop – as above Transdermal patch – as above Cream – as above It would be useful for PEGs as you'd not want these given orally.	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. They were aware that there are a number of different types of pre-printed MAR charts currently in use. However they found no evidence on the safety or effectiveness of different types. The Committee agreed that the recommendations reflect good practice.
234	Prescription Training	Short version	10	14	By additional information, do we mean CALs? If so, there isn't the space on most of the meds charts that are designed by the dom care agencies. Also there is the risk of transcription errors with all that text having to be transferred across from the pharmacy label. The CALs are already on the pharmacy label, do they really also need to be transcribed to the MAR? I have seen lots of examples where staff have handwritten CALs on the MAR and then don't have enough space to neatly write the med, strength, form and directions.	Thank you for your comment. Cautionary and advisory labels are drawn from a pre-prepared list and do not necessarily contain all the information necessary to administer medicines correctly. Additional information may include information from a cautionary or advisory label, but may also include, for example, further advice from a pharmacist. The Committee recognised the risk of transcription errors with handwritten medicines administration records (MARs) and agreed that a printed MAR would be preferred. This is reflected in the recommendations. However, there are circumstances when information may need to be transcribed, and robust processes need to be in place to ensure the risk of error is minimised as far as possible. The Committee were mindful that there is no requirement for supplying pharmacies or dispensing doctors to provide printed MARs.
235	Prescription Training	Short version	13	11	The information needed for PRNs is inconsistent with NICE guidelines on managing medicines in care homes which state: "Recommendation 1.14.2 Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy. The following information should be included: • the reasons for giving the 'when required' medicine • how much to give if a variable dose has been prescribed • what the medicine is expected to do • the minimum time between doses if the first dose has not worked • Details of when to clarify instructions with the prescriber if there is any confusion or ambiguity about what medicines or doses are to be given	Thank you for your comment. The evidence presented and Committee discussions relate to adults receiving social care in the community, not people living in care homes. 'When required' medicines were discussed further by the Committee and the recommendation has been amended for clarity. The Committee agreed that this reflects good practice.

					There is also recommendation 1.9.2 which has some more bullet points: When prescribing variable dose and 'when required' medicine(s) the health professional prescribing the medicine should note in the resident's care record the instructions for: • including the maximum amount to be taken in a day • and how long the medicine should be used" Is there a reason for this? Surely you would want to state the reasons for giving the PRN? i.e. what it is used for. Also, you have stated that you want the PRN information on the pharmacy label rather than on a PRN protocol. Is that deliberate as this would really limit the amount of information the could be recorded. Is this why you have asked for less information.	
236	Prescription Training	Short version	14	1	Can we change to: "Home care workers should ask the person (or establish non-verbal consent) if they want to take their medicine before removing it from its packaging" It could be irritating being always asked e.g. twice a day for X years!	Thank you for your comment. The wording has been amended to add 'unless this has been agreed and it is recorded in the provider's care plan', following further discussion by the Committee.
237	Prescription Training	Short version	17	20	Is this practical? If a client has a headache, are we saying that they must make a GP appointment and wait x days before they can access paracetamol? How else would we supply a headache remedy? Surely they can talk to a pharmacist over the phone (or they can get the home care worker to do this for them). How else would a health professional supply a head ache remedy for someone unless it was based on symptoms described by the person. I designed a process (a 'confirmation of advice to administer a non-prescribed medicine' protocol) for this which is embedded into West Sussex CC's, Surrey CC's, Brent CCs and many other medication policies. For me, 1.9.10 and 1.9.11 are not clear.	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over the counter medicines in this setting. This includes seeking advice from a pharmacist or another health professional. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
238	Prescription Training	Short version	18	23	Insert e.g. before lockable cupboard as many home care agencies use lockable cash boxes. Leaving eg out makes it seem that only lockable cupboards will do.	Thank you for your comment. The wording has been amended to reflect the point raised, following further discussion by the Committee. A lockable cupboard has now been given as an example only.
239	Prescription Training	General	General	General	One big issue with home care is the way that medicines given from mixed monitored dosage systems are recorded. Is there any way that NICE can ensure that medicines given from these "blister packs" are recorded correctly? At present many care providers are just recording a tick or initials against a line on a medicines chart that states "blister pack". There is no record of which medicines were given from that blister pack.	Thank you for your comment. The wording of the recommendation has been amended to ensure that details of each individual medicine are recorded on every occasion.
277	Royal College of General Practitioners	Short	General	General	It may be worth commenting on/stressing the need for up to date records of drug allergies/ history of adverse effects, not just in GP medical records but also in home/social care records We feel that lots of regulations stating documentation are needed according with the document. There is a huge danger of documentation taken preference on caring. We also feel that it would be worth to review the role of the home care provider. It is not clear from reading the recommendations what role a home care provider should take if a patient asks them their opinion on whether a medication is of use to them. Patients may have reservations about a particular	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended to include allergy status in recommendation 25 of the final published full guideline. Thank you for your comment regarding documentation. Whilst the Committee recognise this can be an issue for providers, the requirements as to what aspects of care must be documented are specified by the Care Quality

