Managing medicines in care homes

NICE quality standard

Draft for consultation

September 2014

# Introduction

This quality standard covers the prescribing, handling and administering of medicines for all people (including children and young people) living in care homes, and the provision of care or services relating to medicines in care homes. ‘Care home’ covers the provision of 24-hour accommodation together with either non-nursing care or nursing care. For more information see the [topic overview](http://www.nice.org.uk/Guidance/InDevelopment/GID-qsd88/Documents). This quality standard should be read alongside the [Mental Capacity Act 2005](http://www.legislation.gov.uk/ukpga/2005/9/contents) and accompanying code of practice.

## Why this quality standard is needed

The National Care Forum’s [Safety of medicines in the care home](http://patientsafety.health.org.uk/sites/default/files/resources/safety_of_medicines_in_the_care_home_0.pdf) (2013) report identified that ‘when a person enters a home, staff often automatically assume responsibility for managing medicines. This can lead to a loss of independence and control for the resident’. This quality standard focuses on ensuring that a person-centred approach to medicines in care homes is taken – with care home residents supported to take an active role in decisions about their treatment and, wherever possible, to self-administer their medicines.

The 2009 [Care home use of medicines study](http://www.birmingham.ac.uk/research/activity/mds/projects/HaPS/PHEB/CFHEP/PSRP/papers.aspx) (CHUMS) found that of the 256 care home residents included in the study, two-thirds had been exposed to 1 or more medication errors. A 3-month study published in 2011 (Szczepura et al. BMC Geriatrics 2011, 11:82) also noted that more than 90% of the residents included in this study were exposed to at least 1 potential medicines administration error. To improve the safe and effective use of medicines by people of all ages who live in care homes, clear systems and processes are needed across the medicines management pathway.

The quality standard is expected to contribute to improvements in the following outcomes:

* Adverse events related to medication errors for residents of care homes.
* Care home residents’ quality of life.
* Family and carer confidence in care provision
* Hospital admission of care home residents due to medication errors.
* Individualised care with regard to medicines.
* Management of residents’ health conditions.
* Medication errors.
* Residents’ experience of, and involvement in, their care.

## How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

* [The Adult Social Care Outcomes Framework 2014/15](https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015) (Department of Health, November 2012)
* [NHS Outcomes Framework 2014/15](https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015)
* Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, [Parts 1A, 1B and 2](https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency).

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

### Table 1 [The Adult Social Care Outcomes Framework 2014/15](https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015)

|  |  |
| --- | --- |
| **Domain** | **Overarching and outcome measures** |
| 1 Enhancing quality of life for people with care and support needs | ***Overarching measure***1A Social care related quality of life\* (NHSOF 2)***Outcome measure*****People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs**1B Proportion of people who use services who have control over their daily life |
| 3 Ensuring that people have a positive experience of care and support | ***Overarching measure*****People who use social care and their carers are satisfied with their experience of care and support services**3A Overall satisfaction of people who use services with their care and support3B Overall satisfaction of carers with social services3E Improving people’s experience of integrated care\* (NHSOF 4.9)***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process**3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for**People know what choices are available to them locally, what they are entitled to, and who to contact when they need help**3D The proportion of people who use services and carers who find it easy to find information about support**People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** |
| 4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm | ***Overarching measure***4A The proportion of people who use services who feel safe\* (PHOF 1.19)***Outcome measures*** **People are protected as far as possible from avoidable harm, disease and injuries****People are supported to plan ahead and have the freedom to manage risks the way that they wish**4B The proportion of people who use services who say that those services have made them feel safe and secure |
| **Aligning across the health and care system**\* Indicator complementaryAbbreviations: NHSOF, NHS Outcomes Framework; PHOF, Public health outcomes framework. |

### Table 2 [NHS Outcomes Framework 2014/15](https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015)

|  |  |
| --- | --- |
| **Domain** | **Overarching indicators and improvement areas** |
| 2 Enhancing quality of life for people with long‑term conditions | ***Overarching indicator***2 Health-related quality of life for people with long-term conditions\* (ASCOF 1A)***Improvement areas*****Ensuring people feel supported to manage their condition**2.1 Proportion of people feeling supported to manage their condition**Enhancing quality of life for people with dementia**2.6ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life\* (ASCOF 2F) |
| 4 Ensuring that people have a positive experience of care | ***Overarching indicator***4a Patient experience of primary care4b Patient experience of hospital care***Improvement areas*****Improving the experience of care for people at the end of their lives***4.6 Bereaved carers’ views on the quality of care in the last 3 months of life***Improving people’s experience of integrated care**4.9 People’s experience of integrated care |
| 5 Treating and caring for people in a safe environment and protecting them from avoidable harm | ***Overarching indicators***5a Patient safety incidents reported5b Safety incidents involving severe harm or death5c Hospital deaths attributable to problems in care***Improvement areas*****Reducing the incidence of avoidable harm**5.4 Incidence of medication errors causing serious harm |
| **Alignment across the health and social care system**\* Indicator complementary with Adult Social Care Outcomes Framework (ASCOF) |

