NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Case scenarios for health and social care staff managing medicines in care homes

Implementing the NICE guideline on managing medicines in care homes

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These case scenarios for health and social care staff accompany the NICE guideline on managing medicines in care homes (published March 2014).

Implementing the NICE guideline is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, 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 the guideline should be interpreted in a way that would be inconsistent with compliance with those duties. These case scenarios are a tool to support the implementation of the NICE guideline. **They are not NICE guidance.**

National Institute for Health and Care Excellence

Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT www.nice.org.uk

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Introduction

NICE case scenarios

Case scenarios are an educational resource that can be used for individual or group learning. Each question should be considered by the individual or group before referring to the answers.

These 4 case scenarios have been put together to improve your knowledge of the systems and processes involved in managing medicines in care homes and their application in practice. They illustrate how the recommendations from the NICE guideline on managing medicines in care homes can be applied by individual people and organisations involved with care homes, to ensure that residents receive safe and appropriate care and are as involved with decisions about their medicines as they wish, in line with legislation.

You will need to refer to the NICE guideline while using these case scenarios, so make sure that you have access to copies (either online at http://www.nice.org.uk/guidance/sc/SC1.jsp or as a printout).

Each case scenario includes background information and relevant recommendations from the NICE guideline, which are quoted in the text (at the end of each case scenario), with corresponding recommendation numbers.

Managing medicines in care homes

The management of medicines in care homes is governed by legislation, regulation and professional standards, which are monitored and enforced by different regulatory organisations across England, Wales and Northern Ireland.

People living in care homes have the same rights and responsibilities in relation to NHS care as those who do not live in care homes; these are set out in the NHS Constitution for England. Care homes residents should have the opportunity to make informed decisions about their preferred care and treatment, in partnership with their health professionals and social care practitioners. Person-centred care is particularly important when considering

safeguarding and mental capacity; the NICE guideline considers these issues in relation to medicines.

Helping residents to look after and take their own medicines is important in enabling residents to retain their independence. When a person moves into a care home, staff should assume that the person can look after and manage their own medicines, unless indicated otherwise. Each resident should have an individual risk assessment to determine the level of support they need to manage their own medicines.

The NICE guideline considers all aspects of managing medicines in care homes and recommends that all care home providers have a care home medicines policy. The policy should include written processes for the safe and effective use of medicines in the care home. Sections of the guideline provide recommendations for different aspects of managing medicines covered by the care home medicines policy.

Case scenarios for managing medicines in care homes

Case scenario 1: A new resident is admitted to the care home

A new resident is admitted to the care home; the resident wishes to look after and take (self-administer) their own medicines.

1.1 Question

What needs to be considered when a resident wishes to look after and take (self-administer) their own medicines?

1.1 Answer

- Legislation - Are there any concerns about the resident's mental capacity to make decisions about their care and treatment? See section 1.2 of the guideline.
- NICE guideline – The guideline states that care home staff should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise. See recommendation 1.13.1.
- Governance – Is there an appropriate care home medicines policy (see recommendation 1.1.2) and are there governance arrangements that cover the required aspects of self-administration? The care home medicines policy should include written processes for:
  - sharing information about a resident's medicines, including when they transfer between care settings
  - ensuring that records are accurate and up to date (see below)
  - identifying, reporting and reviewing medicines-related problems
  - keeping residents safe (safeguarding)
  - accurately listing a resident's medicines (medicines reconciliation)
  - reviewing medicines (medication review)
  - ordering medicines (see below)
  - receiving, storing and disposing of medicines
  - helping residents to look after and take their medicines themselves (self-administration)

  Are these arrangements being adhered to?

- Risk assessment – Is there a process in place for assessing risk associated with self-administration (see recommendation 1.13.2), which takes into account:
  - resident choice
  - whether self‑administration will be a risk to the resident or to other residents
  - whether 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 upon individual resident need
  - how the medicines will be stored
  - the responsibilities of the care home staff, which should be written in the resident's care plan (such as reminding the resident to self-administer or assisting residents with certain medicines)?

  The process should detail who will be responsible for coordinating, and who will be involved in, risk assessment (see recommendation 1.13.3 and question 1.2).

- Recording – What should be recorded on the medicines administration record or care plan in relation to a resident's self-administration (see recommendation 1.13.4 and recommendation 1.13.5)?
  This should be detailed in the care home medicines policy and should include:
  - the fact that the resident is taking (self-administering) their medicine or is reminded or assisted to self-administer medicines
  - the medicines supplied to the resident for self-administration
  - whether the resident needs:
    - ◊ checks to make sure they are taking or using their medicines as intended, or
    - ◊ assessment of ability (either by direct observation or by questioning the resident)
  - who has recorded the self-administration.

