



Medicines management in care homes

Quality standard

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This standard is based on SC1.

This standard should be read in conjunction with QS31, QS50, QS63, QS96, QS87, QS97, QS120, QS132, QS136, QS164, QS171, QS184 and QS194.

Introduction

This quality standard covers the prescribing, handling and administering of medicines for all people (including adults, children and young people) living in care homes, and the provision of care or services relating to medicines to those people.

The term 'care home' is used to cover the provision of 24-hour accommodation together with either non-nursing care or nursing care. A care home can be of any size (number of residents) or have any type of resident (for example, children, older people, people with cognitive impairment, young disabled people or people with a learning disability), but should be a registered provider of care (for example, registered with either the Care Quality Commission or Ofsted [the Office for Standards in Education, Children's Services and Skills in England]).

For more information see the [managing medicines in care homes topic overview](#). This quality standard should be read alongside the [Mental Capacity Act 2005](#) and [Mental Capacity Act 2005 code of practice](#).

Why this quality standard is needed

The [National Care Forum's report, Safety of medicines in the care home \(2013\)](#), 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 [Care homes' use of medicines study \(CHUMS; Barber et al. 2009\)](#) 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, [Medication administration errors for older people in long-term residential care \(Szczepura et al. 2011\)](#), reported that more than 90% of the

residents included in this study were exposed to at least 1 potential medicine 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 medicine-related events
- care home residents' quality of life
- family and carer confidence in care provision
- individual care
- medication errors.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for 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:

- [Adult Social Care Outcomes Framework 2015 to 2016](#)
- [NHS Outcomes Framework 2015 to 2016](#)
- [Public Health Outcomes Framework 2013 to 2016.](#)

Service user experience and safety issues

Ensuring that care is safe, effective 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 an associated quality standard 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](#) and [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 are 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 are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on service user experience and are specific to the topic are 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 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 NICE 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 sources on specific types of training for the topic that exceed standard professional training are 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. The views of residents in care homes about who should and should not be involved in their care are important and should be respected. If the resident lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the resident's best interests, taking account of the provisions in the Mental Capacity Act 2005.

List of quality statements

Statement 1 People who transfer into a care home have their medicines listed by the care home on the day that they transfer.

Statement 2 Providers of health or social care services send a discharge summary, including details of the person's current medicines, with a person who transfers to or from a care home.

Statement 3 People who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk.

Statement 4 Prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Statement 5 People who live in care homes have medication reviews undertaken by a multidisciplinary team.

Statement 6 Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.

Quality statement 1: Record-keeping

Quality statement

People who transfer into a care home have their medicines listed by the care home on the day that they transfer.

Rationale

It is important that information about medicines is available for people who transfer into a care home, either for the first time or, for example, when moving back into the care home after a hospital stay (during which their medicines may have been changed). This will allow information about a person's medicines to be available to relevant health and social care practitioners (while taking care to respect confidentiality), improving continuity of care and ensuring that people get the right medicines at the right time at the care home they have transferred to.

Quality measures

Structure

Evidence of local arrangements to ensure that a list is made of a person's medicines on the day that they transfer into a care home.

Data source: Local data collection.

Process

Proportion of transfers of people into a care home where a list of the person's medicines is made by the care home on the day of transfer.

Numerator – the number in the denominator where a list of the person's medicines is made by the care home on the day of transfer.

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

Data source: Local data collection.

Outcome

Time between a person moving into a care home and completion of a list of their medicines.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (care homes) ensure that they make arrangements to produce a list of a person's medicines on the day that they transfer into a care home.

Health and social care practitioners ensure that they coordinate the listing of a person's medicines on the day that they transfer into a care home.

Commissioners (local authorities) ensure that they commission services that make arrangements to produce a list of a person's medicines on the day that they transfer into a care home.

People who move into a care home (either for the first time or moving back after a hospital stay) have their medicines carefully recorded by the care home on the day that they move.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.7.1 and 1.7.3

Quality statement 2: Sharing information

Quality statement

Providers of health or social care services send a discharge summary, including details of the person's current medicines, with a person who transfers to or from a care home.