					medication and ask for judgements about whether it is worth taking. This may relate particularly to preventive medications such as statins or osteoporosis prevention drugs. The role of the home care provider should be to recognise this apprehension and direct patients to have a full discussion with a health professional about the evidence and rationale for the treatment. They should avoid passing judgments about particular medications based on their own experiences or, for example, media reports.	Commission. Additionally good record-keeping gives the provider information for investigating problems and ensuring safe care in relation to managing medicines. Please note that the guideline recommends what a care worker (as the care provider organisation will not be in the person's home) should do if a person asks a clinical question about their medicines (i.e. advise the person and/or their family or carers to seek advice from a health professional).
278	Royal College of General Practitioners	Short	4	16	How is a home meant to manage when people look after their own medication and how can they document things have been taken if an individual has been assessed to be able to manage on their own.	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline. The guideline states that supporting people to manage their medicines is preferred, with help from family members or carers if needed. If a care provider is involved following an assessment of the person's medicines support needs, the recommendations outline what would represent good practice.
279	Royal College of General Practitioners	Short	5	15	Vast amount of information will need to be recorded here.	Thank you for your comment. The Committee agreed that this initial assessment of medicines support needs was an essential part of the process. The discussions and decisions outlined in the recommendation are only relevant if the person is assessed as needing support with their medicines. The Committee was aware from their experience that problems occur because this information isn't explicitly discussed, documented or communicated with the relevant care providers. Recording this information in the care plan supports safe care and aims to protect both the person receiving care and the care worker. See also the NICE guideline on home care.
280	Royal College of General Practitioners	Short	6	8	This recommendation will have a big impact on practice because currently, locally at least, home care providers do not contact the GP to inform them that they are providing medicines support. Currently when a GP wants to make a medication change it is very difficult to identify who the care provider is and inform them of the change. As a result, often there is a delay in an intended change occurring. Having this information accessible in the GP records would make a big impact upon the quality of care provided. I do suspect that this will be a challenge to implement because it will involve getting a large number of home care providers on board with informing GPs, and there will be a perceived increase in their workload. This could be made easier by standardising a form that a home care provider could complete and send to the GP. In addition community pharmacists could be involved in this area with some benefits	Thank you for your comment. The Committee was aware from their experience that many GP's do not know that a person is receiving medicines support from a social care provider. This is a barrier to effective communication and joint working across health and social care, and to the implementation of this guideline. The importance of joint working between health and social care is highlighted in the guideline. See also the NICE guideline on home care. Use of a standardised form to address the issues raised would be for commissioners and providers to determine locally.
281	Royal College of General Practitioners	Full	31	20	A more likely and suitable means of this communication than secure fax or e-mail is through a shared computerised record (e.g. SystmOne).	Thank you for your comment. Implementation is for commissioners and providers to consider and determine locally. The methods of communication highlighted are common examples, and not intended to cover all available methods of secure communication.

282	Royal College of General Practitioners	Short	11	6	We agree in overall. But who should they report to and will those organisations follow a fair blame culture. Sadly most don't.	Thank you for your comment. Local and national arrangements are in place for reporting medicines-related problems, including those that are safeguarding incidents. See also the NICE guideline on medicines optimisation (NG5) – Systems for identifying, reporting and learning from medicines-related patient safety incidents. Advice should sought from the regulator if there are concerns about the practice of care providers.
283	Royal College of General Practitioners	Short	11	19	In addition to this list, please consider adding the following: - the person taking medication that appears to have been prescribed abroad., i.e. medication that their UK GP may not be aware they are taking.	Thank you for your comment. The recommendation has not been amended as it gives examples of concerns about medicines, and is not intended to be an exhaustive list. Medicines that have been prescribed by another prescriber (either in the UK or abroad) without informing the person's GP is a communication issue.
284	Royal College of General Practitioners	Short	14	20	We agree that this statement is included as it is a rare but essential part of good care but the fear is CQC does not allow it.	Thank you for your comment.
285	Royal College of General Practitioners	Short	15	19	It is unclear from this directive who is able to authorise and instruct on this activity. All care companies use different paper work and standards, which further complicates the issue. It is implied that it should be the GP making this decision. I am not sure that the GP is always the person best placed to make this decision. If we had to implement this, I think the GPs that I work with would want some additional training. Each case would have to be dealt with on an individual basis. There would be a time impact / cost.	Thank you for your comment. Covert administration was further discussed by the Committee in detail. The Committee recognised that arrangements for covert administration are not the sole responsibility of GPs, and therefore the resource impact described would not be realised. Covert administration should only takes place in the context of existing legal and good practice frameworks. Please note that these are recommendations not directives. Please see the Mental Capacity Act Code of Practice (section 6.17) which states 'Multi-disciplinary meetings are often the best way to decide on a person's best interests. They bring together healthcare and social care staff with different skills to discuss the person's options and may involve those who are closest to the person concerned. But final responsibility for deciding what is in a person's best interest lies with the member of healthcare staff responsible for the person's treatment.' The recommendations have been amended to reflect the need for a joint approach across health and social care. They are not directed at particular people, groups of people or care providers, and responsibilities will need to be considered and determined locally. Further consideration of the circumstances and principles are given in the full guideline.
286	Royal College of General Practitioners	Short	16	16	Lots of admin work is required here.	Thank you for your comment. The Committee agreed that the recommendations reflect good practice.
287	Royal College of General Practitioners	Short	17	12	Oct medication needs to be used much more as it empowers people to self care and potentially saves NHS resource in many ways. How are people meant to get them if home care workers can't buy on their behalf? If they are self caring how is the home mean to record these details?	Thank you for your comment. Over the counter medicines were discussed further by the Committee and the recommendations have been amended into a single recommendation that incorporates all aspects of managing over the counter medicines in this setting. While the Committee agreed that there are benefits to over-the-counter medicines being used to support self-care, there is also a risk of symptoms being masked through their