- Storage – Is appropriate storage available for the resident to store their medicines (see recommendation 1.13.6), taking into account how the resident will access the medicines, safe keeping of the medicines and any additional storage requirements (for example, temperature) of specific medicines?

1.2 Question

Who may be involved in the risk assessment?

1.2 Answer

The care home manager should coordinate the risk assessment and should help to determine who else should be involved (see recommendation 1.13.3). This should be done individually for each resident and should include:

- the resident (and their family members or carers if the resident wishes)
- care home staff with the training and skills for assessment
- other health and social care staff (such as the GP and pharmacist) as appropriate to help identify whether the medicines regimen could be adjusted to enable the resident to self-administer.

1.3 Question

What information should be included in the process for the self-administration of controlled drugs?

1.3 Answer

The process for the safe self-administration of controlled drugs (see recommendation 1.13.7) should include:

- individual risk assessment
- obtaining or ordering controlled drugs
- supplying controlled drugs
- storing controlled drugs
- recording supply of controlled drugs to residents
- reminding residents to take their medicines (including controlled drugs)
- disposal of unwanted controlled drugs.

Related recommendations

Recommendation 1.1.2

Care home providers should have a care home medicines policy, which they review to make sure it is up to date, and is based on current legislation and the best available evidence. The policy should include written processes for:

- sharing information about a resident's medicines, including when they transfer between care settings
- ensuring that records are accurate and up to date
- identifying, reporting and reviewing medicines-related problems
- keeping residents safe (safeguarding)
- accurately listing a resident's medicines (medicines reconciliation)
- reviewing medicines (medication review)
- ordering medicines
- receiving, storing and disposing of medicines
- helping residents to look after and take their medicines themselves (self-administration)
- care home staff administering medicines to residents, including staff training and competence requirements
- care home staff giving medicines to residents without their knowledge (covert administration)
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.

Recommendation 1.13.1

Care home staff (registered nurses and social care practitioners working in care homes) should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise (see recommendation 1.13.2).

Recommendation 1.13.2

Health and social care practitioners should carry out an individual risk assessment to find out how much support a 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 upon individual resident need
- how the medicines will be stored
- the responsibilities of the care home staff, which should be written in the resident's care plan.

Recommendation 1.13.3

The care home manager should coordinate the risk assessment and should help to determine who should be involved. This should be done individually for each resident and should involve the resident (and their family members or carers if the resident wishes) and care home staff with the training and skills for assessment. Other health and social care practitioners (such as the GP and pharmacist) should be involved as appropriate to help identify whether the medicines regimen could be adjusted to enable the resident to self-administer.

Recommendation 1.13.4

Providers of adult care homes must ensure that records are made and kept when adult residents are supplied with medicines for taking themselves (self-administration), or when residents are reminded to take their medicines themselves.

Recommendation 1.13.5

Providers of children's care homes must ensure that records are made and kept for residents living in children's homes who are able to look after and take their medicines themselves (self-administer). The following information should be recorded on the medicines administration record:

- that the resident is looking after and taking their medicines themselves (self-administering)
- whether any monitoring is needed (for example, to assess ability to self-administer or willingness to take the medicines as prescribed [adherence])
- that medicine has been taken as prescribed (either by seeing this directly or by asking the resident)
- who has recorded that the medicine has been taken.

Recommendation 1.13.6

Care home providers should ensure that medicines for self-administration are stored as identified in the resident's risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Residents should be able to get any medicines that need special storage at a time when they need to take or use them (see recommendations 1.12.1, 1.12.2 and 1.12.3).

Recommendation 1.13.7

Care home providers should ensure that their process for self-administration of controlled drugs includes information about:

- individual risk assessment
- obtaining or ordering controlled drugs
- supplying controlled drugs
- storing controlled drugs
- recording supply of controlled drugs to residents
- reminding residents to take their medicines (including controlled drugs)
- disposal of unwanted controlled drugs.

Case scenario 2: A resident refuses their medicines

A resident who has been living in the care home for some time appears to be increasingly confused and has started to refuse their medicines.

2.1 Question

What should care home staff consider and what should they do?

2.1 Answer

- Is the refusal of the medicine a valid and informed decision (see below)?

Valid decisions

'For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question'. 'To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment.' Department of Health (2009) Reference guide to consent for examination or treatment (second edition).

Informed consent

A person's agreement to treatment after having received full information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.

