Appendix A. Summary of new evidence

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
Section 1.1 Developing and reviewing policies for safe and effective use of medicines		
No new evidence relevant to this area of the guideline was identified through evidence searches.	No information from initial intelligence gathering relevant to this area of the guideline was identified. Topic experts did not provide any comments relevant to this area of the guideline.	**No new evidence was identified, and therefore there is no impact on the recommendations.**
Section 1.2 Supporting residents to make informed decisions and recording these decisions		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: The Care Act (2014)(1) provides regulations regarding the decisions surrounding care. It states that all individuals should participate as fully as possible in decisions, having been provided with the information and support necessary to enable this. The General Pharmaceutical Council commissioned a policy titled Pharmacy and Care Homes (2015)(2) which states that individuals have the right to accept or refuse treatment and unless valid consent has been given, treatment should not be given. If the individual does not have capacity, consent must be obtained from a person legally able to act on the individuals behalf, or the treatment must be in the individual's best interests. Citing the Human Rights Act 1998, this report discusses that there must be a presumption that all patients have capacity unless it is demonstrated otherwise.	**New evidence was identified that does not have an impact on the recommendations.** The evidence identified here states that individuals have a right to be included as fully as possible in decision making regarding their care. This supports the current recommendation (1.2.1), which states that care home residents should be given the same opportunities to be involved in decisions about their care as anyone not living in a care home and that support should be given to help full participation in decision making. Further evidence states that an individual's consent must be obtained before treatment is given, and that capacity to make decisions regarding medicines must be assumed until evidence to the contrary presents itself. When decisions are made on behalf of others, following an informed assessment of a lack of capacity, the Mental Capacity Act Code of Practice must be followed.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	Topic experts highlighted that the Mental Capacity Act Code of Practice(3) was updated in 2016. This guidance provides information on what must be done by care providers when decision making is being performed on behalf of people who cannot make decisions for themselves. The Mental Capacity Act Code of Practice (2016) states that the preparation of a care plan should always include an assessment of a person's capacity to consent to actions covered by the care plan. The Act also states that when making a best interests decision, there should be no discrimination based on age, appearance, condition or behaviour.	The Mental Capacity Act Code of Practice 2016 updates the 2007 version which was considered during guideline development. A number of recommendations are based on discussions of the Mental Capacity Act Code of Practice 2007. Recommendation 1.2.5 states that health professionals prescribing a medicine should assume care home residents have capacity to make decisions. Recommendations 1.2.2, 1.2.4 and 1.2.5 include that consent, issues with consent and assessments of capacity should be recorded on the residents care record. Recommendation 1.2.7 also derives from discussions of the Mental Capacity Act Code of Practice 2007, stating that residents should be involved in best interest decisions. Other references to the Mental Capacity Act Code of Practice 2007 are made in a way such that any changes to the Act would be incorporated into the meaning of the recommendation. This has been ensured by wording recommendations so that they refer to the Mental Capacity Act Code of Practice directly (recommendations 1.2.6 and 1.2.7), and therefore any changes to the Act will be automatically incorporated into the meaning of the recommendation. The relevant areas of the Mental Capacity Act Code of Practice which were considered when forming the recommendations included in this section, have not altered their meaning during the update. An editorial correction will be required to update cross references to the Mental Capacity Act Code of Practice to the 2016 version. However, no other impact is likely.

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Section 1.3 Sharing information about a resident's medicines		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: The Care Act (2014)(1) provides regulations regarding the transfer of adults between local authorities. The Care Act states that the first authority (where the individual has been residing) must provide the second authority (where the individual is moving) with a copy of any care and support plan prepared for the adult. Topic experts did not provide any comments relevant to this area of the guideline.	**New evidence was identified that does not have an impact on the recommendations.** The regulations regarding transfer of adults between local authorities may be of relevance to residents who are being transferred between care settings. The evidence evaluated here supports the current recommendations (1.3.4 and 1.3.5) which state that a discharge summary is sent with an individual when transferred between care settings, including details of medication. As the recommendations within this section of the guideline corroborate the regulations in the Care Act, there is unlikely to be any impact at this time.
Section 1.4 Ensuring that records are accurate and up to date		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: A guide to aid the implementation of children's homes regulations, published by the Department of Education (2015)(4), includes that staff must understand the importance of careful, objective and clear recording and that records must be kept of medicines administration, including when medication is refused. Guidance on delegating record keeping and countersigning records was highlighted by topic experts(5). This guidance suggests that assessment of competency in record keeping is performed and that countersigning of records is	**New evidence was identified that does not have an impact on the recommendations.** Evidence identified during this surveillance review states that record keeping regarding medicines use must be clear and accurate. It is also suggested that competency in record keeping should be evaluated. Recommendation 1.4.1 suggests that records about medicines should be kept accurate and up-to-date, following a care home policy based on legislation and best available evidence. Competency assessments specifically for record keeping are not recommended in SC1, however, recommendation 1.17.4 does suggest that all care home staff involved in managing medicines should successfully complete any training