						inappropriate use. The Committee concluded that the purpose of the recommendations was to set out key principles, due to the variation in medicines support that is provided by care providers. Details of the process are for local consideration and determination.
288	Royal College of General Practitioners	Full	38	3	It is unclear here what the role of the home care provider is to alter future prescription requests based on unused medications (to avoid recurrent waste).	Thank you for your comment. Care providers should request the correct amount of medicines for a person, when it has been agreed they will be responsible for ordering the person's medicines.
251	Royal College of Psychiatrists	Short	9	1 - 10	This is one of the greatest areas of risk especially with none medical/none nursing staff and the potential for misunderstanding and miscommunication is high without immediate written confirmation which can be done by email in particular or phone text	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended. The Committee agreed that this reflects good practice.
252	Royal College of Psychiatrists	Short	8	11	It's not clear who has the responsibility and expertise to assess and determine if there is capacity to consent to treatment,	Thank you for your comment. This is a wider issue that does not just relate to the population included in the guideline. The recommendation is not directed at social care practitioners or community based practitioners. It is not possible to specify the person or organisation responsible, due to the complexity described. This will be for commissioners and providers to determine locally.
110	Royal Devon & Exeter Hospital	Draft	18	18	Does this refer to storing CDs only? CDs in patients own homes are managed as patients own medicines in the same way as other dispensed medicines	Thank you for your comment. The Committee recognised that additional factors may need to be considered when care workers are responsible for managing a person's controlled drugs. Please see the NICE guideline on Controlled drugs.
111	Royal Devon & Exeter Hospital	Draft	18	28	Would this consent need to be written or is verbal consent sufficient	Thank you for your comment. The Committee concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
112	Royal Devon & Exeter Hospital	Draft	19	17	Should training regarding medication be provided by health professionals/accredited schemes?. Training was aided by CQC levels for support with medication (Level 1 ,2 and delegated tasks as 3) but this is no longer published although seen as custom and practice - could this be republished or linked in this guidance or revised to reflect current standards	Thank you for your comment. The system described is no longer used by the Care Quality Commission. The Committee agreed that training should be provided to reflect the duties that care workers are asked to undertake, in line with current legislative requirements.
113	Royal Devon & Exeter Hospital	Draft	8	16	Ref to medicines reconciliation – need to ensure that any problems or miss- matches are dealt with by professionals so that on-going prescribing and medicines management can be optimised and accurate.	Thank you for your comment. Recommendations on medicines reconciliation can be found in the NICE guideline on Medicines optimisation.
114	Royal Devon & Exeter Hospital	Draft	10	3	MAR charts are not always associated with dispensing These should also be provided by a registered health care professional including a pharmacist /doctor	Thank you for your comment. This recommendation has been amended.
240	Royal Pharmaceutical Society	Full	General	General	The Royal Pharmaceutical Society welcomes and supports this guidance on managing medicines for adults receiving social care in the community.	Thank you for your comment.
241	Royal Pharmaceutical Society	Short	11	19-21	The guidance advises that 'Home care workers should report any concerns about a person's medicines to the home care provider or seek advice from the prescriber or another health professional.' We ask that pharmacists are specified alongside prescribers here - as experts in medicines, pharmacists are able to advise on the concerns that are listed following this statement.	Thank you for your comment. This wording has been amended to include the example of a pharmacist, following further discussion by the Committee.
18	Sheffield Teaching Hospital NHS Foundation Trust	Short	5	26	We are concerned this will not happen once a permanent care package is put in place unless the patient is readmitted At present we believe in Sheffield this is reviewed once a year	Thank you for your comment. The NICE guideline on home care recommends an initial review of the care plan within 6 weeks (recommendation 1.3.25).
19	Sheffield Teaching Hospital NHS Foundation Trust	Short	8	19	In our experience it is rare that prescribers contact care providers, including ourselves about changes to medication. Changes are found when carers go in to the property and new medication has been delivered	Thank you for your comment. The Committee recognised that effective communication about medicines and joint

						working between health and social care is essential, which is reflected in the recommendations.
20	Sheffield Teaching Hospital NHS Foundation Trust	Short	8	25	This is not safe / best practice and is unrealistic to expect prescribers to do this due to different carers visiting and a lack of a robust audit trail	Thank you for your comment. This was discussed further by the Committee and the recommendation has been amended. The Committee agreed that this reflects good practice.
21	Sheffield Teaching Hospital NHS Foundation Trust	Short	9	1	As per previous comment	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline.
22	Sheffield Teaching Hospital NHS Foundation Trust	Short	9	17	We view this as a vague recommendation. More specific guidance on what are acceptable sources of current medication is needed for example a discharge letter from hospital or repeat medication list from the GP. A thorough assessment is also needed to see what medication the patient is taking from these lists are required.	Thank you for your comment. However, the Committee agreed that often the suggested actions in the comment would not be within the scope of a care workers responsibilities. For example, a thorough assessment (medication review) would be the responsibility of a health professional. Please see also the NICE guideline on medicines optimisation.
23	Sheffield Teaching Hospital NHS Foundation Trust	Short	10	3	Not all areas will produce MAR charts because it is not a commissioned service. For example in Sheffield the LPC has recently advised community pharmacies not to produce MAR charts from 1st Jan 2017 until a service has been commissioned which will require extra funding. In addition to this we are also aware some care companies do not use MAR charts and record what has been administered in the notes.	Thank you for your comment. Please note that the Committee discussed the safety, effectiveness and resource implications of medicines administration records (MARs) in detail when making their recommendations. The Committee were mindful that there is no requirement in law for printed MARs to be provided however where medicines are administered there is a requirement for a record of the administration to be made. The Committee was aware that not all community pharmacies or dispensing doctors are commissioned to provide printed MARs however the committee agreed that printed MARs (rather than handwritten ones) are less likely to lead to medicines errors. The Committee was aware that commissioners will need to consider and balance the safety and governance implications against the additional cost of commissioning printed MARs where they are not already in place. The recommendation has been amended to take account of the resources needed to produce MARs and the Committee were confident that the recommendations reflect good practice.
24	Sheffield Teaching Hospital NHS Foundation Trust	Short	10	7	We feel that MAR charts should also include the following : • Allergy status • Date of birth • NHS number (which can be found on GP repeat slip)	Thank you for your comment. This wording has been amended to include the points raised, following further discussion by the Committee.
25	Sheffield Teaching Hospital NHS Foundation Trust	Short	12	10	It is unrealistic to expect care workers to know about yellow card scheme unless trained	Thank you for your comment. The Committee agreed that all health and social care practitioners should be aware of the Yellow Card Scheme.
26	Sheffield Teaching Hospital NHS Foundation Trust	Short	12	10	Need to be more specific as to what are time sensitive medicines. We are aware of safeguarding against care agencies where this has been a problem. E.gs being paracetamol or combination paracetamol products. Parkinson's disease medication	Thank you for your comment. The term 'time-sensitive medicine' is explained in the 'Terms used in this guideline' section of the short version and in the glossary of the full guideline. Parkinson's disease medicines have been added to this definition as an example of a time-sensitive medicine.
27	Sheffield Teaching Hospital NHS Foundation Trust	Short	14	13	It is our experience that community pharmacies seldom supply patient information leaflets with monitored dosage systems and as a result this recommendation may not be fulfilled	Thank you for your comment. When medicines are dispensed into a monitored dosage system, it is a legal requirement that a patient information leaflet (PIL) is