- If there is no reason to suspect that the resident does not have capacity to make a valid and informed decision, the care home staff should respect the resident's right to refuse.
- If there is a reason to suspect that the resident does not have capacity to make a valid and informed decision, the care home staff should notify the prescriber of their concerns.
- Whether or not they suspect lack of capacity (see recommendation 1.2.3), care home staff should:
  - notify the prescriber (if the resident agrees, where there is no suspected lack of capacity)

- notify the pharmacy if the resident agrees and refusal is ongoing (to prevent any over-supply of medicines)
- record the refusal:
  - in the medicines administration record along with any reason for the refusal
  - in the resident's care record, unless there is already a care plan in place to cover refusal of medicines by the resident
- record the actions taken in the resident's care record (for example, notifying the prescriber and where appropriate the supplying pharmacy)
- record the refusal even if it is only partial (for example, the resident spits out an oral medicine).

2.2 Question

The prescriber (GP) assesses the resident and decides that the cause of the confusion is treatable (a urinary tract infection) and the medicines being refused are not critical. What should the care home staff do?

2.2 Answer

- If the confusion is thought to be related to a urinary tract infection, care home staff should follow the care instructions given by the health professional treating the resident and record this in the resident's care plan. For further advice see the NICE guideline on delirium.
- Care home staff should be aware that other causes of confusion may include mental health problems, lack of mental capacity to make decisions, other health problems (such as problems with hearing and vision), and difficulties with reading, speaking or understanding English (see recommendation 1.2.4).
- If the medicine is not critical, with the agreement of the prescriber, and in line with the Mental Capacity Act Code of Practice 2007, it may be possible to put off making a further decision about the refused medicine until the resident has the capacity to make the decision themselves.

Related recommendations

Recommendation 1.2.3

Care home staff (registered nurses and social care practitioners working in care homes) should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident's care record and medicines administration record, unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.

Recommendation 1.2.4

Health and social care practitioners should identify and record anything that may hinder a resident giving informed consent. Things to look out for include mental health problems, lack of (mental) capacity to make decisions, health problems (such as problems with vision and hearing), difficulties with reading, speaking or understanding English and cultural differences. These should be taken into account when seeking informed consent and should be regularly reviewed.

Case scenario 3: A resident requires medicine in their best interest

3.1 Question

A GP is notified by care home staff that a resident is refusing medicines. On review, the GP has concerns that the resident no longer has the capacity to make a valid and informed decision about refusal. What needs to be considered by the care team?

3.1 Answer

- Are there any reasons why the resident is refusing the medicine and could any changes be made to make the medicine acceptable? For example:
  - the formulation (tablet or liquid) may make the medicine difficult to swallow or be linked to an unpleasant taste
  - the medicine may be given at an inappropriate time of day.

- Care home staff should check with the GP or other prescriber if the medicine(s) is still appropriate for the resident. For example, is it clinically appropriate and are there any issues with tolerability (how well can the resident tolerate the adverse effects of the medicine) or side effects?
- The health professional prescribing a medicine should arrange for an assessment of the resident's capacity in line with the Mental Capacity Act Code of Practice 2007, and ensure the results are recorded in the resident's care record (see recommendation 1.2.5 and recommendation 1.2.6).
- When assessment shows that a resident lacks capacity to make a specific decision, it may be necessary to hold a multidisciplinary best interest meeting to make a specific decision on the resident's behalf. Health and social care staff should:
  - involve the resident in best interest decisions and consider their past and present views, wishes, feelings, beliefs and values
  - involve people who know the resident in best interest decisions, including family members or carers (informal or unpaid carers), friends and care home staff

  - follow any legal requirements, particularly of those with lasting power of attorney as laid out in the Mental Capacity Act 2005
  - deliver care and treatment in a way that empowers the resident to be involved in decisions and limits any restrictions to their care.

(See recommendation 1.2.6 and recommendation 1.2.7).

- If the best interest decision is to administer the refused medicine covertly (covert administration) to a resident who has been assessed and does not have capacity (see recommendation 1.15.1), follow the care home's written process for covert administration (see recommendation 1.15.3). The process should cover:
  - assessing the resident's capacity
  - holding a best interest meeting and recording decisions
  - 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.

- Medicines should not be administered covertly until a best interest meeting has been held. If the situation is urgent, a decision can be made at a less formal discussion between care home staff, the prescriber and family, carers or advocate. However, a formal best interest meeting should be arranged as soon as possible.
- Health professionals should regularly review a resident's mental capacity and any best interest decisions, in line with the Mental Capacity Act 2005 and the Mental Capacity Act 2005 Code of Practice 2007, taking into account the cause of the loss of capacity and whether this is fluctuating or is temporary (see recommendation 1.2.6).