### Table 3 [Public health outcomes framework for England, 2013–2016](https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency)

|  |  |
| --- | --- |
| **Domain** | **Objectives and indicators** |
| 4 Healthcare public health and preventing premature mortality | ***Objective***Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities***Indicator***4.13 Health-related quality of life for older people |

## Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to managing medicines in care homes.

NICE has developed guidance and associated quality standards on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathways on [patient experience in adult NHS services](http://pathways.nice.org.uk/pathways/patient-experience-in-adult-nhs-services) and [service user experience in adult mental health services](http://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-services)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience will not usually be included in topic-specific quality standards. However, recommendations in the development source(s) for quality standards that impact on patient experience and are specific to the topic will be considered during quality statement development.

## Coordinated services

The quality standard for managing medicines in care homes specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole managing medicines in care homes care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people in care homes.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality managing medicines in care homes service are listed in Related quality standards.

### Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating people in care homes should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training will be considered during quality statement development.

### Role of families and carers

Quality standards recognise the important role families and carers have in supporting people in care homes. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

# List of quality statements

[Statement 1](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). Care homes have a medicines policy that is based on current legislation and the best available evidence, and is regularly reviewed.

[Statement 2](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes are supported to be involved in decisions about their medicines.

[Statement 3](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes are supported to self-administer their medicines unless a risk assessment has indicated that they are unable to do so.

[Statement 4](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes have accurate and up-to-date records of their medicines kept for them.

[Statement 5](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes have details of their medicines shared with their new care provider when they move from one care setting to another.

[Statement 6](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes have accurate and complete information included in their prescriptions including information about how and when their medicines should be taken.

[Statement 7](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). People who live in care homes have at least 1 multidisciplinary medication review per year.

[Statement 8](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). Care homes have a documented process for the covert administration of medicines for adult residents.

[Statement 9](http://publications.nice.org.uk/QSXX/quality-statement-1-referral). Care homes have a development programme for their staff to learn the necessary skills for managing and administering medicines.

# Questions for consultation

## Questions about the quality standard

**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?

**Question 2** If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

**Question 3** For each quality statement what do you think could be done to support improvement and help overcome barriers?

## Questions about the individual quality statements

**Question 4** For draft quality statement 1: Is it appropriate to specify how frequently care homes should review their medicines policies? And, if so, how frequent should these reviews be?

**Question 5** For draft quality statement 2: Does this quality statement add anything beyond what is covered by the CQC’s [Fundamental standards for health and social care providers](https://www.gov.uk/government/consultations/fundamental-standards-for-health-and-social-care-providers) (Regulation 9(3)(d))?

**Question 6** For draft quality statement 4: Is it reasonable to expect care homes to make an accurate listing of a resident’s medicines on the day they transfer into a care home (see structure measure b)?

# Quality statement 1: Care home medicines policy

## Quality statement

Care homes have a medicines policy that is regularly reviewed.

## Rationale

It is important that care homes have a set policy for all aspects of medicines management, providing clear processes for staff to follow in carrying out their medicines-related activities. This includes the medicines administration process, particularly if ‘when required’ medicines are involved. It is also important that a medicines policy is continually reviewed to ensure that it is up-to-date and reflects current legislation and evidence. Care homes need a medicines policy that addresses local requirements and the needs of the individual care home.

## Quality measures

### Structure

a) Written evidence that a care home medicines policy, relevant to an individual care home, is in place and includes a record of the last review date.

***Data source:*** Local data collection.

b) Evidence of local arrangements and written protocols to review the care home medicines policy to make sure it is up-to-date, and is based on current legislation and the best available evidence.

***Data source:*** Local data collection.

c) Written evidence that a care home’s medicine policy includes a medicines administration process (which includes how to manage ‘when required’ medicines).

***Data source:*** Local data collection. [Care Quality Commission (CQC) inspection report.](http://www.cqc.org.uk/content/care-homes)

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that they have in place a care home medicines policy that is based on current legislation and the best available evidence, and is regularly reviewed and updated. NICE’s [Managing medicines in care homes: checklist for care home medicines policy information](http://www.nice.org.uk/Guidance/SC1/Resources) can help care homes to develop and update a care home medicines policy.