						supplied for every dispensed medicinal product included. An additional recommendation has been added after consultation to reflect the requirement for supplying pharmacists and dispensing doctors to supply a patient information leaflet for all medicines supplied, including those supplied in monitored dosage systems. Please also see the Royal Pharmaceutical Society publication Improving patient outcomes – the better use of multi-compartment compliance aids.
28	Sheffield Teaching Hospital NHS Foundation Trust	Short	17	8	Not all areas will produce MAR charts because it is not a commissioned service. For example in Sheffield the LPC has recently advised community pharmacies not to produce MAR charts from 1st Jan 2017 until a service has been commissioned which will require extra funding. In addition to this we are also aware some care companies do not use MAR charts and record what has been administered in the notes.	Thank you for your comment. The Committee discussed the risks and benefits of medicines administration records (MARs) in detail. However, the Committee were also mindful that there is no requirement for the supplying pharmacist or dispensing doctor to provide MAR charts. The recommendations have been amended to reflect the Committee's discussions. They agreed that they reflect good practice Committee agreed that the.
29	Sheffield Teaching Hospital NHS Foundation Trust	Short	18	28	"usually returned to a community pharmacy" should be replaced by "**always** returned to a community pharmacy"	Thank you for your comment. This is not required under The Controlled Waste (England and Wales) Regulations 2012, please see the full guideline for details.
30	Sheffield Teaching Hospital NHS Foundation Trust	Short	19	6	We are concerned at the briefness of this section relating to the training and competency of home care workers. The link to NICE guidance is also very vague on how home care workers are trained. We are aware that some care companies do not assess competencies. A link to the administration of medicines in care homes needs to be included. We are also concerned this is also not comprehensive and does not talk about high risk medication or time sensitive medication. We are happy to share our experience of training support workers to administer medication and how we assess competencies. We are also happy to share our experience of revalidation using an e-learning programme annually and attendance at face to face every two years.	Thank you for your comment. The Committee concluded that the purpose of the recommendations was to set out key principles of good practice. The Committee recognised the importance of training and assessment of competency for health and social care practitioners, but this is not part of NICE's remit. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Advice should sought from the regulator if commissioners have concerns about the practice of care providers.
101	The Dispensing Doctors' Association	Full	28	33 -37	It is unclear in this context who does the 'medicines assessment' and how it will integrate with 'Medicines Use Reviews (MURs) in pharmacy, Dispensing Reviews of Use of Medicines (DRUMs) in dispensing practices and existing care plans. In our view it is essential that the prescriber (usually the GP) be involved at the outset. How will differences in approach between a prescriber or pharmacist and a Home Care Provider be dealt with? Who is ultimately in charge?	Thank you for your comment. The purpose of the assessment is to determine the medicines support needs of a person receiving social care. The Committee was not able to identify a single person, for example a GP or pharmacist who would conduct the assessment, but was aware that in practice, this is often a social care practitioner, rather than a health professional. The recommendations clearly reflect the need for joint working across health and social care. The guideline states that 'The intended audience for each recommendation is clearly stated, except when it is not possible to specify the person or organisation responsible. This will be for commissioners and providers to consider and determine locally'. Medicines support is defined in the guideline. Medication review is a separate process and is outside the scope of