Rationale

Good communication about a resident's medicines is a key factor in preventing medication errors when care home residents transfer between care settings, and also promotes continuity of care following transfer. Providers of health or social care should ensure that comprehensive records of medicines are sent with a person when they are transferred from one care setting to another, including information on what medicines are being taken and related information, such as dosage.

Quality measures

Structure

Evidence of local arrangements to ensure that a discharge summary, including details of a person's current medicines, is sent with a person when they transfer to or from a care home.

Data source: Local data collection.

Process

a) Proportion of transfers of people to a care home in which a discharge summary, including details of a person's current medicines, is sent with the person.

Numerator – the number in the denominator in which a discharge summary, including details of a person's current medicines, is sent with the person.

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

Data source: Local data collection.

b) Proportion of transfers of people from a care home in which a discharge summary, including details of a person's current medicines, is sent with the person.

Numerator – the number in the denominator in which a discharge summary, including details of a person's current medicines, is sent with the person.

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

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as care homes, hospitals, intermediate care services) ensure that a discharge summary, including details of a person's current medicines, is sent with a person who transfers to or from a care home.

Health and social care practitioners compile and send a discharge summary, including details of a person's current medicines, with a person who transfers to or from a care home.

Commissioners (such as local authorities, NHS England and clinical commissioning groups) stipulate that providers of health or social care services have processes in place that enable the sharing of a discharge summary, including details of a person's current medicines, when a person transfers to or from a care home. NHS England area teams and clinical commissioning groups should ensure that health and social care providers are aware that these processes should be in place.

People who move into or from a care home have an accurate and complete summary of their details and care, including detailed information about their current medicines, sent from their previous place of care to their new place of care so that they can safely continue with their treatment.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.3.2., 1.3.3 and 1.3.4

Definitions of terms used in this quality statement

Discharge summary

A discharge summary should contain the following information as a minimum:

- the person's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents)
- GP's details
- details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- other related information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine (adherence support)
- what information has been given to the resident and/or family members or carers.

[NICE's guideline on managing medicines in care homes, recommendation 1.7.3]

Quality statement 3: Self-administration

Quality statement

People who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk.

Rationale

It is important for people living in care homes to maintain their independence, and that they have as much involvement in taking their medicines as they wish and are safely able to. However, when a person enters a care home staff will often automatically assume responsibility for managing their medicines. It should be assumed that people who live in a care home can take and look after their medicines themselves, unless a risk assessment has indicated otherwise. It is important to take into account a person's choice over whether or not they wish to self-administer their medicine and also to consider if self-administration will be a risk to them or others. Risk assessments are also important to determine what support a person needs to help them to self-administer different medicines (for example, a resident may be able to manage oral tablets but not eye drops), allowing care homes to ensure that necessary support is provided. Risk assessment should be reviewed periodically, and whenever circumstances change, to address if any adjustment to support is needed.

Quality measures

Structure

a) Evidence of local arrangements that care home staff provide support for residents to self-administer their medicines unless a risk assessment has indicated otherwise.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that individual risk assessments are carried out that identify and document any support that a care home resident needs to

self-administer their medicines.

Data source: Local data collection.

Process

a) Proportion of people who live in a care home who have an individual risk assessment to identify any support they need to self-administer their medicines.

Numerator – the number in the denominator who have an individual risk assessment to identify any support they need to self-administer their medicines.

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 who wish to self-administer their medicines, and who have not had a risk assessment that indicates that this would put themselves or others at risk, who self-administer their medicines.

Numerator – the number in the denominator who self-administer their medicines.

Denominator – the number of people who live in a care home who wish to self-administer their medicines, and who have not had a risk assessment that indicates that this would put themselves or others at risk.

Data source: Local data collection.

Outcome

Feedback from care home residents that they feel supported to self-administer their medicines, if they wish to and if they have not had a risk assessment that indicates that this would put themselves or others at risk.