**Health and social care practitioners** have clear processes to follow when managing medicines in care homes. These processes are specific to the particular care home and are regularly updated.

**Commissioners** (local authorities, clinical commissioning groups) ensure that service specification contracts for care home providers include a requirement to have a medicines policy based on current legislation and the best available evidence, and that is regularly reviewed and updated. Local authorities should work collaboratively with clinical commissioning groups to monitor and update contracts.

## What the quality statement means for patients, service users and carers

**People who live in care homes** have their medicines carefully managed according to a policy with clear processes. The policy includes how staff should help people take their medicines, keep records, review people’s medication, order, store and dispose of medications, and what to do if mistakes are made. The policy and processes are regularly checked to make sure that they are up-to-date and are based on the best possible information.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.1.2, 1.14.1 and 1.14.2.

## Definitions of terms used in this quality statement

### Care home medicines policy

A care home medicines policy should include written processes for:

* sharing information about a resident's medicines, including when they transfer between care settings [see section 3.3 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* ensuring that records are accurate and up-to-date [see section 3.4 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* identifying, reporting and reviewing medicines-related problems [see section 3.5 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* keeping residents safe (safeguarding) [see section 3.6 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* accurately listing a resident's medicines (medicines reconciliation) [see section 3.7 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* reviewing medicines (medication review) [see section 3.8 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* ordering medicines [see section 3.10 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* receiving, storing and disposing of medicines [see section 3.12 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* helping residents to look after and take their medicines themselves (self-administration) [see section 3.13 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* care home staff administering medicines to residents, including staff training and competency requirements [see section 3.14 and 3.17 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* care home staff giving medicines to residents without their knowledge (covert administration) [see section 3.15 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)]
* care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate [see section 3.16 of [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1)].

[[NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1), recommendation 1.1.2.]

## Equality and diversity considerations

When preparing a care home medicines policy, consideration should be given to barriers that may prevent staff and residents understanding the policy, for example, if English is not their first language. The medicines policy should also be accessible to people with additional needs, such as physical, sensory or learning disabilities. The policy should be written using simple wording that can be understood by everyone, regardless of whether they have had training or experience in medicines management or care home practices. The use of technical terminology should be avoided where possible.

## Question for consultation

Is it appropriate to specify how frequently care homes should review their medicines policies? And, if so, how frequent should these reviews be?

# Quality statement 2: Involvement in decisions about medicines

## Quality statement

People who live in care homes are supported to be involved in decisions about their medicines.

## Rationale

Involving care home residents and/or their family members or carers, as appropriate and in line with the resident’s wishes, in decisions about the medication they receive is essential to ensure a culture of person-centred care. Care home residents should have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes. When care home residents lack capacity, decisions made on their behalf under the Mental Capacity Act 2005 should be made in line with the accompanying code of practice.

## Quality measures

### Structure

Evidence of local arrangements and written protocols to ensure that people who live in care homes are supported to be involved in decisions about their medicines.

***Data source:*** Local data collection

### Outcome

Feedback from people (or their families) who live in care homes that they are supported to be involved in decisions about their medicines.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that staff support people who live in care homes to have the same opportunities to be involved in decisions about their medication as people who do not live in care homes. Service providers ensure staff are familiar with guides on good practice, such as the Social Care Institute for Excellence’s [Fair access to care services](http://www.scie.org.uk/publications/guides/guide33/).

**Health and social care practitioners** (care home staff, social workers, case managers, GPs, pharmacists and community nurses) ensure that they provide all the information necessary for care home residents to make decisions about their medication, and that they are available for discussions about treatment and care if and when residents request this.

**Commissioners** (local authorities) ensure that contracts with care home providers specify that people who live in care homes are provided with the same opportunities to be involved in decisions about their medication as people who do not live in care homes, and monitor compliance with this requirement.

## What the quality statement means for patients, service users and carers

**People who live in care homes** are involved in decisions about their medication, and are given help and support to be involved if they need it. This should include being given information and time to help make decisions. If the resident agrees, families and carers should also have the opportunity to be involved in decisions about treatment and care.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendation 1.2.1.

## Equality and diversity considerations

Consideration should be given to whether a care home resident has sufficient mental capacity to be involved in decisions about their treatment. If not, consideration should be given to involving the resident’s family members or carers, as appropriate and in line with the resident’s wishes.

## Question for consultation

Does this quality statement add anything beyond what is covered by the CQC’s [Fundamental standards for health and social care providers](https://www.gov.uk/government/consultations/fundamental-standards-for-health-and-social-care-providers) (Regulation 9(3)(d))?

