Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

Care Home Medicines Optimisation Toolkit

April 2022

(March 2024 – Minor update made to sections 6.5 and 6.6 to add a 'Date of Birth' field)

This document has been prepared by the Governance Pharmacy team in Aneurin Bevan UHB, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

Please direct any queries to AWTTC:

All Wales Therapeutics and Toxicology Centre
The Routledge Academic Centre
University Hospital Llandough
Penlan Road
Llandough
Vale of Glamorgan
CF64 2XX

awttc@wales.nhs.uk
029 218 26900

The information in this document is intended to help healthcare providers make an informed decision. This document should not be used as a substitute for professional medical advice and although care has been taken to ensure the information is accurate and complete at the time of publication, the All Wales Therapeutics and Toxicology Centre (AWTTC) and All Wales Medicines Strategy Group (AWMSG) do not make any guarantees to that effect. The information in this document is subject to review and may be updated or withdrawn at any time. AWTTC and AWMSG accept no liability in association with the use of its content. Information presented in this document can be reproduced using the following citation:
All Wales Medicines Strategy Group, Care Home Medicines Optimisation Toolkit. April 2022 (Updated March 2024).

Contents

Abbreviations

BNF	British National Formulary
CD	Controlled drug
eMAR	Electronic medication administration record
GP	General practitioner
GSL	General sales list (medicine)
MAR	Medication administration record
MDS	Monitored dosage system
NICE	National Institute for Health and Care Excellence
OOH	Out of hours
P	Pharmacy (medicine)
PIL	Patient information leaflet
POM	Prescription only medicine
PRN	When required (medicine)
SAM	Self-administration of medicines

1.0 Introduction

Care homes have a legal responsibility to ensure that all aspects of medicines management are covered within written policies and procedures. The aim of the document is to bring together a suite of guidance documents, tools and useful resources, in one place, as an easy-access resource library that can be used by staff working in, and supporting, care homes.

The development of standardised set of template documents based on national standards, legislation and best practice, can promote good practice, reduce inappropriate variation and avoid duplication of effort.

This toolkit has been developed based on resources produced by the Aneurin Bevan University Health Board (ABUHB) care home pharmacy team, with experience of what works well in care homes; i.e. short, easy-to-use documents. Resources will be developed and added to the toolkit over time, providing a streamlined approach to advice and guidance for the care home sector.

The resources in this toolkit are intended for use by care home staff who are suitably qualified to administer medication to residents and would mean either:

- a qualified nurse who is registered with their governing body, or
- a care support worker who has completed one of the identified specific education units at Credit and Qualifications Framework for Wales (CQFW) Level 3 as a minimum, or who has demonstrated training that is equivalent to, and can map across to, CQFW Level 3.

2.0 Care home medicine policy requirements

The NICE social care guideline (SC1) Managing medicines in care homes, states that care homes should have a medicines policy which is reviewed to ensure it is up to date, and is based on current legislation and the best available evidence.

NICE recommend that the following areas are included within the medicines policy, ensuring that written processes are in place 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 (medicine 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.

The following list can be used to develop a care home medicine policy to ensure the above areas are covered:

- General responsibilities i.e. duty of care
- Legalities, definitions and scope of administration
- Care worker roles and responsibilities
  - Role and responsibilities
  - The role of the care home
  - The role of the care home manager
  - Training support for care workers and competency assessment
  - The role of the GP
  - The role of the community pharmacist
  - The role of other health professionals
- Medicines cycle
  - Prescribing, medicine review
  - Ordering of prescriptions and supply from pharmacy
  - Storage including fridge, self-administration and controlled drugs
  - Administration including dosage forms, specialist techniques
  - Assessment of self-administration
  - Recording, medicine administration charts and changes to medicine
  - Monitoring
  - Disposal

- Awareness of potential risks, problems and changing circumstances
  - Secondary dispensing
  - Person is away from home e.g. accompanied visits
  - Hospital admission and discharge
  - Covert administration
  - Crushing
  - Refusal of medicine
  - Missed doses of medicines
  - Person is unwell
  - Medicines labelled as directed
  - When required (PRN) medicines
  - Non-prescribed or herbal medicines
  - Homely remedies
  - Oxygen
  - Alcohol or illegal drugs
  - Side effects and adverse reactions
  - Physical or cognitive problems
- Medicine errors and incident reporting
- Author, review date and staff signatures.

3.0 Example policies

3.1 Homely remedies policy

Care home name:	
Signature of care home manager:	
Date policy authorised:	
Date of review:	

Introduction
A homely remedy is a product that can be purchased (e.g. from a pharmacy or supermarket) for the relief of a minor, self-limiting ailment without the need for a prescription. Homely remedies should be made available in care homes to allow access to medicines that would commonly be available in any household. NICE guidance (SC1) Managing medicines in care homes states that care homes may stock a small range of homely remedies for the treatment of minor ailments.

Discussion and agreement on the consent for use of homely remedies in the care home should be held with residents and their families, in addition it is good practice have a discussion with the resident's GP or pharmacist, and inform the GP practice of the care home's homely remedies policy.

Only items purchased by the home may be used as a homely remedy. The homely remedy must be kept in the original container with the patient information leaflet (PIL). Any resident who brings their own homely remedy in to the care home should have the medicine stored, recorded, and administered as per the guidance in this policy; however, the medicine belongs to the resident and is for their use only.

Homely remedies
The following list of medicines are recommended as homely remedies for appropriate use in response to symptoms of a minor nature.

Medicine	Indication for use as a homely remedy
Paracetamol	Mild to moderate pain and/or fever
Senna	Constipation
Rehydration sachets	Fluid and electrolyte loss associated with acute diarrhoea
Gaviscon Advance® / Peptac®	Dyspepsia
Simple Linctus	Dry / irritating cough

Only the conditions included in this policy may be treated with the homely remedies listed, at the specified dose. The maximum duration of treatment should not exceed that stated for each particular medicine within the policy, without obtaining medical advice. If symptoms persist, or give cause for concern, medical advice must be obtained as this may indicate a more serious underlying condition.

Administration
All staff must recognise and act within the parameters of safe practice. The care home manager is responsible for ensuring all staff involved in the administration of medicines receive the appropriate on-going training and support to maintain and update their knowledge on the use and administration of homely remedies.

Administration of homely remedies must only be undertaken by suitably qualified staff who have signed the authorisation to administer homely remedies form, stating that they have read and understood the homely remedy policy.

The care home should inform the GP practice(s) that they will be using homely remedies for the short-term treatment of minor ailments, and provide a copy of the policy for good practice. Care home staff should ensure that they obtain the resident's consent before administering a homely remedy and confirm that the resident has no allergies to the remedy. If unable to obtain consent, or if in doubt, the resident's GP should be contacted. Homely remedies must not be labelled for individuals if they are to be administered to several residents. The administration of the homely remedies listed in this policy are for adults only.

Monitoring
The resident should be checked after taking a homely remedy to determine if the remedy has had the desired effect. If the resident's condition does not respond, or worsens after the administration of the homely remedy, the GP must be contacted for advice.

Recording of homely remedies
It is essential that a record is made of all medicines given to residents, to ensure accurate records are maintained, and to avoid possible overdosing. Administration of homely remedies must be recorded on the resident's MAR chart. The medicine must be clearly marked on the MAR chart as a homely remedy, with full directions and the dose given. The reason for administration must also be recorded on the MAR chart.

Storage of homely remedies
A locked medicine cupboard or trolley is required for the storage of all homely remedies. They should be separated from all prescribed medicines and clearly marked as homely remedies.

Stock checking
When a dose of a homely remedy is given to a resident it must be logged out on the homely remedies stock record, and a running balance maintained so a clear audit trail of these items can be maintained. Stock should be counted every week to maintain an audit trail of usage. A separate record should be held for each individual homely remedy stocked by the care home.

Expiry dates
The expiry dates of all homely remedies stocked must be checked regularly (at least every three months), and before every administration.