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	performed until staff competency has been fully established. The Care Quality Commission Regulations for service providers and managers (2017)(6) states that an accurate, complete and up to date record of treatment and care provided must be kept.	needed to fulfil the learning and development requirements for their role. As an updated, evidence and legislation based care home policy, including record keeping, is recommended (1.1.2), and it is recommended that staff complete relevant training (1.17.4), it is unlikely that the detail provided by the guidance on competency in record keeping would have an impact on the guideline at this time. Further evidence on the importance of clear and accurate record keeping supports the current recommendation on medicines recording (1.4.1) and therefore, there is also unlikely to be any impact of this evidence on the guideline.
Section 1.5 Identifying, reporting and reviewing medcines-related problems		
No new evidence relevant to this area of the guideline was identified through evidence searches.	No information from initial intelligence gathering relevant to this area of the guideline was identified. Topic experts did not provide any comments relevant to this area of the guideline.	**No new evidence was identified, and therefore there is no impact on the recommendations.**
Section 1.6 Keeping residents safe (safeguarding)		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: The Care Quality Commission Regulations for service providers and managers (2017)(6) states that the risks related to the health, safety and welfare of service users should be assessed, monitored and mitigated. Topic experts highlighted that the guidance 'Working together to safeguard children'(7) was updated in 2015, from the 2013 version which	**New evidence was identified that does not have an impact on the recommendations.** Recommendations to promote the safeguarding of care home residents, including assessing, monitoring and mitigating risks related to medicine related safety incidents are included in this section of the guideline. Recommendations 1.6.1-1.6.3 suggest how and when medicines related safety incidents should be reported. Recommendations 1.6.5-1.6.9 suggest processes that aid monitoring and mitigating