# Quality statement 3: Self-administration

## Quality statement

People who live in care homes are supported to self-administer their medicines unless a risk assessment has indicated that they are unable to do so.

## Rationale

It is important for the independence of people living in care homes that they are involved as much as possible in taking their medicines. Care homes should determine the amount of support a person needs to help them to self-administer each of their medicines (for example, a resident may be able to manage oral tablets but not eye drops). Risk assessments are important in determining the different levels of support a person needs to self-administer their medicines, and whether they would be at risk to themselves or others if they were to self-administer their medicines.

## Quality measures

### Structure

a) Evidence of local arrangements to carry out risk assessments to determine how much support residents need to self-administer their medicines.

***Data source:*** Local data collection. [Care Quality Commission (CQC) inspection report.](http://www.cqc.org.uk/content/care-homes)

b) Evidence of local arrangements to plan and provide support for residents to self-administer their medicines.

***Data source:*** Local data collection.

### Process

a) Proportion of people who live in a care home who have a risk assessment to find out what level of support they need to self-administer their medicine.

Numerator – number of people in the denominator who have a risk assessment to find out what level of support they need to self-administer their medicine.

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

***Data source:*** Local data collection.

b) Proportion of people who live in a care home with planned arrangements for self-administration of medicines if risk assessment indicates that they are able to do so.

Numerator – number of people in the denominator with planned arrangements for self-administration of medicines.

Denominator – the number of people who live in a care home whose risk assessment indicates that they are able to self-administer their medicines.

Data source: Local data collection.

### Outcome

Feedback from care home residents that they feel supported to self-administer their medicines, if they wish to do so.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that staff carry out risk assessments to determine if residents are able to self-administer their medicines and support people to self-administer their medicines if needed.

**Health and social care practitioners** carry out risk assessments to determine if people who live in care homes are able to self-administer their medicines, and support people to do so if needed.

**Commissioners** (such as local authorities) ensure that contracts with care home providers specify that they carry out risk assessments to determine if residents are able to self-administer their medicines and support people to self-administer their medicines if needed.

## What the quality statement means for patients, service users and carers

**People who live in care homes** receive help to take and look after their own medicines unless they have had an assessment that shows it might not be possible or safe, or the person would prefer to have their medicine given to them.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.13.1 and 1.13.2.

## Definitions of terms used in this quality statement

### Risk assessment for self-administration

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

* resident choice
* if self-administration will be a risk to the resident or to other residents
* if the resident can take the correct dose of their own medicines at the right time and in the right way (for example, do they have the mental capacity and manual dexterity for self-administration?)
* how often the assessment will need to be repeated based on individual resident need (during periods of acute illness, a resident’s capacity and ability to self-medicate may fluctuate, needing more frequent assessment)
* how the medicines will be stored
* the responsibilities of the care home staff, which should be written in the resident’s care plan.

[Adapted from [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1), recommendation 1.13.2.]

## Equality and diversity considerations

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

# Quality statement 4: Record-keeping

## Quality statement

People who live in care homes have an accurate listing of their medicines made on the day that they transfer into a care home .

## Rationale

Accurate medicines records are essential to ensure that people who live in care homes get the right medicine at the right time. Good record-keeping makes continuity of care easier, supports effective clinical judgements and decisions, and is essential for better communication of information between different members of multidisciplinary health and care teams. It is also important that medicines information is available as soon as possible for people who transfer into a care home, either for the first time or, for example, when re-entering the care home after a hospital stay (where their treatment may have been altered). Therefore, an accurate list of medicines (medicines reconciliation) should be made for residents either before they enter the care home or as soon as possible after entry to a care home.

## Quality measures

### Structure

Evidence of local arrangements and protocols to ensure that an accurate listing is made of a care home resident’s medicines on the day they transfer into a care home.

***Data source:*** Local data collection.

### Outcome

a) Time between a person entering a care home and completion of their medicines reconciliation.

***Data source:*** Local data collection.

b) Medication errors caused by inaccurate or incomplete medicines records.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that they have processes in place to update residents’ medicines records, and that they consider the resources necessary to carry out medicines reconciliation in a timely manner for all residents transferring into their care home.

**Health and social care practitioners** (such as care home managers and people responsible for transfer of people into care homes) ensure that they update medicines records when necessary and also coordinate the accurate listing of a resident’s medication as part of a full needs assessment and care plan.

**Commissioners** (local authorities, clinical commissioning groups) ensure that service specification contracts for care home providers specify that processes must be in place to update residents’ medicines records, and that care home providers consider the resources necessary to carry out medicines reconciliation in a timely manner for all residents transferring into their care home.