						this guideline. Please see the NICE guideline on Medicines optimisation.
102	The Dispensing Doctors' Association	Full	28	38-41	This is an absolute essential!	Thank you for your comment.
103	The Dispensing Doctors' Association	Full	30	9-12	To work properly this recommendation needs the support of GP Software companies to ensure that standard recording (e.g. Read coding and templates) is available to enable easy access to the relevant patient records and searches.	Thank you for your comment. Implementation is for commissioners and providers to consider and determine locally. A standard section on implementation is included at final publication.
104	The Dispensing Doctors' Association	Full	31	20-30	We are unclear how a new prescription can be issued when a medicine is stopped (or indeed when it is only a dose frequency that is altered). This would be better dealt with by a change in the Medicine Administration Record rather than a new prescription. There is a slight mismatch in the verbal vs written instruction advice: if a doctor talks to his patient and/ or carer and gives instructions this has to be followed up in writing but if he writes there is no requirement to follow up with a verbal message where necessary. In some cases, e.g. The blind, a verbal message would work but writing would be a waste of time.	Thank you for your comment. The recommendations on verbal changes to medicines (remote prescribing) were discussed further by the Committee and have been amended.
105	The Dispensing Doctors' Association	Full	32	16-19	This recommendation could present some difficulty for dispensing doctors as there is no resource provision for the management of Medicines Administration Records (MARs) within the GP contract. We further note that this recommendation is a, "should" whereas Recommendation 55 (Page 37 Lines 4-6) is a, "should consider." We feel in view of the resource constraints the latter level of advice should prevail. It would be helpful if some guidance were to be given on standardisation of MARs.	Thank you for your comment. The recommendation was discussed further by the Committee and has been amended to reflect your comment. The Committee were mindful that there is no requirement for the supplying pharmacist or dispensing doctor to provide medicines administration records (MARs). The recommendation on what information should be included in MARs outlines what the Committee agreed as a minimum. Use of a standardised MAR to address the issues raised would be for commissioners and providers to determine locally.
106	The Dispensing Doctors' Association	Full	34	30,31	There may be some difficulty in inserting additional lines of information on a standard prescription label – this additional information might be better communicated through the MAR.	Thank you for your comment. The Committee agreed that this information needed to be available, but how the recommendation will be implemented is for local consideration.
107	The Dispensing Doctors' Association	Full	36 -37	41-43;1-3	The DDA strongly supports this recommendation especially in its insistence on identifying a specific need.	Thank you for your comment.
108	The Dispensing Doctors' Association	Full	36	4-6	See above , comment 5 - This recommendation could present some difficulty for dispensing doctors as there is no resource provision for the management of Medicines Administration Records (MARs) within the GP contract. We further note that this recommendation is a, "should" whereas Recommendation 55 (Page 37 Lines 4-6) is a, "should consider." We feel in view of the resource constraints the latter level of advice should prevail. It would be helpful if some guidance were to be given on standardisation of MARs.	Thank you for your comment. Unfortunately the intention of this comment is unclear as the page and line number stated relates to covert administration, while the response discusses medicines administration records.
109	The Dispensing Doctors' Association	Full	38	19-25	We agree wholeheartedly with this recommendation but consider there will be significant financial implications for home care providers in its implementation	Thank you for your comment. Thank you for your comment. The Committee recognised the challenges and resource implications of training and assessment of competency of care workers, but this is not part of NICE's remit. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
31	United Kingdom Homecare Association	full	general	general	at 134 pages this NICE Guideline seems inordinately weighed down with extensive sections that do not contribute to the performance of the management of medicines for adults receiving social care in the community**:** there are sections, such as 5.5 and 6.2 that detract from the impact of the guidelines and other sections are repetitious such as in section 6.3.1. We question the value that such elaboration gives in the	Thank you for your comment. The format is considered by the NICE publishing team and follows NICE style. The guideline is published in a number of different formats. A short version of the guideline contains recommendations

					development of usable guidelines and we would suggest that four pages are entirely adequate for such a document to have any traction with providers and their care staff. Section 6 seems to be a reiteration of preceding information and is therefore superfluous, even if it used to substantiate those earlier clauses Section 7 attracts the same review as noted immediately above for Section 6 The phrase “in order” used throughout the document lacks meaning and its deletion does not alter the intention of the statement: it’s entirely superfluous	and context, while the full guideline also includes the full evidence reviews and rationale for the Committee’s decisions. An ‘Information for the public’ version is also published. .
32	United Kingdom Homecare Association	Full	general	general	detailed guidance on the decanting of medications in a homecare setting would add value to the guidelines: the requirement of local authority commissioners in contracts of care for the placing of medications in small containers so that the service-user can take the drugs later is fraught with risks	Thank you for your comment. The Committee did not find any evidence on decanting (secondary dispensing) in this setting. However, the recommendation recognises that leaving a medicine out for a person to take later may cause harm.
33	United Kingdom Homecare Association	Full	general	general	detailed guidance on the prompting of medications in a homecare setting would add value to the guidelines: the requirement of local authority commissioners in contracts of care for homecare staff to visit a service-user to prompt them to take medication is fraught with risk – if the prompting does not take place for whatever reason, the service-user could be at risk, which means, in effect, that the medication is actually being given or supervised.	Thank you for your comment. The Committee agreed that in line with legislation care workers should make a record of all medicines support given. This is defined in the guideline and includes reminding or prompting a person to take their medicine.
34	United Kingdom Homecare Association	Full	28	10	“…. best available evidence” is insufficiently precise or defined	Thank you for your comment. Wording was not amended as it was felt that this term would be well understood by the intended audience of the guideline.
35	United Kingdom Homecare Association	Full	28	38	the list should include CQC Inspectors and their line managers	Thank you for your comment. Unfortunately, the reason for your comment is unclear. The recommendations are aimed at people undertaking individual assessment of a person, which is not the role of a regulator.
36	United Kingdom Homecare Association	Full	29	2	“person’s medicines support needs” is too convoluted: simplify	Thank you for your comment. The wording has not been changed as this term was considered and agreed by the Committee and the NICE publishing team. Medicines support is defined in the guideline – see section 1.3, Terms used in the guideline.
37	United Kingdom Homecare Association	Full	29	4 + 5	list should include physical limitations	Thank you for your comment. The Committee agreed that an emphasis on what the person can do for themselves and could potentially do for themselves with support should be the focus of the assessment. This is included in the recommendations.
38	United Kingdom Homecare Association	Full	29	9	“creams” should read as ‘topical applications’	Thank you for your comment. The wording has not been changed as the term ‘cream’ is commonly understood by both health professionals, social care practitioners and the public.
39	United Kingdom Homecare Association	Full	30	6, 7, 8	this clause is very impractical and should be reconsidered	Thank you for your comment. The Committee was aware from their experience that many GP’s do not know that a person is receiving medicines support from a care provider. This is a barrier to effective communication and joint working across health and social care, and to the implementation of this guideline. The Committee agreed that it would be a straightforward task to notify a person’s general practice and community pharmacy when starting to provide medicines support (for example via a telephone