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	was considered during guideline development. This guidance sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children.	medicines related safety incidents. These include recording near misses and sharing experiences to enhance learning; investigating and monitoring incidents to identify trends, and identifying and acting on the root cause of incidents. These recommendations corroborate the regulations identified during this surveillance review, and therefore no impact of this newly identified evidence is anticipated. Topic experts highlighted that an update of 'Working together to safeguard children' has been published since SC1 publication. When comparing the updated 2015 version to the 2013 version of this policy, any sections relevant to SC1 have not been altered through this update. The discussion points around 'Working together to safeguard children 2013' which are in the full guideline, remain valid and are now supported instead by the 2015 update. No impact of the new evidence identified relating to this section of the guideline is anticipated.
Section 1.7 Accurately listing a resident's medicines (medicines reconciliation)		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: Guidance by the Royal Pharmaceutical Society England (8–11) states that medicines reconciliation during transfer into a care home, should be performed by a pharmacist or pharmacy technician. A guide to aid the implementation of children's homes regulations, published by the Department of Education (2015)(4), includes that the management of medication on arrival	**New evidence was identified that does not have an impact on the recommendations.** Recommendation 1.7.1 states that the care home manager should consider the resources needed to ensure medicines reconciliation occurs in a timely manner. This is supported by the policy identified during this surveillance review which indicates it is the responsibility of care home staff to manage medication in children's homes on arrival from a break.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	and departure of a short break from a children's care home, is the responsibility of care home staff. Topic experts did not provide any comments relevant to this area of the guideline.	Recommendation 1.7.2 suggests who should be included in medicines reconciliation, listing a pharmacist as 1 of the individuals who should be involved. This is supported by guidance from the Royal Pharmaceutical Society, suggesting that a pharmacist should perform medicines reconciliation during a transfer into a care home. As the evidence identified is supportive of the current recommendations, there is unlikely to be any impact at this time.
Section 1.8 Reviewing medicines (medication review)		
An observational study(12) (n=422) evaluated a pharmacist led detailed medication review with the intention of optimising medicines use for elderly nursing home residents. The pharmacist used primary care records to review medication, and discussed the findings at a multidisciplinary team meeting which included input from the resident and/or their family, a care home nurse, the resident's GP and a representative from the local psychiatry of old age service where appropriate. 91% of residents undergoing medication review received a medicines intervention, with on average 1.7 medicines being stopped per person. The reasons cited for medication being stopped included: there being no current indication present (57%); the resident choosing to discontinue treatment following an explanation of the risks and benefits (17%) and safety concerns (6%). Per person reviewed, a net annual cost saving of £184 was made. A follow up retrospective analysis(13) of the same 422 care home residents compared a pharmacist only medication review with a pharmacist plus GP review. No statistically significant difference between	Initial intelligence gathering identified the following: The Care Quality Commission Regulations for service providers and managers (2017)(6) states that assessment of needs and preferences for care and treatment should be carried out collaboratively with the service user and/or the person who is lawfully acting on their behalf. Assessments should be reviewed regularly and whenever needed, including during transfer between services. Guidance by the Royal Pharmaceutical Society Wales (2016)(15), makes recommendations focused on improving safe and effective pharmaceutical care for the residents of care homes. It is recommended that residents should receive a review of their medication by a pharmacist when transitioning into the care home. A minimum of 1 annual medication review should be performed per year and pharmacists should have access to update a patient health record with consent. It is also recommended that upon transfer to another	**New evidence was identified that does not have an impact on the recommendations.** The evidence identified during this surveillance review is supportive of the current recommendations on medication reviews. Recommendation 1.8.1 states that medicines reviews should be performed as set out in the residents care plan, which is supported by all the primary evidence identified which indicates that medicines reviews are effective. Recommendation 1.8.3 states that the resident and/or their carers and a multidisciplinary team should be included in medicines reconciliation. This team may include a pharmacist, community matron or specialist nurse, a GP, a member of care home staff, a practice nurse and a social care practitioner. This recommendation is supported by observational evidence identified during this surveillance review, which suggests that the involvement of a multidisciplinary team is an effective method of performing medicine reviews. Further evidence supports the view that medicines reviews are just as effective when performed by pharmacists alone, compared with when there is also input from a GP.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
the 2 types of medication review were identified when measuring the number of stopped medicines. A cluster RCT(14) evaluated the use of the West Wales Adverse Drug Reaction Profile for Mental Health Medicines as a tool for medicines review, compared to usual care. Use of the tool significantly increased the number of problems addressed.	care setting, medicines reconciliation should be performed. Similar guidance, published by the Royal Pharmaceutical Society England (8–11), states that local commissioners should commission pharmacists to provide medicine reviews within care homes and every care home resident should have a pharmacist led medicines review at least once a year, or whenever a medicine is started, stopped or changed and when a resident moves between different care settings. Pharmacists should lead a programme of regular medicine reviews and staff training, working in an integrated team with other healthcare practitioners ensuring medicines safety. An annual report published by the Care Quality Commission(16) on the safer management of controlled drugs, sets out key changes to legislation and gives an overview of prescribing data and prescribing trends in the primary care sector. It also makes recommendations to strengthen existing arrangements. A recommendation that prescribers of controlled medicines should regularly review their patients was included. Topic experts did not provide any comments relevant to this area of the guideline.	However, limited outcome measures were reported by this study and therefore the extent of the effectiveness is unclear. The guidance identified emphasises that a pharmacist should always be involved in medication reviews, however, there is insufficient primary evidence to support this view, and no impact is anticipated on the current recommendation to involve a multidisciplinary team which may include a pharmacist. While recommendations in SC1 do not specify that a pharmacist should lead the medication review, as set out in guidance identified during this surveillance review, recommendation 1.8.2 suggests that the most appropriate healthcare professional to lead the review should be chosen in each circumstance. A pharmacist is also listed as a recommended member of the multidisciplinary healthcare team. This allows a residents individual needs to be taken into account, and allows a pharmacist to fill this role when appropriate. Therefore, the recommendations included in SC1 reflect the evidence identified here, but also allow individual circumstances to be considered, meaning impact on the guideline is unlikely. Policy identified suggests that medication reviews should be performed at a minimum once a year, and more often if required. This is supportive of recommendation 1.8.4 which states that medication reviews should be performed at least once a year, and the time frame chosen should be based on health needs and the promotion of safety, with the interval chosen recorded in the residents care plan.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
		Overall, the evidence identified during this surveillance review is supportive of the use of medication reviews and the recommendations made by SC1. Therefore, there is unlikely to be any impact on the recommendations at this time.
Section 1.9 Prescribing medicines		
A systematic review including 12 studies (17) (n=10,953), evaluated interventions aimed at optimising prescribing for older people living in care homes. Interventions included medication review, education for health and care professionals, multidisciplinary case-conferencing and the use of a clinical decision support technology. Interventions to optimise prescribing may lead to fewer days in hospital, a slower decline in health-related quality of life, the identification and resolution of medication-related problems and may lead to improved medication appropriateness; however, it may make little or no difference to adverse drug events or mortality.	Initial intelligence gathering identified the following: The General Pharmaceutical Council commissioned a policy on pharmacy and care homes (2015)(2). Causes of medication errors which were identified included prescribers having inadequate knowledge about the resident. This was made worse if several GP practices with different systems were providing care for a single care home. A systematic review(18), including 12 studies evaluated interventions aimed at improving the process of prescribing for older people in care homes. Interventions included a computerised decision support and multi-faceted pharmaceutical approaches delivered by healthcare professionals such as prescribers and pharmacists. Intervention was associated with a greater reduction in the Medication Appropriateness Index, and fewer drugs per person being taken on the Beers inappropriate medication list. However, evidence on the effects of interventions on hospital admissions and on medication-related problems was conflicting.	**New evidence was identified that does not have an impact on the recommendations.** 2 systematic reviews were identified during surveillance, which are both updates of reviews which were included during guideline development. It is suggested that interventions to optimise prescribing for people in care homes may lead to an improvement in some outcomes, however there may be little difference made to important outcomes such as adverse events, hospitalisation and mortality. It was also noted by authors that the evidence included was low to very low quality. As updated reviews, the majority of the evidence presented here was previously considered during guideline development. This, in combination with the mixed effectiveness and low study quality reported, as well as the already detailed recommendations in SC1, lead to the conclusion that this evidence is unlikely to have an impact on the guideline at this time. Policy identified during this surveillance review states that prescription errors occur when prescriber knowledge regarding individuals is inadequate. Recommendation 1.9.1 recommends that prescriptions should be made in accordance with patient medical records, which addresses the requirements of this report. Furthermore, it was noted in the report that issues with prescribing were

