Case scenarios for managing medicines in care homes (ANSWERS)

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
Should residents be encouraged/discouraged to self-administer their medicines?

1.1 Answer

Emphasis is laid on the desirability of residents retaining custody of their own medicines, wherever possible. This will preserve independence and prepare those in short term care for their return to the community, where they will need to look after their own medicines.

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.

1.2 Question
How do you determine what their current medicines regimen is?

1.2 Answer

Request confirmation in writing from the prescriber. A personal medication record should be maintained. It should be verified and signed by two members of staff.

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

1.3 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.
- **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 (medicines 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 medicines 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?

1.4 Question
Who may be involved in the risk assessment?

1.4 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. Discuss GP authorisation – is it needed?

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

1.5 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.

DHSSPS MINIMUM STANDARDS REFERENCES:
NH: 28.13
RCH: 33.1, 33.2

Case scenario 2: Refusal of 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) and the advice given

– record the refusal even if it is only partial (for example, the resident spits out an oral medicine).

2.2 Question

The GP is notified by care home staff. 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?

2.2 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/are 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 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

  – 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).

2.3 Question
Can the care staff administer medicines covertly and if so what needs to be done to implement this?

2.3 Answer

- 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, taking into account the cause of the loss of capacity and whether this is fluctuating or is temporary (see recommendation 1.2.6).

2.4 Question
Can the care staff crush medicines and add to food and if so what needs to be done to implement this?

2.4 Answer

Disguising medicines in food or drink can be justified in the best interests of residents who actively refuse medicines but who lack the capacity to refuse treatment. However, it should be a contingency measure rather than regular practice and disguising medicines simply for the convenience of staff is unacceptable.

In certain exceptional circumstances, in which covert administration may be considered to prevent a resident from missing out on essential treatment and where the resident is incapable of informed consent, the following considerations should apply:

- The medicines must be considered essential for the resident's health and well being, or for the safety of others. Disguising medicines simply for the convenience of staff is totally unacceptable.

- The decision should be considered as a contingency measure in an emergency rather than as regular practice.

- There should be broad and open discussion beforehand among the general medical practitioner, other relevant health and social services professionals, home manager and staff, and the resident's relatives or advocates.

- The involvement of the pharmacist is especially important as adding medicines to food or drink can alter its chemical properties and thereby affect its optimum performance.

- The action should be fully documented in the resident's care plan and regularly reviewed. The care plan should provide details guidance on how the medicine is to be administered.

- Regular attempts should be made to encourage the resident to take the medicines voluntarily.

- The manager should ensure that there is a clear policy and procedure that incorporates this guidance and which is known and understood by all designated staff.

DHSSPS MINIMUM STANDARDS REFERENCES:
NH: 28.4, 28.15, 28.16, 28.17
RCH: 33.7, 33.8

Case scenario 3: Medicines change safety incident

A resident who lives in a care home has recently had a medicines review and some changes have been made. These changes were verbally communicated to the care home staff but the discontinued medicine was administered in addition to the new medicine. The resident didn't come to harm as the error was spotted after the first dose was administered.

3.1 Question
Who should be involved in implementing the changes?

3.1 Answer

- Health and social care practitioners should work together to make sure that everyone involved in a resident's care know when medicines have been started, stopped or changed (see recommendation 1.9.3).

- Changes given verbally should be followed by written confirmation of the instructions to the care home as soon as possible (see recommendation 1.9.6).

- Update the medicines records and care plan with any changes to medicines made by remote prescribing.

- Inform pharmacy of changes as soon as possible to prevent incorrect medicines being supplied (This is often forgotten and leads to waste of medicines).

3.2 Question
What are the responsibilities of the prescriber to manage the changes?

3.2 Answer

- The prescriber must be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing.

- Ensure care home staff understand any instructions given verbally through repeating back.

- Send written confirmation of the instructions to the care home as soon as possible.

- Ensure that all details of changes are provided including the medicine which is stopped and replaced with a new medicine.

3.3 Question
What are the responsibilities of the care home staff in this case?

3.3 Answer

- Ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing (by fax or email) before the next or first dose is given.

- Ask the health professional using remote prescribing to provide a new prescription if necessary and confirm when the change is to begin.