						call), and this would support safe care. The Committee did not agree that this action was impractical.
40	United Kingdom Homecare Association	Full	30	9, 10, 11	ditto	Thank you for your comment. The Committee was aware from their experience that many GP's do not know that a person is receiving medicines support from a care provider. This is a barrier to effective communication and joint working across health and social care, and to the implementation of this guideline. The Committee agreed that it would be a straightforward task to record details of the person's medicines support and who to contact about their medicines in the medical record, and this would support safe care. The Committee did not agree that this action was impractical.
41	United Kingdom Homecare Association	Full	30	as at 24	commissioners prescribe care packages and infrequently do health professionals delegate such tasks to homecare staff	Thank for your comment. The intention of the recommendation is to ensure that any such delegation is done in a safe and appropriate way that protects both the person and the care worker.
42	United Kingdom Homecare Association	Full	30	30	the question of training (educating?) care staff has proven problematic in securing competent educators able to award evidence of attendance**:** costs are rarely containable	Thank you for your comment. The Committee recognised the challenges and resource implications of training and assessment of competency of care workers, but this is not part of NICE's remit. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires care providers to ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
43	United Kingdom Homecare Association	Full	30	32	this clause is very impractical and should be reconsidered as it will be very expensive and resource hungry	Thank you for your comment. In line with their professional responsibilities, health professionals are expected to monitor and evaluate the safety and effectiveness of a person's medicines. The guideline is not recommending any action that is different from routine clinical practice, and there will be no additional resource implications as a result. The intention of the recommendation is to ensure that care workers are not expected to make any clinical judgements about medicines when they are supporting people to take their medicines.
44	United Kingdom Homecare Association	Full	31	4	"robust" is ambiguous**:** do you mean 'detailed'? 'comprehensive'?	Thank you for your comment. The wording has not been changed as the term was agreed by the Committee and NICE publishing team, and is consistent with other NICE guidelines on medicines use and practice.
45	United Kingdom Homecare Association	Full	31	13	there appears to be a presumption that the service-user wants this level of third party involvement**:** this may not be the case	Thank you for your comment. The recommendation is that care provider's takes account of the person's expectations for communication and sharing information.
46	United Kingdom Homecare Association	Full	31	26 - 30	this could place unqualified homecare staff in considerable jeopardy**:** who is, or could be, liable in the event of errors of omission or commission or transmission where the details are unclear or have been misinterpreted? What 'exceptional circumstances' are there likely to be? If a Prescriber considers there to be an urgent situation they should make a domiciliary visit or conversely an ambulance should be summoned	Thank you for your comment. The recommendation was discussed further by the Committee and relates to verbal changes to a person's medicines. It is a separate issue from the urgent situation described where the person is medically unstable, and requires a domiciliary visit or an ambulance. The Committee were mindful that delays in treatment may lead to unsafe or suboptimal care. However, the intention of the recommendation is to ensure that remote prescribing

						does not happen routinely, because the person is housebound, for example. The recommendations take account of the need for care providers to have robust processes in place to protect both care workers and the person receiving care.
47	United Kingdom Homecare Association	Full	31	31	as in item 11 above –"robust" is ambiguous: do you mean 'detailed'? 'comprehensive'?	Thank you for your comment. The wording has not been changed as the term was agreed by the Committee and NICE publishing team, and is consistent with other NICE guidelines on medicines use and practice.
48	United Kingdom Homecare Association	Full	31	38, 39	as in item 13 above – this could place unqualified homecare staff in considerable jeopardy: who is, or could be, liable in the event of errors of omission or commission or transmission where the details are unclear or have been misinterpreted? What 'exceptional circumstances' are there likely to be? If a Prescriber considers there to be an urgent situation they should make a domiciliary visit or conversely an ambulance should be summoned	Thank you for your comment. The Committee made a recommendation about prescribers communicating changes to a person's medicines, which includes providing written instructions or issuing a new prescription (see recommendation 18 in the final full guideline). This takes account of the issue highlighted. However, the Committee were also mindful that delays in treatment may lead to unsafe or suboptimal care. The intention of the recommendation on remote prescribing is to ensure that this does not happen routinely, because the person is housebound, for example. The recommendations take account of the need for care providers to have robust processes in place to protect both care workers, he person receiving care and their carers.
49	United Kingdom Homecare Association	Full	32	3	as in item 11 above - "robust" is ambiguous: do you mean 'detailed'? 'comprehensive'?	Thank you for your comment. The wording has not been changed as the term was agreed by the Committee and NICE publishing team, and is consistent with other NICE guidelines on medicines use and practice.
50	United Kingdom Homecare Association	Full	32	10	the word 'support' has been used frequently in the document in different contexts**:** it may be useful to define what is meant by this word and use other words in separate or different contexts, such as 'administer', 'offer', 'prepare' for example – but *not* 'prompt' as there is controversy around what constitutes a 'prompt' and what happens if the prompt is unforthcoming	Thank you for your comment. The wording has not been changed as this term was discussed by the Committee. Medicines support has been defined in the guideline (see section 1.3, Terms used in the guideline) and covers any support that enables a person to manage their medicines. The term has been used consistently in the recommendations, and other terms such as administer and prompt have not been used. Common terms are included in a glossary in the full guideline.
51	United Kingdom Homecare Association	Full	32	12	there is controversy over the concept of 'reminding' or prompting someone to take their medications**:** if the person does not receive their medication if the reminder or prompt is not forthcoming then it can reasonably be thought that the medication is being administered rather than the person being simply reminded. Section 40 p35 of your guidelines reflects this position to a degree.	Thank you for your comment. The Committee discussed this issue and agreed that it is necessary to record the care given in line with the legislation referred to in the guideline recommendation. It should be clearly recorded in the care plan whether the action is reminding or administering for each medicine that the care worker is responsible for administering or supporting the person to self-administer.
52	United Kingdom Homecare Association	Full	32	16	there has been some resistance to the provision of printed MAR type documents because of the lack of payment for this service**:** UKHCA members have reported several instances of difficulties with the regulatory authorities when printed documentation has not been made available and providers are unable to secure other forms of records – this standard should be targeted at prescribers and dispensers rather than at homecare providers, such as ….. "~~Home care workers~~ Prescribers and dispensers ~~should~~ must use a printed medicines administration record to record any medicines that may ~~they~~ be given to a person. (This record should ideally be provided by a community pharmacist or the dispensing doctor (see also recommendation 56 on 18 supplying medicines))".	Thank you for your comment. Please note these are guideline recommendations not standards. The legal requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (2)(c) is for the Registered person (the care provider) to maintain the record. The responsibility for this cannot be transferred, although the action of producing printed medicine administration records can be agreed between the