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	Topic experts did not provide any comments relevant to this area of the guideline.	addressed by NICE quality standard 85: medicines management in care homes (2015), which is based on SC1. Given this, it is unlikely that the evidence identified will impact on recommendations.
Section 1.10 Ordering medicines		
No new evidence relevant to this area of the guideline was identified through evidence searches	No information from initial intelligence gathering relevant to this area of the guideline was identified. Topic experts did not provide any comments relevant to this area of the guideline.	**No new evidence was identified, and therefore there is no impact on the recommendations.**
Section 1.11 Dispensing and supplying medicines		
A qualitative study(19) utilising semi-structured interviews with 8 pharmacists with care home medicines management expertise, evaluated the use of multi-compartment compliance aids. The limitations associated with the use of multi-compartment compliance aids were identified as a reduction in staff alertness during medication administration, a restricted ability to identify medicines and medicines wastage. The reasons multi-compartment compliance aids were introduced into care homes were reportedly to address unsafe medicines administration and because of pharmacy commercial interest. There were mixed results concerning the recommended future use of multi-compartment compliance aids, with some participants perceiving they brought benefits of improved safety and efficiency and others recommending that they are removed and care home staff trained to administer medicines from original packaging.	Initial intelligence gathering identified the following: The General Pharmaceutical Council commissioned a policy on pharmacy and care homes (2015)(2), including evidence from observational studies which showed that where monitored dosage systems were used, medication administration errors occurred more frequently in medication which couldn't be managed by such a system, such as inhalers. As 40% of medicines cannot be handled using a medicine dosage system, another study concluded that only specific groups of patients should be considered for the use of medication dosage systems – patients with physical impairment but no formal or informal carers and patients with cognitive impairment and formal or informal carers. Following this, a 2012 Department of Health report noted that the supply of medicines dosage systems can be	**New evidence was identified that does not have an impact on the recommendations.** Recommendation 1.11.2 suggests that care home providers should determine the best system for the supply of medicines for each individual. During development, this recommendation derived in part from evidence regarding multi-compartment compliance aids, which suggested that these tools should not automatically be the intervention of choice for all residents. This is based partly on the fact that their use has been associated with an increase in errors in medication which cannot be managed with multi-compartment compliance aids. The evidence identified here corroborates the mixed efficacy which has previously been considered during guideline development. While there is some evidence to support the use of multi-compartment compliance aids, evidence such as the Department of Health report supports the recommendation allowing choice regarding an individual's personal circumstances