Paracetamol

Medicines information	
Name & form(s) of medicine	Paracetamol 500 mg tablets Paracetamol 500 mg soluble tablets Paracetamol 250 mg/5 ml sugar free suspension
Indication	Relief of mild to moderate pain and/or fever
Route	Oral
Dose and Frequency according to weight	**Over 50kg** Take ONE or TWO tablets (500 mg – 1g) OR 10-20 ml up to four times a day when required
	Between 40-49kg Take ONE and a HALF tablets (750 mg) OR 15 ml up to four times daily when required (max 3g in 24 hours)
	Under 40kg Take ONE tablet (500mg) OR 10 ml up to four times a day when required
Required interval between doses	Dose not to be repeated within 4 hours of the last dose
Maximum duration of treatment as a homely remedy	Up to 48 hours, then seek advice
Do not give in these circumstances	If the resident: • is already receiving prescribed paracetamol or other medicines containing paracetamol (e.g. co-codamol, co-dydramol, Solpadol®, Zapain®, Remedeine® etc.). • is intolerant to paracetamol. • has alcohol dependence. • has liver impairment/disease or is having any investigation of the liver. • has severe kidney impairment. • has hypersensitivity to any components of the preparation.
Warnings / adverse reactions (see product information for full details)	Rashes, blood disorders, liver damage following overdose
Action if resident excluded	Refer to GP / OOH

Senna

Medicines information	
Name & form(s) of medicine	Senna 7.5 mg tablets Senna 7.5 mg/5 ml solution
Indication	Relief of constipation
Route	Oral
Dose	One to two 7.5 mg tablets or 5 ml to 10 ml of 7.5 mg/5 ml solution
Frequency	Once a day, at night
Maximum dose in 24 hours	15 mg
Maximum duration of treatment as a homely remedy	Up to 48 hours, then seek advice
Do not give in these circumstances	If the resident: • has hypersensitivity to any of the ingredients • has abdominal pain • is feeling nauseous or is vomiting
Warnings / adverse reactions (see product information for full details)	May colour urine May cause temporary mild griping pain
Action if resident excluded	Refer to GP

Rehydration sachets

Medicines Information	
Name & form(s) of medicine	Oral rehydration sachets
Indication	For treatment of fluid and electrolyte loss associated with acute diarrhoea
Route	Oral
Dose	One sachet after each loose motion (reconstituted according to manufacturer's instructions)
Frequency	As required
Maximum dose in 24 hours	Five sachets
Maximum duration of treatment as a homely remedy	12 hours then seek and document advice from GP
Do not give in these circumstances	If the resident has: • diarrhoea that has lasted for more than 24 hours • hypersensitivity to any of the ingredients • severe dehydration • intestinal obstruction • liver or kidney disease • antibiotic-associated diarrhoea • bloody diarrhoea • low potassium or sodium diet • diabetes Where more than one resident is affected
Warnings / adverse reactions (see product information for full details)	Oral rehydration sachets must only be reconstituted in water. Follow the manufacturer's guidance when preparing the sachets. Refer to the PIL. If vomiting is present then the solution should be given in small frequent sips. Ensure appropriate infection control procedures are followed to minimise risk of an infection spreading.
Action if resident excluded	Refer to GP

Gaviscon® / Peptac®

Medicines Information	
Name & form(s) of medicine	Gaviscon® suspension, Peptac® suspension
Indication	Dyspepsia
Route	Oral
Dose	10 ml to 20 ml after meals and at bedtime
Frequency	As needed
Maximum dose in 24 hours	40 ml in divided doses
Maximum duration of treatment as a homely remedy	48 Hours
Do not give in these circumstances	If the resident: • Has taken another medicine within the last two hours – wait two hours before administering dose. • Has heart failure • Is on a low salt diet
Warnings / adverse reactions (see product information for full details)	May affect absorption of enteric coated tablets
Action if resident excluded	Refer to GP

Simple linctus

Medicines Information	
Name & form/s of medicine	Simple linctus (sugar free)
Indication	For a dry / irritating cough
Route	Oral
Dose	5 ml to 10 ml
Frequency	Up to four times a day
Maximum dose in 24 hours	40 ml
Maximum duration of treatment as a homely remedy	48 hours
Do not give in these circumstances	If the resident has a productive cough
Warnings / adverse reactions (see product information for full details)	N/A
Action if resident excluded	Refer to GP

3.1.1 List of staff authorised to give homely remedies

Care home name……

Only staff members named below may administer a homely remedy. Staff members must sign below to confirm they have had relevant medicine administration training and have read and understood this policy. Only staff listed below have the authority to decide whether a resident is able to receive a dose of a medicine listed in the homely remedies policy.

Print name	Designation	Signature	Date

3.1.2 Resident homely remedies authorisation

Resident name		**Care home name**	
Resident DOB		**NHS number**	

Homely remedies are for short term use and for the management of minor conditions.

- Homely remedies must only be administered in accordance with the manufacturer's directions and only to those residents whose GP, pharmacist, or nurse has agreed to their use.
- These medicines must not be administered indefinitely and maximum treatment duration, as stated for each medicine in the policy, must be adhered to. If symptoms persist beyond this period, additional medical advice must be sought.
- The administration of homely remedies must be recorded. This should be done in both the MAR chart and the resident's care plan.
- It is important to maintain an audit trail for each homely remedy by additionally completing the relevant homely remedies stock record for the medicine being administered.
- Homely remedies for the resident should be reviewed at least every 6 months or sooner if any changes to medication are made. This should ideally take place during the medicine review or care plan review.
- Retain this form in the resident's medicine profile.

I authorise use of the following homely remedies to the resident named above:

Medicine	Approved (Y/N)	Signature
Paracetamol		
Senna		
Rehydration sachets		
Gaviscon® / Peptac ®		
Simple linctus		

Any additional comments:

Name: ……..Place of work:…….....Date:…….

Signature:…….Designation:……

To be reviewed no later than:……..

3.1.3 Homely remedies stock record

Medicine name	Strength	Formulation	Batch number	Expiry	Date of opening (Liquids)

Date	Quantity obtained	Quantity administered	Quantity disposed	Details (For example: 'Purchased', or record name of resident medication administered to)	Running balance	Staff signature
Balance transferred to new sheet						

- A separate sheet is required for each medicine, form and strength.
- A record of the medicine administered must be made on the resident's MAR chart and care plan.

3.2 Example Policy: Self-administration of medicines (SAM)

Care home name:	
Signature of care home manager:	
Date policy authorised:	
Date of review:	

Pre-requisites for SAM

- Each resident self-administering medicines must have a lockable bedside cabinet or locker in which to store their medicines.
- The care home manager/clinical lead must have a set of master keys to open all bedside cabinets used for storing medicine.
- All appropriate staff must understand the processes detailed in this guidance.

Considerations for SAM

It is important for residents 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. Temporary care home residents in interim care beds should be encouraged to maintain their independence where possible as this will help with the transition to their own homes. It should be assumed that residents can take and look after their medicines themselves, unless a risk assessment has indicated otherwise.
If a resident wishes to self-administer their medicine, consider whether the resident:

- was responsible for administering their own medicine at home, if not, SAM is not suitable
- is considered to have chronic confusion or otherwise considered not competent (lack capacity), if so, SAM is not suitable
- has a history of drug abuse, if so, SAM may not be suitable depending on the individual circumstances.

Discussion with the resident

If a resident expresses an interest in self-administration:

- give the resident a SAM information leaflet
- a member of staff with knowledge and understanding of SAM should discuss with the resident how the system works, the process of consent, and the conditions attached.

If the resident wishes to self-administer, an assessment of their suitability should be undertaken by a registered nurse, GP, pharmacist, pharmacy technician, senior carer or other suitability qualified care support worker, or discussed and agreed by the resident's multidisciplinary team (MDT).

Assessment of resident suitability and consent

- Once a request for self-administration has been received, the assessment of suitability to participate should be undertaken promptly.
- The individual undertaking the self-administration of medicine assessment must recognise and take personal responsibility for the assessment and subsequent recommendation.
- The outcome of the assessment (i.e. the is resident suitable or unsuitable for self-administration) should be clearly annotated on the assessment form.
- The assessor must sign and date the assessment form.
- The completed form must be filed in the resident's notes.

If deemed suitable for self-administration:

- the resident must sign the self-administration of medicines resident consent form, which must be filed in the resident's notes.
- the resident's MAR chart must clearly state that the resident is self-administering.
- assessment of ongoing suitability should be undertaken monthly using the monthly assessment of self-administration of medicines form.

Medicines reconciliation

Before self-administration can commence, a qualified member of staff must undertake medicines reconciliation to confirm that the prescribed medicine on the MAR chart matches the medicine that the resident was taking prior to starting self-administration. In addition, it is suggested that regular (i.e. weekly) medicines reconciliation is undertaken to identify any compliance issues.

Storage

All medicines must be stored in the resident's lockable bedside cabinet or locker. Exceptions to this include medicines likely to be needed urgently (e.g. GTN (glyceryl trinitrate) spray, "when required" inhalers), nicotine patches and large containers of creams. A thermometer and temperature record chart should be stored within the cabinet/cupboard, with the temperature regularly checked and recorded as per the care home's policy. Where oxygen is used within the room, a warning sign must be used on the door.

Keys

- The resident must be reminded that the key should not be left unattended at any time.
- The care home staff must ensure that the resident returns the key if they are no longer administering their own medicines.
- If the master key is lost, a risk assessment must be performed and consideration given to changing the locks of all affected cabinets.
- Residents must immediately inform staff if they have mislaid the key for their lockable medicine bedside cabinet.
- Every effort should be made to find the key. If the key is not found then the resident's lockable medicine bedside cabinet should be emptied with the master key. These medicines should be placed in the locked cupboard in the medicine room.
- If after 24 hours the key is still not found, then a replacement key will need to be obtained, or the lock changed.