					item 36 in your guidelines reflects this approach	social care provider and either a pharmacy or dispensing doctor.
53	United Kingdom Homecare Association	Full	32	37 - 40	this paragraph is of very limited value and does not offer any particular insights	Thank you for your comment. The wording has not been changed. The Committee recognised the problems of care workers not feeling able to raise concerns or report mistakes with medicines, for fear of being blamed or disciplined. In addition, people receiving care often do not want to raise concerns for fear of it affecting their care. The text recognises that managing medicines is a complex task in this setting and it is important that concerns are raised in a fair-blame environment so that any identified risk can be minimised in the future. The Committee felt that this should be emphasised in the text preceding the recommendations.
54	United Kingdom Homecare Association	Full	33	8	the concept of 'fair blame' may have currency within the sector but the public are likely only to appreciate 'blame' and this could have unintended consequences and suggest liability	Thank you for your comment. The Committee agreed that it is the concept of 'fair blame culture' which needs to be incorporated into processes for identifying, reporting, reviewing and learning from medicines-related problems. The use of the term within each care providers processes is for local determination.
55	United Kingdom Homecare Association	Full	33	38 - 41	homecare staff are unlikely to have sufficient pharmaceutical knowledge to appreciate every potential iatrogenic effect, especially in polypharmaceutical situations, or where psychotropic and behavioural issues are at play**:** this could usefully be re-phrased as it's not the reporting that's the problem but the recognition of the event that is suspect	Thank you for your comment. Please note that this recommendation is aimed at both health and social care practitioners. While the Committee agreed that care workers may have limited knowledge of potential side effects, they agreed that it is important that all staff know how to report problems if they suspect one.
56	United Kingdom Homecare Association	Full	34	18	see comment 05 above - "creams" should read as 'topical applications'	Thank you for your comment. The wording has not been changed as the term 'cream is commonly understood by both health professionals, social care practitioners and the public.
57	United Kingdom Homecare Association	Full	35	17 - 19	homecare staff are infrequently in a position to police such requirements and it should more properly be the responsibility of the prescriber and dispenser to ensure the availability of this documentation. Homecare staff are often not the only people visiting service-users in their own homes and it is unclear as to why this responsibility is conferred upon the least qualified staff to undertake this requirement. Homecare staff will rarely have the time or resources to pursue non-availability of this documentation, particularly when homecare visits are restricted to 15 minute calls. It is inequitable to place this responsibility on homecare providers who rarely have any formal position in the procurement and supply chain of prescribed medications.	Thank you for your comment. The Committee agreed that as patient information leaflets are already supplied by law with original packs (and must also be supplied with monitored dosage systems) to the patient, there is minimal burden in retaining one for each medicine in the patients care plan. In addition, having access to the additional information contained in the leaflet is likely to be helpful to care workers. An additional recommendation has been added after consultation to reflect the requirement for supplying pharmacists and dispensing doctors to supply a patient information leaflet for all medicines supplied, including those supplied in monitored dosage systems.
58	United Kingdom Homecare Association	Full	35 - 36	29 - 04	comments in item 24 above apply equally in this section 45 and Section 46 of your guidelines supports this position	Thank you for your comment.
59	United Kingdom Homecare Association	Full	36	23 - 27	in the case of state funded care the responsibility to ensure that there is sufficient time available belongs to care commissioners who should be held to account for making provision within the care contract**:** homecare providers are exceedingly unlikely to have the resources to undertake this unilaterally or without funding.	Thank you for your comment. The guideline makes recommendations for good practice when a care provider is responsible for ordering a person's medicines. It is recognised that in most cases the person or their family member or carer will order the person's medicines.
60	United Kingdom Homecare Association	Full	36	38	medications in original packaging adds significantly a- to the time required to administer the drugs which may not be available in a 15 minute call b- to the risk of administration errors c- to the risk of mis-identification of medications	Thank you for your comment. The Committee considered the risks and benefits of original packaging compared with monitored dose systems in detail when making their recommendations. They were aware of guidance from the