Data source: Local data collection.

What the quality statement means for different

audiences

Service providers (care homes) ensure that staff support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

Health and social care practitioners support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

Commissioners (local authorities) ensure that services they commission support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

People who live in care homes are given support to take and look after their own medicines if they want to, unless they have had an assessment that shows it might not be possible or safe.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.13.1 and 1.13.2

Definitions of terms used in this quality statement

Risk assessment

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:

- the resident's 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.

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.

[Adapted from [NICE's guideline on managing medicines in care homes](#), recommendations 1.13.2. and 1.13.3]

Support to self-administer medicines

Support may include practical help to self-administer medicine, such as providing a glass of water with which to take medicine, reminder charts, large-print labels, hearing labels, easy-to-open containers, help measuring liquids, devices to help with the use of inhalers, colour coding of labels (for example, for different times of day) and providing prompts for when medicines should be taken, (for example, with or after food or on an empty stomach).

Support may also involve providing the person with suitable information about the medicine, information on how to take the medicine and advice on any potential side effects.

Individual risk assessments should identify how much support a resident needs to take and look after their medicine.

[Adapted from expert consensus and [NICE's guideline on managing medicines in care homes](#)]

Self-administration

Self-administration of medicines is when a resident stores, or stores and administers, their own medicines.

[[NICE's guideline on managing medicines in care homes](#)]

Equality and diversity considerations

Consideration should be given to 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 are identified and taken into account.

Quality statement 4: Prescribing medicines

Quality statement

Prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Rationale

If too few instructions are given to a resident (if self-administering) or the care home staff it can reduce the effectiveness of a medicine or even potentially increase the risk of harm. Clear instructions are therefore important to ensure resident safety. This is particularly the case with variable dose or 'when required' medicines (when a clear indication of the circumstances to administer the medicine is needed). If a resident's capacity changes, care home staff may need to start administering the person's medicine for them, and will need instructions. Requirements for recording clear instructions on how a medicine should be used and monitored should be included as part of a clear written process for prescribing and issuing prescriptions for people who live in care homes (see [recommendation 1.9.1 in NICE's guideline on managing medicines in care homes](#)).

Quality measures

Structure

Evidence of local arrangements that prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Data source: Local data collection.

Process

The proportion of newly prescribed medicines for people who live in care homes that are provided with comprehensive instructions for use and monitoring.

Numerator – the number in the denominator that are provided with comprehensive instructions for use and monitoring.

Denominator – the number of newly prescribed medicines for people who live in care homes.

Data source: Local data collection.

Outcome

Medicines-related problems attributable to incomplete information provided with a prescription.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices, pharmacies) ensure that comprehensive instructions for using and monitoring all newly prescribed medicines are provided for people who live in care homes.

Healthcare professionals (such as GPs, pharmacists and nurse prescribers) provide comprehensive instructions for using and monitoring all newly prescribed medicines for people who live in care homes.

Commissioners (such as NHS England and clinical commissioning groups) ensure that any services they commission that prescribe medicines for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines for people who live in care homes.

People who live in care homes have accurate and complete information given to them and

to the care home staff about any new medicines they are prescribed. This should include information about how and when their medicines should be used, and any checks that should happen.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.9.1 and 1.9.2

Definitions of terms used in this quality statement

Comprehensive instructions for using and monitoring newly prescribed medicines

These include:

- 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)
- 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.

When prescribing variable dose and 'when required' medicine(s), information should include:

- dosage instructions on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label

- instructions for:
 - when and how to take or use the medicine (for example, 'when low back pain is troublesome take 1 tablet')
 - monitoring
 - the effect the medicine is expected to have.

[Adapted from [NICE's guideline on managing medicines in care homes](#) (NICE guideline SC1), recommendations 1.9.1 and 1.9.2]

Quality statement 5: Medication reviews

Quality statement

People who live in care homes have medication reviews undertaken by a multidisciplinary team.