Related recommendations

Recommendation 1.2.5

Health professionals prescribing a medicine should:

- 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 assessment of mental capacity in the resident's care record.

Recommendation 1.2.6

Health professionals prescribing a medicine should review mental capacity, in line with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice 2007, when a resident lacks capacity to make a specific decision. How often they do this should depend on the cause, as this may affect whether lack of capacity fluctuates or is temporary.

Recommendation 1.2.7

Health and social care practitioners should ensure that residents are involved in best interest decisions, in line with the Mental Capacity Act Code of Practice 2007, and:

- find out about their past and present views, wishes, feelings, beliefs and values
- involve them, if possible, in meetings at which decisions are made about their medicines
- talk to people who know them well, including family members or carers (informal or unpaid carers) and friends, as well as care home staff deliver care and treatment in a way that empowers the resident to be involved in decisions and limits any restrictions to their care.

Recommendation 1.15.1

Health and social care practitioners should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care.

Recommendation 1.15.3

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.

Case scenario 4: A medicines-related safety incident in a children's home

A 15-year-old, who lives in a children's home, attends a GP practice for an annual asthma check. The young person has asked to attend the practice by himself and as he has been risk assessed by care home staff as safe to manage the administration of his own medicines the care home staff agree.

The GP reviews the young person's asthma control and use of his blue salbutamol reliever inhaler. The young person explains that he has been using it quite often (more than 3 times a week). The GP discusses this with him and they agree that he needs a brown preventative inhaler to be used regularly.

The young person is given a prescription for this, but he forgets to hand it to the care home staff member when he returns to the care home. The young person gives the prescription to a member of the care home staff a few days later and the preventative inhaler is ordered. The young person's condition is not affected by the delay. No harm is felt to have arisen, so the delay is not reported or documented.

4.1 Question

Do you think that a medicines-related safety incident has occurred? If so, what is the incident?

4.1 Answer

Yes, a medicines-related safety incident has occurred. Even though no harm has arisen, there was potential for harm from the delayed treatment of asthma. Therefore the incident should be documented and investigated as a medicines-related safety incident (see recommendation 1.6.5).

4.2 Question

How should this incident be investigated and why?

4.2 Answer

The incident happened because processes (for example, processes covering communication and training) were not followed. Root cause analysis process

would be the most useful method of investigation to identify how and importantly why the incident took place (see recommendation 1.6.8).

4.3 Question

Who might be involved in an investigation and what issues might be identified?

4.3 Answer

- A thorough investigation of the root causes of the incident would involve the care home, the GP practice and the resident.

- As part of a young person's transition into adult care it is recommended by the 2012 BTS/SIGN guideline on asthma that young people are seen on their own by health professionals, but not for the whole consultation. This should be part of the care plan for a young person with asthma, which should be discussed and agreed between the young person, GP and care home staff.

- The GP practice and the care home should each review their processes for communicating that a new medicine has been prescribed for the young person (see recommendation 1.9.3).

Related recommendations

Recommendation 1.6.5

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 should be reported to the CQC (or other appropriate regulator).

Recommendation 1.6.8

Care home staff should find out the root cause of medicines‑related incidents.

Recommendation 1.9.3

Health and social care practitioners should work together to make sure that everyone involved in a resident's care knows when medicines have been started, stopped or changed.

Glossary

Best interest decisions

If a resident lacks mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

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.

Informed consent

A person's agreement to treatment after having received full information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.

Lack of mental capacity

The Mental Capacity Act 2005 defines a lack of mental capacity as 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

Lasting power of attorney

The Mental Capacity Act Code of Practice 2007 defines a lasting power of attorney as when one person gives another person authority to make a decision on their behalf, through a power of attorney, which is a legal document. 'Under a power of attorney, the chosen person (the attorney or donee) can make decisions that are as valid as one made by the person (the donor).'

Medicines administration record

A document on which details of all medicines given in a care setting are recorded; usually designed to show the dose given, the time when given and the identity of the person who gave it.

Risk assessment

Method used to determine a person's level of ability to manage their medicines and their suitability to administer their medicines themselves.

Root cause analysis

A systematic investigation technique that seeks to understand the underlying causes and environmental context in which an incident happened

Other implementation tools

NICE has developed tools to help organisations implement the guideline on managing medicines in care homes (listed below). These are available on the NICE website (http://www.nice.org.uk/guidance/sc/SC1.jsp).

- Managing medicines in care homes: baseline assessment tool.
- Managing medicines in care homes: checklist for care home medicines policies.

A practical guide to implementation, 'How to put NICE guidance into practice: a guide to implementation for organisations', is also available.