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
A prospective observational study(20) compared the effect of administering medicines from original packaging or from multi-compartment compliance aids on medication errors, across 10 care homes. A statistically significantly greater medication administration error rate was seen for original packaging than multi-compartment compliance aid administration.	driven by patient demand and care home managers, and that pharmacists have the responsibility of ensuring only those residents needing medicines dosage systems were using them. Topic expert feedback indicated that there have not been changes in the use of, or discussion around, administering medicines from original packaging in comparison to using monitored dosage systems since publication of the guideline.	(recommendation 1.11.2) and therefore the guideline is not likely to be impacted.
Section 1.12 Receiving, storing and disposing of medicines		
No new evidence relevant to this area of the guideline was identified through evidence searches.	No information from initial intelligence gathering relevant to this area of the guideline was identified. Topic expert feedback raised that discussions regarding expiry dates which are noted in the full guideline (section 3.12) were not included in the NICE version. This included discussion that if medicines are still currently prescribed, are within the expiry date and the manufacturer's literature does not specify a short shelf-life when the product is opened, there is no requirement for the medicine to be disposed of early and it should be carried forward to the next 28-day cycle. It was raised that there is a large waste of medicines in care homes from throwing away medication that is still within date.	**New evidence was identified that does not have an impact on the recommendations.** Recommendation 1.12.4 in SC1 states that before disposing of a medicine that is still being prescribed for a resident, care home staff should find out if it is still within its expiry date and if it's still within its shelf life if it has been opened. The issues raised by topic experts, that medicines should not be disposed of when within their expiry dates, are addressed by this recommendation. While feedback indicates that there may be issues with implementation, this is not likely to impact on the guideline at this time.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
Section 1.13 Helping residents to look after and take their medicines themselves (self-administration)		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following: The Care Quality Commission Regulations for service providers and managers (2017)(6) states that opportunities must be provided for service users or those lawfully acting on their behalf, to manage their own care and treatment. Service users should also be given suitable information, advice, instruction and/or emotional support to help manage any care and treatment safely. Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment, reflecting their personal preferences. Where peoples preferences are not in line with treatment that meets their needs, and there is a lack of mental capacity, providers must act in accordance with the Mental Capacity Act 2005 and/or the Mental Health Act 1983. Guidance published by the Department of Health (2016)(22), states that residents should be given the opportunity to manage their own medication, and a person must be assumed to have capacity unless it is otherwise established that they lack capacity. A guide to aid the implementation of children's homes regulations, published by the Department of Education (2015)(4), includes that children who wish to keep and take their own medication should be supported to, if they are able to do so safely.	**New evidence was identified that does not have an impact on the recommendations.** Evidence identified during this surveillance review emphasises that care home residents should be given opportunities and help to manage their own medicines. Policies stating this have been identified regarding both adult and children's care homes. This supports the current recommendation in SC1 (1.13.1) which states that care home residents should be assumed to have the capacity to look after and take their own medication unless a risk assessment has indicated otherwise. Recommendation 1.13.2 also states that when a risk assessment is performed, it should aim to determine how much help a resident requires to take their medication properly. As the evidence identified supports the recommendations in SC1, it is unlikely that there is any impact at this time.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	Topic experts did not provide any comments relevant to this area of the guideline.	
Section 1.14 Care home staff administrating medicines to residents		
A qualitative study(23) utilised semi-structured interviews to investigate nurses views regarding single nurse dispensing and administration of controlled drugs (SNAD), in palliative care. The use of SNAD was compared to the usual practice of 2 nurses performing controlled drug administration. It was identified that SNAD reduces patient and family anxiety when patients experience episodic pain, and enabled a prompt response to requests for 'as required' analgesia. It was also identified that this contributed to family and patient confidence in the hospice team and a decrease in nurse stress levels. SNAD was shown to help alleviate nurse time, allowing more time to coordinate and organise nursing care. However, this was only the case when all nurses working in the hospice were able to undertake SNAD, as exclusions for agency staff and new staff applied. It was also identified that SNAD may in some cases not save any time, as it would take longer for the administration process due to 'triple checking' all processes and calculations. Reliance on SNAD during a night shift was also a concern. A lack of confidence in the initial use of SNAD was identified among nurses, which was due to the difference in safety concerns regarding controlled drugs over other medication. However, others discussed that there was less confusion around medicines calculations after the initiation of SNAD. A review regarding medication safety in care homes(24) highlights the Nursing and Midwifery Council's Code, which makes it clear that district	Initial intelligence gathering identified the following: A guide to aid the implementation of children's homes regulations, published by the Department of Education (2015)(4) includes that care must be taken to ensure prescribed medicines are only administered to the individual for whom they are prescribed and that medicines must be administered in line with a medically approved protocol. Topic expert feedback highlighted that if dysphagia is an issue, that the prescriber and the pharmacist should work together to find the most appropriate medicine and its formulation for the patient. It was suggested that liquid preparations are not always appropriate, and this needs to be considered for each circumstance.	**New evidence was identified that does not have an impact on the recommendations.** The recommendation on the administration of controlled drugs requiring a secondary signature from a witness (recommendation 1.14.16) are based on the Nursing and Midwifery Council Standard for Medicines Management. The evidence identified here indicates that this may not be the most effective use of nursing time, or provide the best quality of care. However, the evidence suggests that SNAD may also have negative effects on nurse confidence in administrating controlled drugs. There was no evidence identified which reported the outcome of patient safety when using SNAD. This, in combination with the mixed qualitative results, indicates that the recommendations in NICE guideline SC1 would not be impacted by the new evidence identified, as the basis for the current recommendations are patient safety regulations. Evidence was identified that highlights the importance of medication being administered in the form it was prescribed, which is an issue that has arisen for residents with dysphagia. Topic expert feedback also indicated that prescribers and pharmacists should work together to prescribe appropriate formulations of medicines for the individual, which may not always be a liquid. While SC1 does not make specific recommendations on medication-related dysphagia, recommendation 1.14.6 states that care home staff must have the