## What the quality statement means for patients, service users and carers

**People who live in care homes** have accurate records of their medicines kept up to date.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.4.1, 1.7.1 and 1.7.3.

## Question for consultation

Is it reasonable to expect care homes to make an accurate listing of a resident’s medicines on the day they transfer into a care home (see structure measure b)?

# Quality statement 5: Sharing information

## Quality statement

People who live in care homes have details of their medicines shared with their new care provider when they move from one care setting to another.

## Rationale

Good communication of information about a resident’s medicines is a key factor in preventing medication errors when care home residents transfer between care settings. Providers of health or social care should ensure that comprehensive records of medicines are sent with a resident when they are transferred from one care setting to another.

## Quality measures

### Structure

Evidence of local arrangements and written processes to ensure that accurate and complete information about a resident’s medicines is shared when a resident moves from one care setting to another (including hospital).

***Data source:*** Local data collection.

### Process

a) Proportion of transfers of people to a care home in which the person is accompanied with an accurate record of their medicines.

Numerator – the number in the denominator in which the person is accompanied with an accurate record of their medicines.

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

b) Proportion of transfers of people from a care home in which the person is accompanied with an accurate record of their medicines.

Numerator – the number in the denominator in which the person is accompanied with an accurate record of their medicines.

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

***Data source:*** Local data collection.

c)Proportion of transfers of people into a care home in which the person has an accurate listing of their medicines made as part of their full needs assessment and care plan.

Numerator – the number in the denominator in which the person has an accurate listing of their medicines made as part of their full needs assessment and care plan.

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

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (such as care homes) ensure that processes are in place that enable the sharing of accurate information about a resident’s medicines.

**Health and social care practitioners** are aware of, and follow, a care home’s policy about the sharing of a resident’s information and prepare an accurate record of a resident’s medicines to be sent with a resident when they transfer to or from a care home.

**Commissioners** (such as local authorities) stipulate that care homes have processes in place that enable the sharing of accurate information about a resident’s medicines. NHS England area teams and clinical commissioning groups should ensure that health and social care providers are aware that processes should be in place in line with this statement.

## What the quality statement means for patients, service users and carers

**People who are being transferred to or from a care home** have accurate and complete information about their medicines shared with their new place of care so that they can continue with their treatment.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.3.3 and 1.3.4.

# Quality statement 6: Prescribing medicines

## Quality statement

## GP practices have a clear written process for prescribing medicines for their patients who live in care homes. Rationale

The [Care home use of medicines study](http://www.birmingham.ac.uk/research/activity/mds/projects/HaPS/PHEB/CFHEP/PSRP/papers.aspx) (CHUMS; 2009) reported that more than a third of care home residents experienced at least one prescribing error; most commonly incomplete information on prescriptions. It is important that the healthcare professional who prescribes a medicine also provides all the necessary details about how a medicine is to be used. In particular, clear instructions from the prescriber about when to use ‘when required’ medicines should be given to provide clarity for care home staff if they are administering medicines to residents. Clear systems and processes for issuing and recording prescriptions will also help to reduce prescribing errors such as dosage errors and the omission of medicines that should have been prescribed. Clear processes should also be in place for repeat prescriptions and also for urgent or acute prescriptions to avoid delays in getting urgent medicines.

## Quality measures

### Structure

Evidence of local arrangements that GP practices have written processes for prescribing and issuing all prescriptions for their patients who live in care homes.

***Data source:*** Local data collection.

### Process

The proportion of prescriptions for variable dose and ‘when required’ medicines issued for people who live in care homes that include clear instructions of when and how (including dosage instructions) the prescribed medication is to be used.

Numerator – the number in the denominator that include clear instructions of when and how (including dosage instructions) the prescribed medicine is to be used.

Denominator – the number of prescriptions for variable dose and ‘when required’ medicines issued for people who live in care homes.

***Data source:*** Local data collection.

### Outcome

Medication errors attributable to incomplete information provided with a prescription.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (GP practices) ensure that they have clear written processes in place for prescribing and issuing prescriptions for their patients who live in care homes.

**Health practitioners** have, and follow, clear written processes for prescribing and issuing prescriptions for all their patients who live in care homes.

**Commissioners** (NHS England area teams) ensure that GP practices have clear written processes for prescribing and issuing prescriptions for their patients who live in care homes, in accordance with local needs.

## What the quality statement means for patients, service users and carers

**People who live in care homes** have accurate and complete information included in their prescriptions and receive clear information about how and when their medicines should be used.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.9.1 and 1.9.2.