Rationale

Many care home residents have multiple and complex conditions. These conditions can change, and the medicines that residents receive to treat these conditions need to be reviewed regularly to ensure that they remain safe and effective. The frequency of multidisciplinary medication reviews should be based on the health and care needs of the resident, with their safety being the most important factor when deciding how often to do the review. The interval between medication reviews should be no more than 1 year, and many residents will need more frequent medication reviews. There can be uncertainty over who should undertake medication reviews. While a number of different health professionals can conduct medication reviews for care home residents, the review should involve a multidisciplinary group of key people who agree and document the roles and responsibilities of each member of the team and how they work together.

Quality measures

Structure

Evidence of local arrangements that medication reviews for people who live in care homes involve a multidisciplinary team who agree and document the roles and responsibilities of each member of the team and how they work together.

Data source: Local data collection.

Process

Proportion of medication reviews carried out for people who live in care homes that involve

a multidisciplinary team.

Numerator – the number in the denominator that involve a multidisciplinary team.

Denominator – the number of medication reviews carried out for people who live in care homes.

Data source: Local data collection.

What the quality statement means for different audiences

Health and social care practitioners (such as GPs and care home managers) ensure that medication reviews involve a local team of health and social care practitioners (multidisciplinary team) who agree and document the roles and responsibilities of each member of the team and how they work together.

Commissioners (such as NHS England area teams and local authorities) stipulate that medication reviews in care homes involve a local team of health and social care practitioners (multidisciplinary team) who agree and document the roles and responsibilities of each member of the team and how they work together.

People who live in care homes have their medicines reviewed by a team of people who look after their health and social care to check for any problems.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.8.3, 1.8.4 and 1.8.5

Definitions of terms used in this quality statement

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 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.

[NICE's guideline on managing medicines in care homes, recommendation 1.8.5]

Multidisciplinary team

Health and social care practitioners 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's guideline on managing medicines in care homes](#), recommendations 1.8.2 and 1.8.3]

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 medicine 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. If appropriate, family members and carers could be involved in the decision-making process about investigations, treatment and care. The views of residents in care homes about who should and should not be involved in their care are important and should be respected. If the resident lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the resident's best interests, taking account of the provisions in the Mental Capacity Act 2005.

Quality statement 6: Covert medicines administration

Quality statement

Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.

Rationale

The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time). Medicines should not be administered covertly until after a best interests meeting has been held. If the situation is urgent, it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate to make an urgent decision. However, a formal meeting should be arranged as soon as possible.

Quality measures

Structure

Evidence of local arrangements to agree a management plan after a best interests meeting in which a decision is made to covertly administer medicines to an adult care home resident.

Data source: Local data collection.

Process

Proportion of adults in a care home being covertly administered medicine who have a record of a best interests meeting and management plan.

Numerator – the number in the denominator with a record of a best interests meeting and management plan.

Denominator – the number of adults in a care home being covertly administered medicine.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (care homes) ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan is also agreed and recorded after a best interests meeting.

Health and social care practitioners who participate in a best interests meeting agree and record a management plan after the best interests meeting if a decision is taken to covertly administer medicine to an adult care home resident.

Commissioners (local authorities) ensure that service specification contracts for care home providers include a requirement to ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan is also agreed and recorded after a best interests meeting.

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 without them knowing (known as 'covert administration'), for example hidden in their food or drink. Care home staff should have a meeting with healthcare professionals and family members to discuss this and agree whether it is the best option for the person. If it is agreed, a plan should be made after the meeting to make sure it is done safely and reviewed regularly to check if it should continue.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendation 1.15.3

Definitions of terms used in this quality statement

Best interests meeting

When covert administration of medicines is being considered, there should be a 'best interests' meeting. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or independent mental capacity advocate depending on the resident's previously stated wishes and individual circumstances). If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.