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nurses and community matrons must ensure patient safety by encouraging and supporting care home staff in managing patients with medication-related dysphagia. It advises that altering solid-dose formulations by crushing medication for the management of dysphagia needs to be avoided. This is not only to avoid patient harm, but to avoid nurse liability. The Human Medicines Regulations (2012) require that medicinal products are used in accordance with their product licence, which may be breeched if medication is altered during administration, for example by crushing. It may be more appropriate, if available, to prescribe liquid versions of medication to aid patients who have difficulty swallowing solid formulations. An assessment of the individual and the medication formulations available would need to be made before making a decision. A report(21) evaluated an electronic medicine management solution (Proactive Care System) for care homes which aims to connect pharmacies and care homes, in order to produce a system that allows 2-way exchange of data. It was indicated that there were improvements in quality and safety in medicines management following implementation, with 21 out of 23 potential error types associated with paper based systems being eradicated. The use of the system also resulted in a 55% reduction of waste associated with medicines being returned and a 22% reduction of overstock of medicines in care homes.		training and skills to administer medicines. Recommendation 1.14.8 also includes that administration records should include any support the resident needs to continue taking their medication and special instructions on how it should be taken. These measures should be appropriate to avoid incorrect administration, despite the lack of specific recommendations on this subject. Therefore, there is unlikely to be an impact on the guideline. Recommendation 1.11.1 suggests that processes such as standard operating procedures should be in place to aid accuracy of medication supply. Evidence published by the Department of Education emphasises the importance of this recommendation, and is unlikely to have an impact on the guideline. Research was identified on the use of electronic medicine management solutions. Recommendations in the guideline suggest that care home providers should have a care home policy that is reviewed and kept up to date across various areas of medicines management (1.1.2). There are also references to the use of electronic management systems for recording medicine administration (1.14.7 and 1.14.8). As the current recommendations suggest that the most appropriate systems for each care home are used, which may include electronic systems, it is not anticipated that there would be any impact on the guideline at this time. Overall, it is not anticipated that the newly identified evidence in this area has any impact on current recommendations.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
Section 1.15 Care home staff giving medicines to residents without their knowledge (covert administration)		
No new evidence relevant to this area of the guideline was identified through evidence searches.	A report (2) by UK Medicines Information (UKMi) states that there is evidence of care givers altering medicinal products (for example crushing tablets) during covert administration, which could be outside the terms of the licence and often there will be no information available regarding the stability of medicines when mixed with food or drink. The risks of administering a potentially degraded medicine versus the risk of the patient not receiving the medicine needs to be considered. Topic experts did not provide any comments relevant to this area of the guideline.	**New evidence was identified that does not have an impact on the recommendations.** Evidence was identified that highlights the importance of medication not being altered in order to comply with the need for covert administration. While this is not specifically referred to in SC1, Medicines management in care homes NICE quality standard 85 details that once the decision to covertly administer has been made, it should be considered how administration will be performed and whether it is safe to do so. Recommendation 1.15.3 in SC1 also suggests that methods for covert administration should be planned in advance. As related NICE guidance (QS85) provides further details on maintaining safe administration following the decision to covertly administer, it is not likely that the evidence identified has an impact on SC1 at this time.
Section 1.16 Care home staff giving non-prescription and over-the-counter products to residents (homely remedies)		
No new evidence relevant to this area of the guideline was identified through evidence searches.	No information from initial intelligence gathering relevant to this area of the guideline was identified. Topic experts did not provide any comments relevant to this area of the guideline.	**No new evidence was identified, and therefore there is no impact on the recommendations.**
Section 1.17 Training skills (competency) of care home staff		
No new evidence relevant to this area of the guideline was identified through evidence searches.	Initial intelligence gathering identified the following:	**New evidence was identified that does not have an impact on the recommendations.**