Medicine not suitable for self-administration

Some medicines may not be suitable for self-administration under this policy if they cannot be stored safely and easily accessible to the resident. For example, items requiring special storage - such as fridge items (please note, insulin may be used for up to a month after it has been taken out of the fridge and therefore may be used in a SAM scheme).

Any medicines that are not suitable for self-administration, or medicines that the resident may be unable to self-administer, should be administered by a suitably qualified staff member.

Administration of time critical medication
Where a resident is prescribed time critical medicines, the resident may require addition support from care home staff to ensure that self-administration can be supported appropriately.

Medicine changes
Suitably qualified care home staff must:

- inform the resident that their MAR chart has been amended (signed and countersigned if a new MAR is not provided) if a medicine is newly prescribed, stopped or the dose changed
- ensure that any dispensed medicine is placed into the lockable medicine bedside cabinet in a timely manner
- remove any medicine that has been stopped from the lockable medicine bedside cabinet.

Daily administration
On a daily basis, it is the responsibility of a suitably qualified member of staff to:

- Assess those residents participating in the SAM scheme**,** to ensure their ability to continue.
  - This should be recorded on the self-administration of medicines ongoing assessment record. This must be kept with the residents MAR chart.
  - If it is considered that the resident's condition has changed so that self-administration is no longer appropriate, the scheme must be discontinued immediately for that resident.
- Check with the resident that they have taken their medicines. This should be at each drug round.
- Mark the MAR chart with "SELF" in each appropriate box to denote the resident is self- administering.
- Check for any prescription changes, and if there are any:
  - discuss with the resident to confirm their understanding,
  - inform the pharmacy if the medicine has not been supplied or amended.
- Check that the resident still holds the key securely for the lockable medicine bedside cabinet.

Errors in administration
If an administration error is found to have occurred (or a near-miss observed), action must be taken to prevent any harm (or further harm) to the resident:

- The resident must be assessed and immediate actions taken to ensure safety.
- The prescriber and manager/clinical lead in the home must be informed.
- The resident must be re-assessed to determine whether they are suitable to continue self-administration.

3.2.1 a Self-administration of medicines - patient information leaflet

Taking your own medicines
In this care home, you may be able to be responsible for taking your own medicines, if you express a preference to do so, and it is deemed appropriate. This is known as self-administration of medicines.

- If you wish to be responsible for taking your own medicines, a suitably qualified member of staff will perform a short assessment to ensure that you are a suitable candidate for self-administration.
- If self-administration is appropriate, your medicines will be stored in a lockable medicine bedside cabinet at all times. You will be issued with a key for the cabinet.
- Care home staff will confirm that you have taken your medicines and will update the care home's Medication Administration Record.

Self-administration of medicines is not compulsory so you do not have to take part. If you do not take part, care home staff will administer your medicines.

Medicines safety

- Medicines can be dangerous if not used properly.
- It is your responsibility to keep the medicines and key in a safe place. If you mislay the key, inform a member of the care home staff immediately.
- If a visitor or other resident tries to take your medicines inform a member of the care home staff immediately.
- Do not exceed the prescribed dose.
- Never share your medicines with anyone else.
- If you forget to take a dose of medicine, tell a member of the care home staff.

3.2.1 b Hunan-weinyddu meddyginiaethau - taflen wybodaeth i gleifion

Cymryd eich meddyginiaethau eich hun
Yn y cartref gofal hwn, efallai y gallwch fod yn gyfrifol am gymryd eich meddyginiaethau eich hun, os ydych yn mynegi dewis i wneud hynny, ac y teimlir bod hynny'n briodol. Gelwir hyn yn hunan-weinyddu eich meddyginiaethau.

- Os ydych yn dymuno bod yn gyfrifol am gymryd eich meddyginiaethau eich hun, bydd aelod staff sydd wedi'i gymhwyso'n briodol yn cynnal asesiad byr i wneud yn siŵr eich bod yn addas ar gyfer hunan-weinyddu.
- Os yw hunan-weinyddu yn briodol, caiff eich meddyginiaethau eu storio bob amser mewn cwpwrdd meddyginiaethau y gellir ei gloi wrth erchwyn eich gwely. Rhoddir allwedd i chi ar gyfer y cwpwrdd.
- Bydd staff y cartref gofal yn cadarnhau eich bod wedi cymryd eich meddyginiaethau ac yn diweddaru Cofnod Gweinyddu Meddyginiaethau y cartref gofal.

Nid yw hunan-weinyddu meddyginiaethau yn orfodol felly nid oes yn rhaid i chi gymryd rhan. Os na fyddwch yn cymryd rhan, bydd staff y cartref gofal yn gweinyddu eich meddyginiaethau.

Diogelwch meddyginiaethau

- Gall meddyginiaethau fod yn beryglus os na chânt eu defnyddio'n iawn.
- Eich cyfrifoldeb chi yw cadw'r meddyginiaethau a'r allwedd mewn man diogel. Os byddwch yn colli'r allwedd, rhowch wybod i aelod o staff y cartref gofal ar unwaith.
- Os bydd ymwelydd neu breswylydd arall yn ceisio cymryd eich meddyginiaethau rhowch wybod i aelod o staff y cartref gofal ar unwaith.
- Peidiwch â chymryd mwy na'r ddos a ragnodwyd.
- Peidiwch byth â rhannu eich meddyginiaethau gydag unrhyw un arall.
- Os byddwch yn anghofio cymryd dos o feddyginiaeth, rhowch wybod i aelod o staff y cartref gofal.

3.2.2 Self-administration of medicine assessment

To be completed by a suitably qualified member of staff

Resident's name	
Date of birth	

Assessment criteria		Yes	No
Has the resident expressed a wish to self-administer their medicine?			
Was the resident responsible for administering their medicine at home?			
Is the resident mentally and physically able to self-administer?			
Can the resident open child resistant lids/blister strips, use their eye drops and inhalers, etc.?			
Can the resident read a label?			
Can the resident open the lockable medicine bedside cabinet?			
Does the resident know:	What the medicines are for?		
	What dosage to take?		
	How to take the medicine?		
Has the resident read and understood the SAM leaflet?			

Every effort should be made to accommodate residents with visual and other disabilities to be able to safely and effectively self-medicate. This may require the use of aids which pharmacy can help advise on. If any of the answers to the questions above are 'No', the resident is unlikely to be suitable for self-administration. The final decision lies with the individual undertaking the assessment.

The resident is deemed (tick appropriate box and provide brief explanation):

Suitable for self-administration		
Unsuitable for self-administration		

Assessed by	
Role	
Signature	
Date	

3.2.3 Self-administration of medicine resident consent

Resident's name	
Date of birth	

- I have read and understood the self-administration of medicines information leaflet.
- The self-administration of medicines has been fully explained to me.
- I am willing to take responsibility for my medicine and will store them in the lockable medicine bedside cabinet provided.
- I will keep the key safe.
- I understand that I must not share my medicine with anyone.
- I know that I must inform a staff member immediately if someone else tries to take my medicines, if my key is lost or missing or I have any other problems with my medicines.
- I understand that I may withdraw from self-administration at any time without prejudice, by informing the care home staff.
- I understand that I may be withdrawn from the scheme if a member of the nursing team believes it is in my best interests.
- I agree to accept responsibility for the safe keeping of my medicines and any consequence of failing to take my medicine in the prescribed way.

Resident signature	
Staff name	
Staff signature	
Date	

3.2.4 Monthly assessment of self-administration of medicines

Resident's name	
Date of birth	

Date	Resident taking medicine?	Resident still suitable for SAM?	Drug chart signed SELF?	Resident still has keys?	Staff signature

3.3 Bulk prescribing example policy

Care home name:	
Signature of care home manager:	
Date policy authorised:	
Date of review:	

Bulk prescribing can be used by the care home, with the agreement of the prescriber, to administer certain medicines from stock held by the care home (as on hospital wards for example), negating the need to have individual medicines for each resident. However, it should be remembered that all other medicines are prescribed on a named patient basis and cannot be used for other residents

Implementation of bulk prescribing can:

- reduce space needed on the medicines trolley,
- improve medicine round times,
- reduce potential for administration errors, by reducing clutter,
- reduce waste by reducing the total amount of stock required.

Requirements for bulk prescribing:

- The care home must have at least 20 residents.
- Ten or more of those residents must be registered with the same GP practice and only these residents can be part of bulk prescribing.
- Two or more residents must be prescribed the same medicine by the same GP practice. If this drops to one resident, bulk prescribing is no longer suitable.
- The medicine is classified as either a pharmacy (P) or general sales list (GSL) medicine. Prescription only medicines (POM) cannot be supplied via a bulk prescription.