- Update the medicine records with the authorised change and the care plan with any changes to medicines. Two staff should verify and sign all transcriptions. Discontinued medicines should be removed for disposal from the medicines trolley and any overstock cupboards.

- Use an appropriate method within the home to ensure that all care staff are aware of changes and when they are to begin.

See recommendation 1.9.7

3.4 Question
What should care home staff do if the resident does not accept the changes and refuses their medicines?

3.4 Answer

- Report back to GP as soon as possible

- Does resident have capacity?

- Everyone has the right to make “unwise” decisions.

- Consent to treatment is a discussion for the GP to have with the resident.

3.5 Question
What type of medicine incidents need to be reported to RQIA and safeguarding?

3.5 Answer

In this scenario, a medicines related safety incident has occurred. No harm has arisen, although continued treatment could have potential to be harmful. The incident should be documented and investigated as a medicines-related safety incident (see recommendation 1.6.5)

Nursing homes:

Notification of death, illness and other events

30.—(1) The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of –

(d) any event in the nursing home which adversely affects the wellbeing or safety of any patient;

Residential Care Homes:

Notification of death, illness and other events
30.—(1) The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of –

(d) any event in the home which adversely affects the care, health, welfare or safety of any resident;

DHSSPS MINIMUM STANDARDS REFERENCES:
NH: 28.8
RCH: 30.6

Case scenario 4: Medicines Governance

You have been recently appointed as the manager of a care home. There have been some care issues in the home, including an increase in the number of **medicine** *incidents.*

4.1 Question
How would you address this?

4.1 <u>Answer</u>

Review the medicine incidents to identify why they happened. Carry out a root cause analysis. Are there any patterns? Are the incidents happening during a particular medicine round? Are staffing being disturbed? Are staff under pressure? Are all staff aware of the incidents? Has any learning been shared to prevent a recurrence? Are agency staff involved? Have they received a comprehensive induction in the home? Is there a robust handover procedure which includes medicines management?

Training – have all staff received appropriate training and been deemed competent to manage and administer medicines? Provide training which is **specific** to the home. Complete supervisions. Check understanding.

Audit – introduce a robust auditing system. If delegating this task, ensure that it is being carried out effectively.

4.2 Question
How would you implement an effective medicines auditing system? What would you include in the audits?

4.2 <u>Answer</u>

Measurement of adherence to the criteria in the medicines minimum standards (development of an audit tool).

- An effective audit tool covers all aspects of the management of medicines, not just audit trails and running stock balances. We often see a small number of audit trails with no discrepancies or running stock balances for medicines, but no action is taken if the balance is incorrect – these types of audits do not drive improvement
- The audit must be able to identify and address any shortfalls in the management and administration of medicines. Action plans should be developed and followed up.
- Audit trails should focus on medicines which are not supplied in MDS systems.
- Staff should know what action to take if they identify a discrepancy e.g. the running stock balance is incorrect, a medicine is out of stock, signatures have been omitted. It is not acceptable to take no action.

- Previous inspection reports: have all areas for improvement been met and has the improvement been sustained.
- Is medicines management included in the Reg 29 monitoring visits?

4.3 Question
Who should complete the audits and how often?

4.3 Answer

No “one size fits all.”
Management and staff.
Frequency can vary depending on the issues.

If audits are delegated then the manager must maintain oversight. Sometimes we are advised that there are no issues. However issues are identified at the inspection. If there is an effective auditing system we should not be finding anything different at inspection.

4.4 Question
How would you manage any issues arising from medicine audits?

4.4 Answer

Try to establish why the issue occurred and what action is necessary to prevent a recurrence.
Learning identified and shared with staff (may involve further training).
Follow-up at next audit.

4.5 Question
How would you ensure that all staff are aware of the audit findings?

4.5 Answer

Circulate findings, staff meetings, supervisions.
Emphasis on driving improvement, supporting staff, not blame. However staff should be made aware of their individual accountability in relation to ensuring that medicines are administered as prescribed on all occasions.

DHSSPS MINIMUM STANDARDS REFERENCES:
NH: 28.3, 28.10
RCH: 30.4, 30.8