## Definitions of terms used in this quality statement

### Written process for prescribing and issuing prescriptions

The process should cover:

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

[[NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1), recommendation 1.9.1]

# Quality statement 7: Medication reviews

## Quality statement

People who live in care homes have at least 1 multidisciplinary medication review per year.

## Rationale

People who live in care homes often have higher incidences of polypharmacy (the use of multiple medicines) with an associated increase in the risk of adverse medication events. They may also be less likely to report problems or issues with their medication. As a consequence, medication issues are often only discovered once they cause noticeable health problems. A proactive review of medication will help to identify issues with medicines before they can cause harm. In addition, the medication needs of residents with long-term conditions are likely to change over time with age and/or disease progression. More than 1 medication review per year may be necessary if clinically indicated for a specific medicine.

## Quality measures

### Structure

Evidence of local arrangements to ensure that people in care homes who have received medication within the last year have at least 1 multidisciplinary medication review per year.

***Data source:*** Local data collection.

### Process

Proportion of people who live in care homes and are receiving medication whose last multidisciplinary medication review occurred no more than 1 year ago.

Numerator – the number in the denominator whose last multidisciplinary medication review occurred no more than 1 year ago.

Denominator – the number of people who live in care homes and are receiving medication.

***Data source:*** Local data collection.

***Data source:*** Local data collection.

Feedback from care home residents that they feel involved in their medication reviews.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (GP surgeries) ensure that arrangements are made for their patients who are care home residents and are receiving medication, to have at least 1 multidisciplinary medication review per year.

**Healthcare professionals** ensure that people who live in care homes and are receiving medication have at least 1 multidisciplinary medication review per year.

**Commissioners** (NHS England area teams) ensure that GPs make arrangements to carry out at least 1 multidisciplinary medication review per year for patients who are care home residents and who are receiving medication.

## What the quality statement means for patients, service users and carers

**People who live in care homes** have at least 1 review of their medicines every year, although it may be more depending on the medicines they take. This will help to identify any problems with their medicines early on.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.8.1, 1.8.4 and 1.8.5.

## Definitions of terms used in this quality statement

### Multidisciplinary medication review

Health and social care practitioners should discuss and review the following during a medication review:

* the purpose of the medication review
* what the resident (and/or their family members or carers, as appropriate, and in line with the resident’s wishes) thinks about the medicines and how much they understand
* the resident’s (and/or their family member’s or carer’s, as appropriate, and in line with the resident’s wishes) concerns, questions or problems with the medicines
* all prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
* how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
* any monitoring tests that are needed
* any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
* helping the resident to take or use their medicines as prescribed (medicines adherence)
* any more information or support that the resident (and/or their family members or carers) may need.

Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers (if appropriate) and a local team of health and social care practitioners (multidisciplinary team). This may include a:

* pharmacist
* community matron or specialist nurse, such as a community psychiatric nurse
* GP
* member of the care home staff
* practice nurse
* social care practitioner.

The roles and responsibilities of each member of the team and how they work together should be carefully considered and agreed locally. GPs should work with other health professionals to identify a named health professional who is responsible for medication reviews for each resident. This should take into account the clinical experience and skills of the health professional, how much they know about the resident and the resident’s condition, and whether they can access the relevant information.

[[NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1), recommendations 1.8.2, 1.8.3 and 1.8.5]

## Equality and diversity considerations

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

# Quality statement 8: Covert medicines administration

## Quality statement

Care homes have a documented process for the covert administration of medicines for adult residents.

## Rationale

Increases in the occurrence of dementia in care homes means that the proportion of residents lacking capacity is likely to increase. However, many care homes do not have policies in place to set out the processes that need to occur to determine if covert administration of medicines is appropriate or plan how to carry it out. The covert administration of medicines should only take place within the context of legal and good practice frameworks to protect the resident receiving the medicines and the care home staff involved in administering the medicines.

## Quality measures

### Structure

Evidence of a written process for the covert administration of medicines to adult residents in care homes.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that they have in place written processes for covert administration of medicines for adults in care homes.

**Health and social care practitioners** are aware of, and follow, processes for covert administration of medicines for adults in care homes.

**Commissioners** (local authorities) ensure that service specification contracts for care home providers include a requirement for a documented process for the covert administration of medicines.

## What the quality statement means for patients, service users and carers

**Adults who live in care homes** who may not be able to make decisions about their treatment and care may need to be given their medicines in a disguised form without them knowing (known as ‘covert administration’). Care homes have written processes in place about how and when this should be done. Family members and/or carersof adults who live in care homes may be involved in best interest meetings to decide if a resident should be given medicines covertly, depending on the resident’s previously stated wishes and individual circumstances.

## Source guidance

* [Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.1.2 and 1.15.3.