The medicine(s) required by the care home on a bulk prescription should be agreed with the GP and if required, confirmed by the community pharmacy that they meet the P or GSL classification.

A list of the residents covered by the bulk prescription must be included on the bulk prescribing order form. Only residents from the specific GP practice can be included on the list.

Considerations for bulk prescribing

- Discuss with the GP and supplying pharmacy to confirm that they would be happy to bulk prescribe and dispense.
- Agree with the GP and pharmacy, the medicines that are required to be prescribed via bulk prescription. Decide which residents are suitable for having some of their medicine via bulk prescription.
- Medicine prescribed on a bulk prescription from a specific GP practice can only be administered to residents registered with that GP practice.
- Ensure that all relevant staff, particularly those involved with ordering and administering medicine, are familiar with bulk prescribing.
- A resident’s initial prescription for a medicine must be on a regular prescription; this identifies the clinical need for the medication and allows for the full directions to be clearly stated on the resident’s MAR chart.

- Residents already taking the medicine can be considered as having had the prescription already written. Subsequent supplies can be requested on the bulk prescribing order form with the directions ‘as directed’.
- If a new resident is started on a medicine currently being bulk prescribed for other residents, the initial supply must be made for the individual resident via prescription, to ensure appropriate directions are included on the MAR chart. Subsequent supplies can be requested on the bulk prescribing order form.
- If the GP alters a dose of a medicine currently being bulk prescribed, a new prescription must be supplied to ensure appropriate directions are included on the MAR chart. Subsequent supplies can be requested on the bulk prescribing order form.
- Bulk prescribing is not to be used for any self-administered medication.
- Bulk prescribing is not to be used to obtain stock for use as a homely remedy.

Ordering

- When ordering medication on the bulk prescribing order form, the total amount required should be calculated and the amount still in stock taken away from that total to give the amount required for the next order, see example below. The amount remaining for liquid medicines can be estimated.
- Once complete, the bulk prescribing order form should be sent with the regular medication order to the GP practice via the usual method, and a copy saved in the care home.
- Order forms can be stored and completed electronically if the care home has the facility.
- If the prescriptions come directly to the care home from the GP practice, the bulk prescriptions should be checked against the bulk prescribing order form and any discrepancies rectified before sending the prescription to the supplying pharmacy.

Resident’s name	Dose	Total quantity required per month
Resident A	10 ml twice daily / as required	560 ml
Resident B	10 ml twice daily / as required	560 ml
Resident C	10 ml once daily / as required	280 ml
Resident D	15 ml twice daily / as required	840 ml
Resident E	15 ml once daily / as required	420 ml
Total		**2660 ml**
Current stock		1240 ml
Estimated amount remaining		380 ml
Amount required		1880 ml
Amount to be ordered		2000 ml (4 x 500 ml) bottles)

Receiving bulk prescription medicine from the pharmacy

- Ensure the medicine has the name of the care home in place of a resident’s name.
- Confirm that the total amount requested for each medicine has been received. Any discrepancies should be reported at once.
- Check that the directions state ‘as directed’ and the wording ‘bulk prescription’ is included.
- The medicine can be booked in as a bulk quantity and stored in a locked medicine room.

Administration

- Ensure that all remaining supplies of the resident's medicine are used up before starting the bulk supplies.
- The MAR chart will indicate if the resident's medicine is to be dispensed from bulk medicine stock.
- Administer the medicine as you would any other medicine, following the care home procedure.
- If more than one GP practice is using bulk prescriptions, ensure the medicine administered to the resident comes from the supply prescribed by their registered GP practice.

Bulk prescribing by more than one GP practice

If more than one GP practice wishes to utilise bulk prescribing, it is essential to distinguish between the medicines prescribed by different GP practices. Ask the GP practice and community pharmacy to include the name of the GP practice on the prescription and medicine labels, as per the example below.

Bulk prescription
3000 ml Lactulose To be given in accordance with GP directions on the MAR chart. GP practice name: Care home name: Date:

3.3.1 Bulk prescribing order form

To (GP practice)	
From (care home name)	
Month	
Bulk prescribed medicine	

Resident's name	Dose	Total quantity required (per month)
Total		
Current stock		
Estimated amount remaining by the end of this cycle		
Amount to be ordered		

3.3.2 Bulk prescribing amendment form

Care home name	
Form completed by	
Job role	

Dose changes
Please note, any dose changes for a resident will require a new prescription to be written for the resident to ensure correct directions are used on the MAR chart. Bulk prescribing can then be reintroduced the following month.

Resident's name	Current dose	New dose	Date of change

Discontinuations
Please note if only one resident remains on a bulk prescribed medicine, bulk prescribing is no longer appropriate

Resident's name	Date stopped	Resident's name	Date stopped

A copy of this form must be sent to the supplying pharmacy.

4.0 Controlled drug schedule guidance

Controlled drug	Brand name(s) include:	Legal requirements (these are minimum storage requirements)
Schedule two controlled drugs (CD)		
Morphine	MST Continus®	Requires safe custody in a CD cabinet. Must be recorded in CD register. Two trained members of staff required to record in CD register. Stock checks should be carried out at least once a week, but they may be carried out more or less often depending on the circumstances (NICE guideline 46).
	Sevredol®	
	Zomorph®	
	MXL®	
	Oramorph® concentrated oral solution 100 mg/5 ml	
Diamorphine	-	
Dexamphetamine	Dexedrine®	
Pethidine	-	
Oxycodone	OxyContin®	
	Oxynorm®	
	Longtec®	
	Shortec®	
Methadone	Physeptone®	
Methylphenidate	Ritalin®	
	Concertav®	
Fentanyl	Durogesic DTrans®	
	Mezolar Matrix®	
	Matrifen®	
	Fentalis®	
	Fencino®	
Schedule three controlled drugs (CD)		
Buprenorphine	Reletrans®	Buprenorphine and temazepam must be stored in the CD cabinet. Other CDs listed in schedule three do not require CD cabinet storage. Schedule three CDs do not need to be recorded in the CD register. However, it is good practice to make records for temazepam and buprenorphine. It is also good practice to treat the other schedule three drugs as drugs liable to misuse and record their usage.
	Butec®	
	Butrans®	
	Subutex®	
	Temgesic®	
Pregabalin	Lyrica®	
Gabapentin	Neurontin®	
Midazolam	Hypnovel® Injection	
	Buccolam® oromucosal solution	
Temazepam	-	
Phenobarbital	Fortral®	
Tramadol	Zydol®	
	Zamadol®	
	Marol®	

Controlled drug	Brand name(s) include:	Legal requirements (these are minimum storage requirements)
Schedule four controlled drugs (CD)		
Diazepam	Valium®	There are no legal requirements for safe custody in a CD cabinet, or for records to be made in the CD register, however safe storage and maintenance of records may be undertaken as good practice.
Clobazam	Frisium®	
Lorazepam	Ativan®	
Nitrazepam	Mogadon®	
Clonazepam	Rivotril®	
Chlordiazepoxide	Librium®	
Zolpidem	Stilnoct®	
Zopiclone	Zimovane®	
	Zimovane LS®	

5.0 Good practice guidance for social leave

Provision should be made for the administration of medicine(s) when residents are away from the care home, for a period longer than a simple adjustment to their dosing regimen would allow.

Periods of leave up to one day
The medicines from the care home can accompany the resident in their packaging as supplied by the pharmacy. Clear instructions for how to take the medicines should be provided by the care home and a copy of the MAR chart given to the person accompanying the resident, to record administration. Where possible the person accompanying the resident should sign for receipt of the medicine(s) and be aware of their responsibilities in administering the medicine.

Periods of leave lasting more than one day
The above procedure will still apply, however the care home would need to supply all medicines. Alternatively, the GP can be asked to supply a prescription to cover the time the resident is away from the home. Discuss any potential issues with the GP before a resident has extended leave from the home.

Care home staff accompanying residents
When care home staff accompany a group of residents, arrangements must be made for the safe and secure transportation of the medicine and any special storage requirements. Each resident's medicine must be kept in separate containers and all kept within a lockable container. The MAR charts should also be taken with the staff and a safe and secure system used to administer the medicines, and maintain the confidential information contained on the MAR charts.

Returning to the care home
When the resident returns to the care home, an entry should be made on the MAR chart and (where applicable) in the controlled drugs register, of any and all returned medicine. The records should be signed by the person returning the medicine and an appropriate member of care home staff.