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	The Care Quality Commission Regulations for service providers and managers (2017)(6) states that staff responsible for management and administration of medication must be suitably trained and competent and this should be kept under review. The provider must have appropriate processes for assessing and checking that the individual is suitable. Guidance published by the Department of Health (2016)(22), makes clear the legislation regarding the training requirements for care workers administering medication in care homes. Care workers such as care assistants are not prohibited from administering medicines to residents in care homes. Any staff employed by the care home who are responsible for the management and administration of medicines must be suitably trained and competent, and this should be kept regularly under review. The guidance states that training care assistants to administer medicines should include supply, storage, and disposal of medicines; safe administration; quality assurance; record-keeping; accountability; responsibility and confidentiality. Care assistants should understand policies for reporting errors, have training highlighting common issues with medicines administration and complete a formal assessment process. A guide to aid the implementation of children's homes regulations, published by the Department of Education (2015)(4), includes that it should be ensured that systems are in place, so that all staff receive supervision of their practice from an appropriately qualified and experienced professional. All staff must also	Recommendations 1.17.1-1.17.6 state that staff administering medication must have completed the relevant training as well as being competent in the skills required to complete this task. Staff must also have appropriate knowledge, skills and expertise in the safe use of medicines. It is suggested that training should be provided so that staff can develop these skills and that an accredited learning provider could be used for this. As well as this, it is recommended that competency is reviewed annually. These recommendations are supported by the evidence identified during this surveillance review, which emphasise that staff administering medication must be competent, must receive the relevant training, and that competency is reviewed regularly. Therefore, it is unlikely that the new evidence identified will have an impact on SC1.