## Definitions of terms used in this quality statement

### Process for covert administration of medicines

Health and social care practitioners should ensure that the process for covert administration of medicines to adult residents in care homes includes:

* assessing mental capacity
* holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident’s best interests
* recording the reasons for presuming mental incapacity and the proposed management plan
* planning how medicines will be administered without the resident knowing
* regularly reviewing whether covert administration is still needed.

[Adapted from [NICE social care guideline 1](http://www.nice.org.uk/Guidance/SC1), recommendation 1.15.3]

### Covert administration

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink.

[[NICE social care full guideline 1](http://www.nice.org.uk/Guidance/SC1), glossary]

# Quality statement 9: Training

## Quality statement

Care homes have a programme for their staff to learn the necessary skills for managing and administering medicines.

## Rationale

Increasing staff knowledge has the potential to prevent sub-optimal use of medicines in care homes and consequently reduce morbidities and the use of healthcare. In particular, for long-term conditions it is important that care home staff are able to support the resident in making the best use of their medicines. Training staff in how to report medication errors and near-misses and how to learn from such experiences is important in establishing a culture of openness and improvement in medicines use in care homes. Care homes should ensure that all staff have induction training relevant to the type of care home they are working in and an annual review of their knowledge, skills and competencies relating to managing and administering medicines. Medicines may be administered orally but may also be administered by other routes, such as topically or by injection.

## Quality measures

### Structure

Evidence of local arrangements made by care home providers to provide a learning and development programme for care home staff to gain the necessary skills for safely and effectively managing and administering medicines.

***Data source:*** Local data collection. [Care Quality Commission (CQC) inspection report.](http://www.cqc.org.uk/content/care-homes)

### Process

a) Proportion of new staff in a care home who receive induction training relevant to the type of care home they work in and relevant to their role with medication.

Numerator – the number in the denominator who receive induction training relevant to the type of care home they work in and relevant to their role with medication.

Denominator – the number of new staff in a care home.

***Data source:*** Local data collection.

b) Proportion of staff in a care home who receive ongoing training relevant to their role with medication.

Numerator – the number in the denominator who receive ongoing training relevant to their role with medication.

Denominator – the number of staff in a care home.

***Data source:*** Local data collection.

### Outcome

Documented evidence of learning from near-misses or medicines errors.

***Data source:*** Local data collection.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

**Service providers** (care homes) ensure that they provide a learning and development programme for all their care home staff to allow them to gain the necessary skills for managing and administering medicines, and that this can be demonstrated during visits by local authorities.

**Health and social care practitioners** ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines for residents living in care homes.

**Commissioners** (local authorities) ensure that service specification contracts include a requirement for care home providers to have a learning and development programme for all their care home staff to allow them to gain the necessary skills for managing and administering medicines.

## What the quality statement means for patients, service users and carers

**People who live in care homes** are cared for by staff who are trained and have the necessary skills for managing medicines in care homes, including giving medicines, providing support to people taking their own medicines and helping people with problems related to their medicines.

## Source guidance

[Managing medicines in care homes](http://www.nice.org.uk/Guidance/SC1) (NICE social care guideline 1), recommendations 1.17.1, 1.17.2, 1.17.4, 1.17.5 and 1.17.6.

# Status of this quality standard

This is the draft quality standard released for consultation from 26 September to 24 October 2014. It is not NICE’s final quality standard on managing medicines in care homes. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 24 October 2014. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee’s considerations. The final quality standard will be available on the [NICE website](http://www.nice.org.uk/standards-and-indicators) from March 2015.

# Using the quality standard

## Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](http://www.hscic.gov.uk/iqi). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE’s [What makes up a NICE quality standard?](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/NICE-quality-standards-FAQs) for further information, including advice on using quality measures.

## Levels of achievement

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

## Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

# Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](http://www.nice.org.uk/Guidance/InDevelopment/GID-QSD88/Documents) are available.

Good communication between health and social care practitioners and children, young people and adults in care homes, and their parents/families or carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Children, young people and adults in care homes, and their parents/families or carers (if appropriate), should have access to an interpreter or advocate if needed.

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

# Development sources

Further explanation of the methodology used can be found in the quality standards [Process guide](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards).

## Evidence sources

The documents below contain recommendations from NICE guidance or other NICE‑accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

* [Managing medicines in care homes.](http://www.nice.org.uk/Guidance/SC1) NICE social care guidance 1 (2014).