6.0 Medicine administration template resources

6.1 Resident Information

Care home name:……

Resident's photograph
Date of photograph:

Full name	
Likes to be called	
Room number	
Date of birth	
Allergies (if none, state 'no known allergies)	
GP name	
GP surgery	
Medical conditions	
Do not attempt cardiopulmonary resuscitation status	
Comments	

6.2 Staff signature list for medicine administration

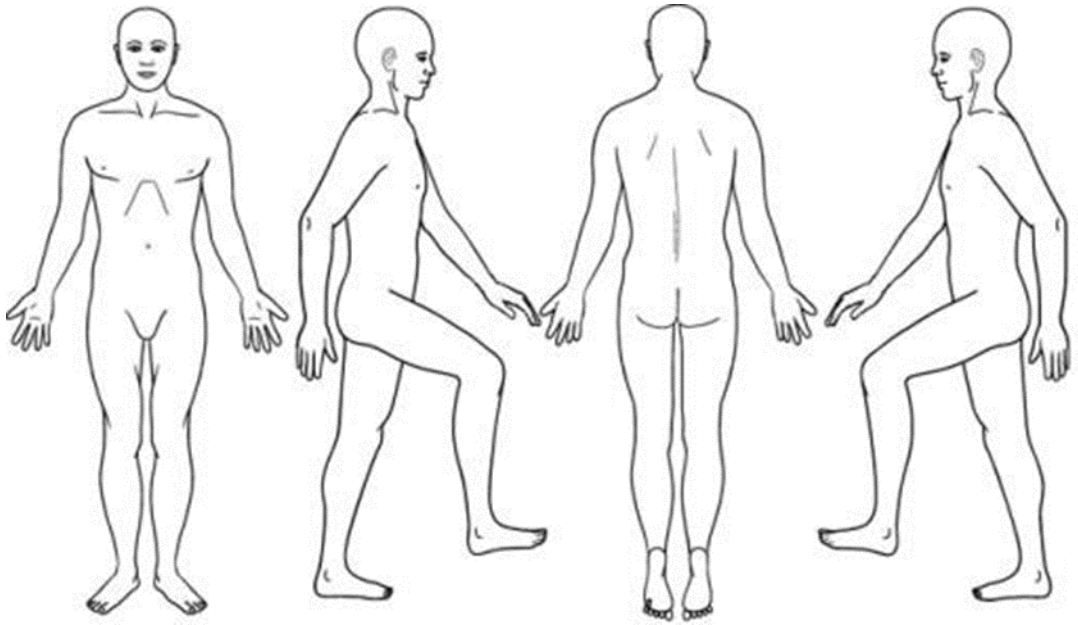
Care home name:……

Ensure this list is kept up to date with signatures and initials of all staff who have been assessed as having the competency to administer medicines. Both initials must be used on MAR charts. Retain this form at the front of the MAR chart folder.

Staff name	Position	Signature	Initials	Date

6.3 Topical medicines application record

Resident's name		Date of birth		Room number	
GP practice		Allergies (if none known, state 'no known allergies')			
Topical preparation		Frequency of application		Completed by	
Site of application		How to apply		Checked by	
Storage		Date opened		Expiry date	



Time / day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
00:00																												
01:00																												
02:00																												
03:00																												
04:00																												
05:00																												
06:00																												
07:00																												
08:00																												
09:00																												
10:00																												
11:00																												
12:00																												
13:00																												
14:00																												
15:00																												
16:00																												
17:00																												
18:00																												
19:00																												
20:00																												
21:00																												
22:00																												
23:00																												

6.4 Non-administration information

Resident's name	Date	Time	Details	Signature

6.5 Transdermal patch placement chart

Name of resident		**Date of birth:**	
Name of patch		**Strength**	

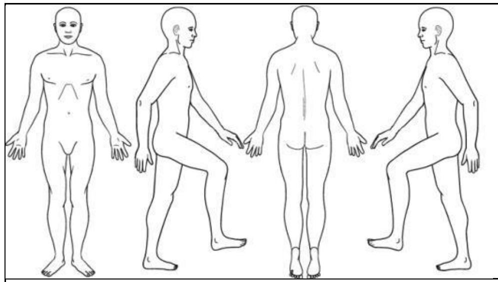
The transdermal patch must be checked on a daily basis, to make sure it is still securely in place and there is no evidence of skin degradation/tear. The daily patch check box must be checked once this action is complete.

The table below is a guide to the duration of use for each patch, the frequency of rotation of patch application sites and the interval before which a patch applicate site can be reused. This does not replace your responsibility in ensuring you have all the information needed to use the patch correctly. Please consult the patient information leaflet for further information.

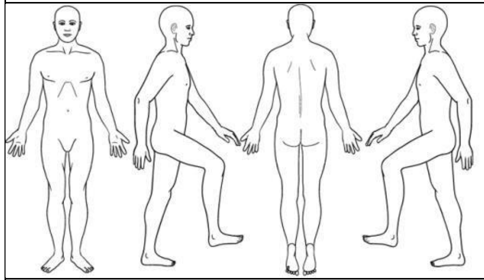
	Fentanyl	**Butrans®/Butec® (buprenorphine)**	**Transtec® (buprenorphine)**	**Hyoscine**	**Rivastigmine** Use fourteen-day patch rotation chart	**Rotigotine**
Duration of use	72 hours	1 week	4 days	72 hours	24 hours	24 hours
Number of sites on rotation	3 sites	4 sites	2 sites	2 sites	14 sites	Use the specific chart for rotigotine, available at: https://neupro.relayto.com/e/patch-placement-tracker-pjdbkoom
Interval before reusing a site	1 week	3-4 weeks	1 week	72 hours	14 days	

Patches must be applied to clean, dry, undamaged skin, do not apply broken or irritated skin or to bony prominent parts of the body. Hyoscine patches must be placed behind the ear. Before applying a new patch, remove the old patch and fold in half, with sticky sides together, before disposal. Be aware of heat from external sources leading to increased absorption e.g. hot water bottles, electric blankets. Use the chart overleaf to indicate where the patch has been applied using a cross (x). If the resident is prescribed multiple patches, use a separate chart for each patch applied. The patch application chart does not replace the need to record administration on the resident's medicines administration record (MAR) chart.

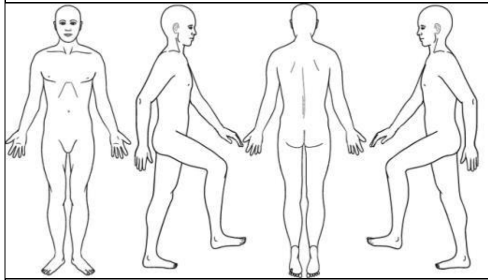
Resident name:	Date of birth:	Patch name and dosage:



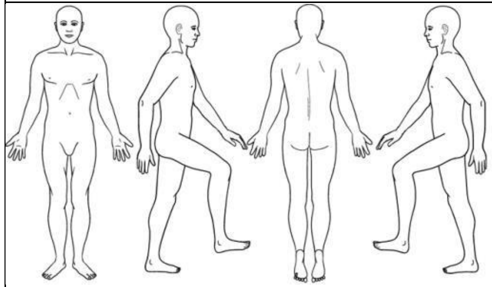
Date patch applied				Time		
Applied by						
Daily patch check	2	3	4	5	6	7
Date patch removed				Time		
Removed by						



Date patch applied				Time		
Applied by						
Daily patch check	2	3	4	5	6	7
Date patch removed				Time		
Removed by						



Date patch applied				Time		
Applied by						
Daily patch check	2	3	4	5	6	7
Date patch removed				Time		
Removed by						



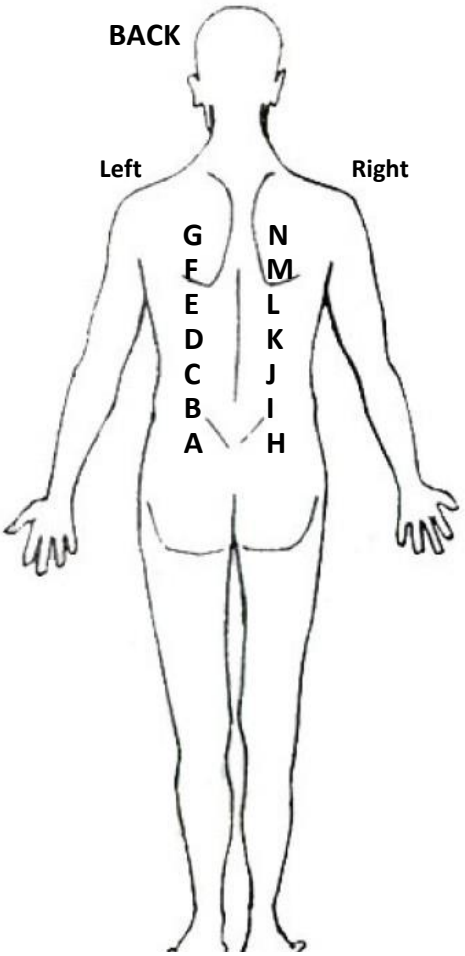
Date patch applied				Time		
Applied by						
Daily patch check	2	3	4	5	6	7
Date patch removed				Time		
Removed by						

6.6 Fourteen-day transdermal patch rotation chart

Use this chart to record details of patch administration and removal. Before a new patch is applied, ensure that the old patch is removed and disposed of appropriately. The new patch must be placed on a different site. This does not replace your responsibility in ensuring you have all the information needed to use the patch correctly.