					d- to storage and safekeeping requirements e- because it could obscure when, and if, doses have been given or missed that would otherwise be easily recognisable from a metered dosing system f- as this could necessitate counting all remaining medications after every administration which is inviting inaccuracies	Royal Pharmaceutical Society (Improving patient outcomes through the better use of multi-compartment compliance aids) and felt this gave a balanced and accurate view of the risks and benefits of monitored dosage systems. The Committee concluded that monitored dosage systems should be used for the benefit of the person receiving care, rather than for the ease of carers or care workers. The Committee recommendations make provision for the use of monitored dosage systems, when an assessment has been carried out, in line with legislation and when a specific need has been identified to support medicines adherence. It does not state that all medication should be supplied in original packaging in all circumstances. The Committee also agreed that the person receiving care and/or their family members or carers and the care provider should be involved in decision-making and the person's needs and preferences should be taken into account. Furthermore, the points raised could equally be applied to the use of monitored dosage systems. There are many disadvantages to using monitored dosage systems, for example, not all medicines are suitable, pharmacies are not reimbursed for their use, they are time consuming to fill and check, and there are issues with variable doses. No evidence was found that the risk of administration errors is greater with monitored dosage systems.
61	United Kingdom Homecare Association	Full	36	41	this clause appears to limit personal preferences and does not give recognition to limitations that are frequently within the contracting framework: to imply that the Disability Discrimination Act 1995 should be the only legitimate source of authority or permission for providing medications in, for example, blister packs or dosimeters, appears to disallow preferences or does not recognise the limitatio0ns of time available for visits	Thank you for your comment. The Committee considered the risks and benefits of original packaging compared with monitored dose systems in detail when making their recommendations. They were aware of guidance from the Royal Pharmaceutical Society (Improving patient outcomes through the better use of multi-compartment compliance aids) and felt this gave a balanced and accurate view of the risks and benefits of monitored dosage systems. The Committee concluded that monitored dosage systems should be used for the benefit of the person receiving care, rather than for the ease of carers or care workers. The Committee recommendations make provision for the use of monitored dosage systems, when an assessment has been carried out, in line with legislation and when a specific need has been identified to support medicines adherence. It does not state that all medication should be supplied in original packaging in all circumstances. The Committee also agreed that the person receiving care and/or their family members or carers and the care provider should be involved in decision-making and the person's needs and preferences should be taken into account. There are many disadvantages to using monitored dosage systems, for example, not all medicines are suitable, pharmacies are not reimbursed for their use, they are time consuming to fill and check, and there are issues with variable doses.
62	United Kingdom Homecare Association	Full	37	7 - 13	it may be of considerable benefit to all parties if there was an approved list of iatrogenic interactions and proscribed combinations of OTC and POM medications	Thank you for your comment. Please note that the British National Formulary and British National Formulary for

						children contain appendices with lists of interactions for over-the-counter and prescribed medicines. These resources are publicly available.
63	United Kingdom Homecare Association	Full	37	24	the safe disposal of medications should be undertaken by a pharmacist for a variety of reasons: your item 63 at page 38 elaborates and which makes this section redundant	Thank you for your comment. Please note that whilst the Committee agree that it is best practice to dispose of medicines at a pharmacy, the recommendation recognises that a person receiving care is able to dispose of unwanted medicines either as household waste or at a pharmacy. The recommendation is aimed at care providers who are disposing of waste on behalf of that person.
64	United Kingdom Homecare Association	Full	37	34 & 35	rarely will a homecare provider be in a position to equip service-users with refrigerators or lockable storage facilities: formal reports can be submitted but the budget holder is the point of responsibility for the provision of facilities	Thank you for your comment. The Committee agreed that the recommendation reflects good practice. Implementation is for commissioners and providers to consider and determine locally.
65	United Kingdom Homecare Association	Full	37	38 - 40	there is considerable hesitation that homecare providers or care staff have the level of continuous updates about a topic where professionally qualified staff are, or should be, routinely available: few care staff will have 'licence' to offer advice as described and this could create significant issues around liability for incorrect advice from unqualified personnel	Thank you for your comment. This has been amended and incorporated into recommendation 63 in the published full guideline. This now includes a point about seeking advice from a health professional about how to store medicines safely, if needed. There is no expectation that social care practitioners will offer this advice.
66	United Kingdom Homecare Association	Full	38	16 - 18	this statement lacks clarity and does not define its intended outcome as it starts with a question ["If a person is receiving …."] and ends in a statement that is disjointed.	Thank you for your comment. This statement has been amended.
67	United Kingdom Homecare Association	Full	38	21	reference "receive appropriate training and support" – what other sort of training and support is there if not 'appropriate'?	Thank you for your comment. This reflects the need for training to cover the tasks the care worker is responsible for, and may include more specific training, for example how to give medicines via a feeding tube (where it has been agreed that the care worker will do this).
68	United Kingdom Homecare Association	Full	43	6 - 25	it is important to remember that the defining of care needs is the statutory responsibility of the local authority commissioners-of-care who prepare a detailed Care Plan in the form of instructions to the provider of homecare and this forms the contractual basis for the provision of that *specified* care	Thank you for your comment. The Committee identified that there are a number of possible options for assessment that are all in current common use, including local authority assessment, self-assessment and part self-funding and budget holding assessment.
69	United Kingdom Homecare Association	Full	44	35	incomplete statement with non-functioning link	Thank you for your comment. The broken sentence has been amended and the hyperlink is now functioning.
70	United Kingdom Homecare Association	Full	44	36	this statement is not clear as to what is required	Thank you for your comment. The broken sentence has been amended.
71	United Kingdom Homecare Association	Full	45	20 - 23	Is this a question ?	Thank you for your comment. This section has been amended.
72	United Kingdom Homecare Association	Full	45 & 46	27 – 47 & 1 - 26	this is duplicated information available elsewhere in the document	Thank you for your comment. The evidence is given in full and then evidence statements are derived. This is the standard approach for all NICE guideline products. Please see Developing NICE guidelines: the manual.
73	United Kingdom Homecare Association	Full	46	29	Section 5.5 Table 3 does not add value to the guideline	Thank you for your comment. The intention of the 'Linking evidence to recommendations' (LETR) table is to provide an overview of the Committee's discussions of the evidence and give the rationale behind making their decisions. This is the standard approach for all NICE guidelines. The guideline has been developed following processes outlined in Developing NICE guidelines: the manual.
74	United Kingdom Homecare Association	Full	51	1 - 8	this list does not appear to be linked to anything and seems to be somewhat random	Thank you for your comment. Please see the guideline appendices for details of how recommendations are linked to the evidence.

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

75	United Kingdom Homecare Association	Full	45	20 - 23	Is this a question ?	Thank you for your comment. This section has been amended.