## Policy context

It is important that the quality standard is considered alongside current policy documents, including:

* [Best practice for ensuring efficient supply and distribution of medicines to patients.](https://www.gov.uk/government/publications/best-practice-for-ensuring-efficient-supply-and-distribution-of-medicines-to-patients) Department of Health (2013).
* [Medicines optimisation: helping patients to make the most of medicines](http://www.england.nhs.uk/2013/05/02/med-opt). Royal Pharmaceutical Society (2013).
* [Polypharmacy and medicines optimisation: making it safe and sound.](http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation) The King’s Fund (2013).
* [Safety of medicines in the care home.](http://patientsafety.health.org.uk/sites/default/files/resources/safety_of_medicines_in_the_care_home_0.pdf) National Care Forum (2013).
* [Meeting the health care needs of people in care homes.](http://www.cqc.org.uk/content/meeting-health-care-needs-people-care-homes) Care Quality Commission (2012).
* [Action plan for improving the use of medicines and reducing waste.](https://www.gov.uk/government/publications/action-plan-for-improving-the-use-of-medicines-and-reducing-waste) Department of Health (2012).
* [Improving pharmaceutical care in care homes.](http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf) Royal Pharmaceutical Society (2012).
* [Keeping patients safe when they transfer between care providers – getting the medicines right.](http://www.rpharms.com/current-campaigns-pdfs/rps-transfer-of-care-final-report.pdf) Royal Pharmaceutical Society (2012).
* [Commissioning care homes: common safeguarding challenges.](http://www.scie.org.uk/publications/guides/guide46/commonissues/maladministration.asp) Social Care Institute for Excellence’s [SCIE; 2012).
* [A report for the project: Working together to develop practical solutions – an integrated approach to medication in care homes](http://www.cpa.org.uk/information/reviews/Managing_and_Administering_Medication_in_Care_Homes.pdf). Centre for Policy on Ageing (2011).
* [Care home use of medicines study (CHUMS): prevalence, causes and potential harm of medication errors in care homes for older people.](http://www.birmingham.ac.uk/research/activity/mds/projects/HaPS/PHEB/CFHEP/PSRP/papers.aspx) Report to the Patient Safety Research Portfolio, Department of Health (2009).
* [A guide to good practice in the management of controlled drugs in primary care (England).](http://www.npc.nhs.uk/guidance_cd.php) National Prescribing Centre (2009).
* [Medicines management: everybody’s business.](http://webarchive.nationalarchives.gov.uk/20080205132320/http%3A/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_082200) Department of Health (2008).
* [Medicines reconciliation: a guide to implementation.](http://www.npc.nhs.uk/improving_safety/medicines_reconciliation/resources/reconciliation_guide.pdf) National Prescribing Centre (2008).
* [The handling of medicines in social care.](http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf) Royal Pharmaceutical Society (2007).
* [National service framework for children, young people and maternity services: medicines for children and young people.](https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services) Department of Health (2003).

## Definitions and data sources for the quality measures

* [Managing medicines in care homes.](http://www.nice.org.uk/Guidance/SC1) NICE social care guidance 1 (2014).

# Related NICE quality standards

## Published

* [Mental wellbeing of older people in care homes.](http://www.nice.org.uk/Guidance/QS50) NICE quality standard 50 (2013).
* [Health and wellbeing of looked-after children and young people.](http://www.nice.org.uk/Guidance/QS31) NICE quality standard 31 (2013).

## Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

* Care and support of older people with learning disabilities.
* Home care.
* Long-term conditions, people with comorbidities, complex needs.
* Medicines management: managing the use of medicines in community settings for people receiving social care.
* Medicines optimisation (covering medicines adherence and safe prescribing).
* Regaining independence: short-term interventions to help people to regain independence.
* Transition between inpatient hospital settings and community or care home settings for adults with social care needs.
* Transition between social care and health care services
* Transition from children’s to adult services.

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library) on the NICE website.

# Quality Standards Advisory Committee and NICE project team

## Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

**Miss Alison Allam**Lay member

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**Dr Jo Bibby**Director of Strategy, The Health Foundation

**Mrs Jane Bradshaw**Lead Nurse Specialist in Neurology, Norfolk Community Health and Care

**Dr Allison Duggal**Consultant in Public Health, Public Health England

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**Mr Roger Hughes**Lay member

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**Mr John Walker**Head of Operations, Greater Manchester West Mental Health NHS Foundation Trust

The following specialist members joined the committee to develop this quality standard:

**Mr Gerry Bennison**Lay member

**Mrs Delyth Curtis**Director of adult services, Blackpool Council

**Ms Amanda De La Motte**Lead Nurse Care Homes Services, Central Nottinghamshire Clinical Services

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# About this quality standard

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

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards).

This quality standard has been incorporated into the [NICE pathway for managing medicines in care homes](http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes).

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