Resident's name	Date of birth
Name of patch and strength	**Frequency of changing**

Letter	Date applied	Applied by	Date removed	Removed by
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				
L				
M				
N				



6.7 PRN ‘when required’ example medication administration record (MAR)

Record ‘when required’ medicines only when they have been administered, noting the dose administered and the quantity left to ensure adequate supplies and reduced waste

Resident’s name		**Date of birth**				**Care home**			
As required medicines		**Allergies**							
Medicine (approved name)		**Date**							
		Time							
		Dose							
		Signed							
		Date							
		Time							
		Dose							
Dose	Frequency	**Signed**							
		Date							
Route	Max dose in 24 hours	**Time**							
		Dose							
Indication	Start date	**Signed**							
Medicine (approved name)		**Date**							
		Time							
		Dose							
		Signed							
		Date							
		Time							
		Dose							
Dose	Frequency	**Signed**							
		Date							
Route	Max dose in 24 hours	**Time**							
		Dose							
Indication	Start date	**Signed**							

6.8 ‘When required’ medicine outcome record

Date	Time	Initials	Medicine	Dose	Reason	Result	Time	Initials

7.0 In-house medication administration record (MAR) reviews

7.1 In-house monthly medicine review

Staff member completing review: …….. Date…….

Review criteria		Yes / No / N/A
1.0	**General**	
1.1	Were any medicine issues raised at the last regulatory inspection?	
1.2	If so, have they been addressed?	
1.3	Can a copy of the Handling of medicines in social care be produced?	
1.4	Are patient information leaflets available for all medicines?	
2.0	**Receipt of medicine**	
2.1	Is the receipt of medicines recorded on the MAR chart and signed?	
2.2	Are all medicines fully labelled with drug name, dispensing date and resident name?	
2.3	Are all medicines labelled with full directions? (Please note 'as directed' is not a suitable direction).	
2.4	Are multiple packs labelled individually?	
2.5	Are 'when required' medicines carried forward onto the new MAR chart when the new monthly cycle commences?	
3.0	**Storage**	
3.1	Are all medicines stored in a locked trolley/cupboard? If medicines are stored in a trolley, is it secured to a wall when not in use?	
3.2	Are the keys to the trolley/cupboard held by a designated person?	
3.3	Are the spare keys secure?	
3.4	Is there a suitable procedure for the handover of the keys between shifts?	
3.5	Are discontinued medicines stored and disposed of correctly?	
3.6	Are stock levels acceptable? Consider whether excess stock is evident.	
3.7	Is there a designated policy for dealing with medicines waste?	

4.0	**Refrigerated items**	
4.1	Are appropriate items stored in a lockable fridge?	
4.2	Are maximum, minimum and actual fridge temperatures recorded daily?	
4.3	Are out of range fridge temperatures reported and acted on?	
4.4	Is the fridge clean, and a cleaning schedule in place?	
5.0	**Controlled drugs (CD)**	
5.1	Are all CDs are stored in a separate, locked metal cabinet that complies with the misuse of drugs safe storage requirements?	
5.2	Are CDs only stored in the CD cabinet?	
5.3	Are the keys to the CD cabinet stored in a safe location?	
5.4	Is there a spare set of keys? If so, state where they are kept:	
5.5	Is there a CD register in place?	
5.6	Does the CD register conform to current specification?	
5.7	Is there a written procedure for the ordering, receipt, administration and disposal of CDs in the home?	
5.8	Does the CD stock in the cabinet match the records amount in the CD register?	
5.9	Are there two staff signatures for every entry in the CD register?	
5.10	Are CD stock levels checked at every administration?	
5.11	Are CD balances counted, checked and signed for at each shift handover?	
5.12	Are all CD records up to date?	
5.13	Are all CD's disposed of correctly? In doom kits?	
5.14	Is the administration of CDs recorded on the MAR chart and in the CD register?	
6.0	**Homely remedies**	
6.1	Is there a homely remedies policy in place, signed by GP, pharmacist and manager?	
6.2	Does the homely remedies policy cover all homely remedies used?	
6.3	Are homely remedies administered recorded on the MAR chart?	

7.0	**Oxygen**	
7.1	Do any residents currently use oxygen? If no, move on to section 8.0	
7.2	Is it supplied to the resident individually?	
7.3	Are empty cylinders returned?	
7.4	Is the oxygen stored appropriately and appropriate warning signs displayed?	
8.0	**Labelling & safe administration of medicines**	
8.1	Are all administration instructions on the MAR charts clear enough to ensure accurate administration?	
8.2	Does every resident have a MAR chart?	
8.3	Are MAR charts legible and completed correctly at the time of administration?	
8.4	Where a medicine is prescribed at a variable dose, is the actual quantity given recorded on the MAR chart?	
8.5	Are correct codes used to explain missing doses?	
8.6	Is the prescriber informed after an agreed number of doses have been recorded as refused?	
8.7	Do stock levels match those calculated-on MAR charts?	
8.8	Is the pharmacy informed of any changes to a resident's medicine?	
8.9	Is the medicine always administered directly from a labelled container supplied by the pharmacy?	
8.10	If monitored dosage systems (MDS) are used, are they being used appropriately?	
8.11	Are named and dated photographs available for all residents?	
8.12	Are there appropriate allergy alerts on necessary charts?	
8.13	Is there a policy in place for safe and appropriate medicine administration?	
8.14	Are the application of all dressings recorded?	
8.15	Are expiry dates checked regularly?	
8.16	Are all short life medicines dated on opening?	
8.17	Is an up to date BNF available within the care home?	

Questions answered 'No'	Action to be taken and time limit	Date completed

Managers name	Signature	Date
Comments		

7.2 28-day MAR review

Care home name:……Monthly cycle start date:……...

This record can be used for as long as necessary, it does not have to be used for a full 28-day period. If the answer to any of the questions below is no, please provide further details by completing the table overleaf.

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Have all residents received all of their medicine?																												
Are all MAR charts fully completed with no gaps?																												
Have all non-administrations been recorded with the relevant code?																												
Is there a record of the dose given, for all variable doses medicines?																												
Are all hand-written entries for additional medicines double signed?																												
For administrations recorded elsewhere i.e. on topical MAR chart, are these signposted on the MAR chart?																												
Are all topical MAR charts fully completed?																												
Are all transdermal patch application charts fully completed?																												

Completed by		Date		Checked by		Date	

Date	Non-compliance issue noted	Action(s) required	Actions complete (Y/N)	Signature

7.3 Individual resident MAR chart review

Care home name: **Date:**

Review up to 5 residents' MAR charts and medicine		**Resident 1**	**Resident 2**	**Resident 3**	**Resident 4**	**Resident 5**
1	Are the quantities of medicine remaining correct? Consider the amount that has already been administered. For example, if there were 28 tablets to start with, and 14 have been given, there should be 14 left.					
2	Has the MAR chart been completed in indelible ink?					
3	Does the MAR chart contain the resident's full name, date of birth, GP details and allergy information? Is an up to date photo available with the MAR chart?					
4	Do MAR chart entries correspond with the medicine and directions on the labels, and are clear and legible?					
5	Has the MAR chart been completed accurately for all medicine given i.e. no signatures missing (except PRN medicine) and/or codes used correctly?					
6	Are the reasons for non-administration of regular medicine recorded correctly on the back of the MAR chart?					
7	Are all handwritten additions, alterations and discontinued medicines signed by a qualified person and countersigned by an appropriately qualified second person?					
8	Are all medicines with a variable dose recorded on the MAR chart accurately - i.e. is the actual amount administered recorded on the MAR chart?					
9	If the resident is on warfarin, is there evidence that regular INR checks are being undertaken?					
10	Does the MAR chart demonstrate that the medicine follows all relevant policies, and code of professional conduct with regards to the safe administration of medicine?					
11	Is the GP informed if a medicine is refused after an agreed number of doses (normally 3 days or within 24 hours for medicines such as anticonvulsants, medication for Parkinson's and hypoglycaemics)?					
12	Have opening dates been recorded on all relevant medicines - i.e. creams, drops, liquids?					
Staff member completing the audit Once the form is complete, give to care home manager to sign overleaf.		Name: Signature:				

Managers name	Signature	Date
Comments		

8.0 Storage of medicines

8.1 Good practice guidance: Medicine expiry dates for use in care homes

This guidance is primarily for care home staff but also mentions good practice tips for prescribers and community pharmacists and technicians.

Introduction
The aim of this document is to provide guidance on the expiry dates of medicines, resulting in reduced medicines wastage, and ensuring residents do not receive expired medicine.