Summary of new evidence from 4-year surveillance	Summary of new intelligence from 4-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
	have their performance and fitness to carry out their role formally appraised at least once annually. The Children's homes regulations amendments (2014)(25), published by the Department of Education, sets out the qualifications required for care staff working in children's homes. The policy states that a Level 3 diploma in 'Children and Young People's Workforce – Social Care Pathway', or equivalent, should be obtained by care staff of children's homes within 2 years of commencing the role. Managers of care homes must complete a Level 5 diploma. Topic experts highlighted the guidance on legislation for medicines administration published by the Department of Health (2016)(22), which is summarised above.	

Editorial corrections

A number of editorial corrections were identified during surveillance.

- Recommendation 1.2.5 requires an amendment to replace the word ‘should’ with ‘must’. An amendment from the current recommendation should be made to read instead:

‘Health professionals prescribing a medicine must:

  - assume that care home residents have the capacity to make decisions
  - assess a resident’s mental capacity in line with appropriate legislation (for example, the Mental Capacity Act 2005) if there are any concerns about whether a resident is able to give informed consent
  - record any assessments of mental capacity in the resident’s care record.

- Recommendation 1.6.5 requires an amendment to replace the word ‘should’ with ‘must’. An amendment from the current recommendation should be made to read instead:

  ‘Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these must be reported to the CQC (or other appropriate regulator).’

- Recommendation 1.14.6 requires an amendment from the current recommendation to read instead:

  ‘Care home staff must have the training and skills to use system(s) adopted in the care home for administering medicines in line with regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for adult care homes and regulation 32.3 of the Children's Homes Regulations 2015 for children's care homes.’

- References made in the useful resources section of the guideline which will require updating are detailed as follows:

- Care Quality Commission (CQC) essential standards of quality and safety. This has been replaced by CQC guidance for providers on meeting the regulations.

- Working together to safeguard children 2013 was updated in 2015.

- The Mental Capacity Act Code of Practice 2007 was updated in 2016. This is also referenced in recommendations 1.2.6 and 1.2.7 and these recommendations will require an update to reflect this.

- The Children's Homes Regulations 2001 was updated in 2015 (referenced as National Minimum Standards from the Department of Education Children's homes). This is also referenced in recommendation 1.14.6 and this recommendation will require an update to reflect this.

- The link to the Health and Social Care Information Centre: A guide to confidentiality in health and social care does not work. An editorial correction to replace to this link will be required.

- The link to the Royal Pharmaceutical Society: Keeping patients safe when they transfer between care providers – getting the medicines right does not work. An editorial correction to replace to this link will be required.

- The Nursing and Midwifery Council: record keeping: guidance for nurses and midwives has been updated by The Code for nurses and midwives.

- Records Management: NHS Code of Practice was withdrawn in 2016.

- Department for Education: What to do if you're worried a child is being abused (2006) was updated in 2015.

- The link to Royal Pharmaceutical Society: Improving pharmaceutical care in care homes does not work. An editorial correction to replace to this link will be required.

- NICE guideline PSG001 linked to in the useful resources section has been replaced by NICE guideline NG5.

- The link to the British National Formulary does not work. This is also referenced in recommendation 1.14.9. An editorial correction to replace to this link will be required.

- The link to the British National Formulary for Children does not work. This is also referenced in recommendation 1.14.9. An editorial correction to replace to this link will be required.

- The link to the NICE Evidence portal does not work. An editorial correction to replace to this link will be required.

On-going research

Ongoing research was identified through experts and the initial intelligence gathering (NIHR research in progress). If this was within the scope for SC1 it has been included:

1. Care Homes Independent Pharmacist Prescribing Service (CHIPPS): Development and delivery of a cluster randomised controlled trial to determine both its effectiveness and cost-effectiveness. Work Package 5: Feasibility Study

This is an observational study which will evaluate whether making a specially trained pharmacist prescriber part of the care home team could improve the use of medicines and the care of residents. This trial was due to end in May 2017.

2. Nurse-led Medicines' Monitoring in Care Homes: a Process Evaluation

This qualitative study design will evaluate the barriers and enablers to sustaining the implementation of the WWADR profile, which involves nurse led medicine monitoring. The trial end date is unknown, with recruitment ending September 2017.

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