[NICE's guideline on managing medicines in care homes]

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's full guideline on managing medicines in care homes, glossary]

Management plan

This would usually include:

- medication review by the GP
- medication review by the pharmacist to advise the care home how the medication can be covertly administered safely
- clear documentation of the decision of the best interests meeting

- a plan to review the need for continued covert administration of medicines on a regular basis.

[[NICE's full guideline on managing medicines in care homes](#)]

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.

See [NICE's how to use quality standards](#) 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 for this quality standard](#) 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](#).

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. NICE guideline SC1 \(2014\)](#)

Policy context

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

- [Care Quality Commission. Guidance for providers on meeting the regulations \(2015\)](#)
- [Royal Pharmaceutical Society. Pharmacists improving care in care homes \(2014\)](#)
- [Department of Health. Best practice for ensuring efficient supply and distribution of medicines to patients \(2013\)](#)
- [General Medical Council. Good practice in prescribing and managing medicines and devices \(2013\)](#)
- [National Care Forum. Safety of medicines in the care home \(2013\)](#)
- [National Care Forum. Safety of medicines in care homes: Framework: Making the best use of medicines across all care settings \(2013\)](#)
- [Royal Pharmaceutical Society. Medicines optimisation: helping patients to make the most of medicines \(2013\)](#)
- [The King's Fund. Polypharmacy and medicines optimisation: making it safe and sound \(2013\)](#)

- [Care Quality Commission. Meeting the health care needs of people in care homes \(2012\)](#)
- [Department of Health. Action plan for improving the use of medicines and reducing waste \(2012\)](#)
- [Royal Pharmaceutical Society. Improving pharmaceutical care in care homes \(2012\)](#)
- [Social Care Institute for Excellence's \(SCIE\). Commissioning care homes: common safeguarding challenges \(2012\)](#)
- [Centre for Policy on Ageing. A report for the project: Working together to develop practical solutions – an integrated approach to medication in care homes \(2011\)](#)
- [Report to the Patient Safety Research Portfolio, Department of Health. Care home use of medicines study \(CHUMS\): prevalence, causes and potential harm of medication errors in care homes for older people \(2009\)](#)
- [National Prescribing Centre A guide to good practice in the management of controlled drugs in primary care \(England\) \(2009\)](#)
- [Department of Health. Medicines management: everybody's business \(2008\)](#)
- [National Prescribing Centre \(2008\) Medicines reconciliation: a guide to implementation \(2008\)](#)
- [Nursing and Midwifery Council. Standards for medicines management \(2007\)](#)
- [Royal Pharmaceutical Society. The handling of medicines in social care \(2007\)](#)
- [Department of Health. National service framework for children, young people and maternity services: medicines for children and young people \(2003\)](#)

Definitions and data sources for the quality measures

[Managing medicines in care homes. NICE guideline SC1 \(2014\)](#)

Related NICE quality standards

- [Learning disability: care and support of people growing older. NICE quality standard 187 \(2019\)](#)
- [Medicines management for people receiving social care in the community. NICE quality standard 171 \(2018\)](#)
- [Transition between inpatient mental health settings and community or care home settings. NICE quality standard 159 \(2017\)](#)
- [Multimorbidity. NICE quality standard 153 \(2017\)](#)
- [Transition from children's to adults' services. NICE quality standard 140 \(2016\)](#)
- [Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE quality standard 136 \(2016\)](#)
- [Medicines optimisation. NICE quality standard 120 \(2016\)](#)
- [Home care for older people. NICE quality standard 123 \(2016\)](#)
- [Mental wellbeing of older people in care homes. NICE quality standard 50 \(2013\)](#)
- [Health and wellbeing of looked-after children and young people. NICE quality standard 31 \(2013\)](#)

The full list of quality standard topics referred to NICE is available from the [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:

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

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Lay member

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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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standard advisory committees](#) for details of standing committee 4 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

This quality standard has been incorporated into the [NICE Pathway on managing medicines in care homes](#), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for

commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [British Geriatrics Society](#)
- [Royal College of General Practitioners \(RCGP\)](#)