The expiry date of a medicine is the point in time when a pharmaceutical product is no longer within an acceptable condition to be considered effective. The medicine reaches the end of its 'shelf life'.
Depending on the product, the expiry date may be set as a fixed time:

- after manufacture,
- after dispensing,
- after opening of the manufacturer's container.

The shelf life of medicines is determined by either the breakdown of the active drug or by risk of contamination. Not all medicines deteriorate at the same rate. The expiry date for any medicine is calculated by the manufacturer, who has a legal responsibility to include it on the original container.

As part of good medicines management, residents must receive medicine that is 'in date', in order to ensure:

- the active ingredients are fully effective,
- the risk of contamination is reduced,
- the medicine is safe to use.

Medicines may go 'out of date' due to:

- inefficient prescribing or re-ordering systems,
- stockpiling,
- ordering excessive quantities,
- poor stock rotation,
- expiry dates not being checked.

Storage guidelines

- Keep all medicines in the original container in which they were dispensed.
- Keep medicines in their original outer packaging, to protect from sunlight.
- All medicines should be stored in a cool (below 25°C) dry place unless refrigeration is required (between 2°C and 8°C).
- The expiry date of products can change once opened.
- Record the date opened and the calculated expiry on the medicine package/label.
- Be vigilant with product expiry dates.
- Store as recommended by the manufacturer.
- Seek advice from the community pharmacist if medicines are found to have been stored outside their intended conditions or if dispensing labels become illegible.

Effects of using expired stock

- The active drug could become chemically unstable.
- The effectiveness of the medicine may change.

- The break down products of the drug may be toxic and harmful to the resident.
- There is an increased risk of contamination.

Example expiry dates

Wording on packaging	Definition
Best before January 2022	Discard 31/12/2021
Use before end January 2022	Discard 31/01/2022
Use by January 2022	Discard 31/12/2021
Discard after January 2022	Discard 31/01/2022
Expires January 2022	Discard 31/01/2022
Use within one month of opening	Discard 28 days after opening
Discard 7 days after opening	Self-explanatory

Generally, solid dose formulations have a longer expiry date than liquid preparations. The manufacturer's expiry on a container is the unopened expiry date. After opening, the expiry date may be dramatically shortened. This should be highlighted on the medicine label / container and in the resident's medicine profile.

Certain external factors can affect the expiry of a medicine, for example, contact with water, increased or decreased temperature, exposure to air or light e.g. antibiotics to be taken as a liquid formulation are stored in the pharmacy as a dry powder, which is then reconstituted with water and given a shorter expiry date.

Monitored dosage system (MDS)
It is recommended that medicines dispensed in MDS are discarded after 8 weeks if they have not been used. Please note, not all medicines are suitable for inclusion in MDS for example:

- Medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate.
- Medicines that are sensitive to moisture, e.g. effervescent tablets.
- Light-sensitive medicines, e.g. chlorpromazine.
- Medicines that should only be dispensed in glass bottles, e.g. glyceryl trinitrate (GTN) tablets.
- Medicines that should only be taken when required, e.g. painkillers.
- Medicines whose dose may vary depending on test results, e.g. warfarin.

In all cases, the manufacturer's expiry date, contained on the original packaging, should be used if it is earlier than the suggested guideline dates listed in the table below. Some products, i.e creams and ointments, now show an expiry symbol. However, in the care home setting where storage conditions may be variable, it is recommended that the suggested expiry dates in the table are followed.

Any product whose appearance suggests it may be unfit for use should be discarded irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.

When required (PRN) medicine
Be aware of the expiry date of PRN medicine, especially if they are not used frequently. It is good practice to date and initial upon opening all PRN medicines for audit trail purposes.

Storage of medication following a death
When a resident passes away, their medication should be quarantined separately from other residents medication for 7 days before being disposed of. If there is a coroner's enquiry they must be kept until the enquiry closes. CD medication in both cases must be quarantined in the CD cupboard until they can be destroyed.

Tips for care home staff:
Ordering medicines:

- A nominated member of staff should be responsible for ordering medicine with a named deputy.
- Check the quantities of medicine(s) ordered are appropriate, in order to avoid medicine waste.
- Do not forget to check medicine not routinely stored in the medicines trolley e.g. PRNs, topical preparations.
- Request PRNs in original packs rather than in MDS. (MDS has reduced expiry therefore more frequent prescriptions will be necessary and more medicine waste generated).

Receiving medicines:

- Check if there are any specific expiry date instructions on labels e.g. some liquid antibiotics.
- Check the medicine is still within its expiry date.

Storing medicines:

- Note and act on any specific storage instructions e.g. store in the fridge.
- Rotate stock so the earliest expiry is at the front and therefore used first i.e. 'first in, first out'.
- Check expiry dates of medicine stock monthly.
- Medicine is to remain in the container in which it was received – different batches must not be mixed.
- Use medicine dispensed in amber bottles first as these are subject to a shorter expiry.

Administering medicines:

- Check the expiry date before each administration.
- Record the date opened and the calculated expiry on the medicine package/label where appropriate e.g. creams, eye drops. Some packaging does not allow for the pharmacy label to be placed on the product e.g. eye drops. In these instances, the outer packaging will have to be endorsed with the date of opening. It is essential that the product remains in the outer packaging throughout duration of the treatment
- Highlight any short expiry dates as a reminder to all staff.

Tips for prescribers:

- Prescribe appropriate quantities of medicine in order to avoid waste.
- Quantities requested which appear to be excessive should be queried with the care home.
- Consider nominating a named practice member to process care home prescription requests and to act as contact known to the care home to deal with queries.

Tips for community pharmacies:

Dispensing medicine:

- If decanting from a bulk container, label with the appropriate expiry date.
- Highlight any shortened expiry dates.
- Do not obscure expiry dates with labels.
- If the care home generally receives medicines in MDS, inform staff if a particular medicine is unsuitable for inclusion due to problems with stability. The foil packing around individual tablets must not be cut and placed in a MDS; doing so has potential to cause harm if inadvertently swallowed by a resident.

8.2 Suggested expiry dates of medicinal products once opened

Formulation type	Expiry details*	Comments
Tablets and capsules dispensed in original blister strips or container with printed expiry date.	Manufacturer's expiry date as printed on original box or individual foils (check patient information leaflet).	PRN medicine, wherever possible, should be used from the manufacturer's original pack. The expiry date is printed on each strip.
Tablets and capsules dispensed in amber bottles.	6 months from date of dispensing, or as advised by pharmacy.	The date of dispensing is printed on the pharmacy label.
Tablets and capsules dispensed in pharmacy packed blister pack i.e. monitored dosage system (MDS).	8 weeks from date of dispensing.	The date of dispensing is printed on the pharmacy label.
Oral liquids dispensed in original manufacturer's packaging or amber bottles.	6 months from date of opening or follow manufacturer's guidance e.g. for specially manufactured items or expiry date on packaging. For antibiotics, check with community pharmacist if not clear from label.	Write the date of opening on the label.
External liquids such as lotions, shampoos & bath oils dispensed in original containers.	6 months from opening, or manufacturer's recommendation if shorter.	Write the date of opening on the label.
Creams dispensed in tubes or pump dispensers.	3 months from date of opening for tubes or manufacturer's expiry date for pump dispenser.	Write the date of opening on the label.
Creams dispensed in pots, tubs or jars.	3 months from date of opening.	Write the date of opening on the label.
Eye/ear/nose drops/ointments.	Many, but not all, 28 days from date of opening. Check packaging for specific details.	Write the date of opening on the label.

Formulation type	Expiry details*	Comments
Rectal diazepam	Individual foil wrapped tubes: manufacturer's expiry date.	N/A
	Non-foil wrapped: 6 months from date of opening.	Write the date of opening on the label.
Sip feeds / oral supplementary nutrition	Unopened, follow manufacturer's expiry date.	N/A
Inhalers	Manufacturer's expiry date.	Some newer inhalers have a shortened expiry after dispensing or once opened, these should have a written expiry date by pharmacy.
Glyceryl trinitrate (GTN) sprays	Manufacturer's expiry date.	N/A
Glyceryl trinitrate (GTN) tablets	8 weeks after opening.	Write the date of opening on the label.
Insulin	Unopened: manufacturer's expiry date when stored in a fridge at between 2°C and 8°C.	N/A
	Once opened: 4 weeks for insulin vials and pens unless otherwise stated. When in use can be kept at normal room temperature (i.e. less than 25°C).	Write the date of opening on the label.
Any product whose appearance suggests it may be unfit for use should be discarded, irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.		

**Unless otherwise stated by manufacturer and still within manufacturer's expiry date*

8.3 Examples of product-specific expiry dates

The following table includes examples with expiry dates specific to that particular product. Please note, this list is not exhaustive.

Product	Expiry
Persantin Retard® (Dipyridamole SR)	6 weeks after opening original dispensing container. Once capsules are packed down into another container then 4 weeks expiry.
Madopar® capsules and tablets	2 weeks when dispensed into another
Nicorandil®	Manufacturer recommendation, then once opened each blister has a 30-day expiry. Use one blister strip at a time before opening the next. The blister strip contains a drying agent to protect the tablets from moisture which should not be removed or swallowed.
Asasantin Retard® capsules	6 weeks after opening original dispensing container. Once capsules are packed down into another container then 4 weeks expiry.
Chlorpromazine syrup 25 mg/5 ml & 100 mg/5 ml (Rosemont)	6 months after opening
Gastrocote® liquid	1 month after opening
Largactil® syrup	1 month after opening
Oramorph® 10 mg/5 ml liquid	90 days after opening
Risperdal® 1 mg/ml liquid	3 months after opening

These guidelines are subject to correct storage at ambient temperatures recommended by manufacturers, and are based on general consensus and not evidence-based, due to the lack of information available.

8.4 Medicine expiry date checklist

Regular date checking of stock will reduce the risk of out of date, discontinued or unwanted stock being administered. Every month each section should be checked for out of date, discontinued or unwanted medicine. Any items identified as being out of date, discontinued or unwanted must be removed from the general stock and segregated for disposal/return to the pharmacy. Highlight any items that are due to expire within the next month to the manager. Initial and date the relevant box once completed.

Care home name: Floor /Unit: Year:

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Dressings												
Topical preparations												
Tablets and capsules												
Liquids												
Fridge items												
Trolley items												
Controlled drugs cupboard												
Homely remedies												
Nutritional supplements												

8.5 Storage requirements of common medicines

The table below contains a list of common medicines requiring storage at a particular temperature. The list is not exhaustive, please check the patient information leaflet (PIL) for storage requirements if you are unsure. The date of opening must be written on the label the first time the medicine is opened.

Eye / ear drops	Brand names include:	Storage requirements
Chloramphenicol	Chloromycetin®	Store in fridge (2ºC-8ºC).
Cyclopentolate	Mydrilate®	Before first opening, store in a fridge (2ºC-8ºC). Prior to first opening, remove from fridge and store are room temperature for 30 minutes. After first opening do not store above 25ºC.
Latanoprost / timolol	Xalacom®	Before first opening, store in fridge (2ºC-8ºC). Once open, can be stored at room temperature (below 25ºC) for 28 days whilst in use.
Tafluprost	Saflutan®	Store in fridge (2ºC-8ºC). After opening, store below 25ºC.
Liquids	**Brand names include:**	**Storage requirements**
Chlormethiazole	Hemineverin®	Store in fridge (2ºC-8ºC).
Reconstituted Antibiotics e.g. amoxicillin	N/A	
Multivitamin	Ketovite®	
Alfacalcidol	One-Alpha drops®	
Amlodipine oral solution	N/A	
Some special-order medicines	N/A	Check with pharmacy
Tablets	**Brand names include:**	**Storage requirements**
Multivitamins	Ketovite®	Store in fridge (2ºC-8ºC). Not all brands - check label
Chlorambucil	Leukeran®	
Phenelzine sulphate	Nardil®	
Melphalan	Alkeran®	
Fludrocortisone	Florinef®	

Injections	Brand names include:	Storage requirements
All insulin		Before use, store in fridge (2ºC-8ºC). Once in use, can be stored at room temperature (below 25ºC) for up to 28 days.
Exanatide	Byetta®	
Liraglutide	Victoza®	
All vaccines		Store in fridge (2ºC-8ºC)

Topical	Brand names include:	Storage requirements
Tetracaine	Ametop gel®	Store in fridge (2ºC-8ºC).
Miconazole/ hydrocortisone	Daktacort cream®	
Nystatin/ dimeticone / hydrocortisone	Timodine cream®	Store below 15°C

Others	Storage requirements
Glucagen Hypokit	Can be stored at room temperature (below 25ºC) for up to 18 months.
Pulmozyme nebuliser solution	Store in fridge (2ºC-8ºC).
MUSE urethral application	Can be stored at room temperature (below 25ºC) for up to 14 days.
Fostair Inhalers	Once started can be stored at room temperature (below 25ºC) for 6 months.

Items often prescribed locally Use this section to record storage requirements of medicines not already listed, but which are often prescribed locally.	

8.6 Refrigerated medicines

Aim: To outline the controls that should be in place to ensure safe storage of medicines that require refrigeration.
Note: Care homes are required to have a policy for storing fridge medicines.

Monitoring fridge temperatures

The four 'Rs' of fridge temperature monitoring

Read: read temperatures at least daily using a thermometer that measures minimum and maximum temperature.

Record: record temperatures on a fridge temperature record sheet or other suitable alternative.

Reset: reset the thermometer after each temperature reading.

React: react by taking action if temperature is outside 2°C to 8°C and, document this action.

Fridge requirements

- Medicines that need to be refrigerated (e.g. insulin), should be stored in a separate, secure, fridge that is only used for medicines (do not keep any food or pathology samples in 'medicines fridge').
- The fridge must either be locked or kept in a locked medicines room. Staff should be aware of key storage and access.
- When medicines requiring refrigeration are received within the care home they should be immediately identified and placed in the 'medicines fridge'.
- Check that the designated fridge electrical wall socket is clearly labelled to leave on so that it is not inadvertently switched off. Some pharmaceutical fridges are directly wired so that this cannot occur.
- All fridges where medicines are stored must be serviced at least annually.
- Store medicines in an orderly fashion on the shelves, not on the floor of the fridge, or in the door. Avoid overfilling and keep a space between boxes and vials for air circulation. Do not keep large amounts of medicines in the fridge, this can lead to inadequate air flow and potential freezing. Medicines should not touch the sides of the fridge or the cooling plate at the back of the fridge.
- Specialised refrigerators are available for the storage of pharmaceutical products and must be used for vaccines and diluents. Vaccines must not be stored in domestic refrigerators.
- Ensure medicines stored in the fridge are regularly date checked and the stock rotated.
- All fridges should be cleaned as part of the general cleaning rota and dated records kept. Domestic fridges (that are not self-defrosting) should be defrosted regularly and dated records kept. The care home policy should state where the fridge contents should be refrigerated whilst cleaning and defrosting takes place.

Thermometer requirements

The 'medicines fridge' must be monitored using a thermometer which measures both the minimum and maximum temperature. The thermometer, or its temperature monitoring probes, should be sited in a central location within the fridge, preferably between the products - they should not be placed in the door.

Daily temperature recording

- The fridge temperature must be checked and recorded daily. It is recommended that the minimum and maximum temperatures and the current temperature are all recorded. (See fridge temperature monitoring record).
- The fridge temperature must be kept between the range of 2°C and 8°C. If the fridge temperature is outside of this range, action must be taken immediately - see below for required actions.
- Staff taking fridge temperature readings must demonstrate understanding of how to read and reset the thermometer, and why this is necessary.

What to do when the fridge temperature is out of range

- Inform the care home manager immediately.
- Quarantine (separate and put in a safe place) the affected fridge stock by bagging and labelling ‘not for use’ and keep within a designated fridge, ideally an alternative medicines fridge, while advice is sought. If the home does not have an alternative medicines fridge, the quarantined stock should be placed in a sealable container and placed in the kitchen fridge whilst advice is sought.
- Attach a notice to the fridge clearly stating ‘do not use’.
- Estimate how many hours the fridge has been out of range (you should have the reading from the previous day’s check).
- Contact your pharmacy for advice.
- If you are advised that the stock is no longer usable, ensure that it is disposed of promptly in line with local protocols.
- Contact the GP to explain what has happened and request replacement medicines, if required.
- If necessary, call out an engineer to repair the fridge.
- Remember to record the action taken on the fridge temperature record sheet.
- Ensure that it is clear where medicines should be stored (in an emergency) if the fridge malfunctions.

8.7 Fridge temperature monitoring record

Care home: Floor/Unit: Month:

Date	Time	Fridge maximum (must be at or below 8ºC)	Fridge minimum (must be at or above 2ºC)	Fridge current (must be 2ºC – 8ºC)	Room temperature (must be below 25ºC)	Reset	Signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

Please ensure that fridge temperatures are recorded daily and the thermometer is reset after each recording. If the fridge temperatures are outside of the recommended limits of 2ºC to 8ºC you must inform the manager or clinical lead as soon as possible.

8.8 Medicine disposal record

Care home name:

Date	Residents name	Medicine	Amount	Reason for disposal	Initials

9.0 Community pharmacy notification: Medicine dispensed out of hours

Care home name:…… Tel:.....

Contact name:…… Fax:…….

Community pharmacy:……..

Dear pharmacist,

We have had to obtain the medicine (listed below) from an alternative pharmacy. We would be grateful if you can inform us whether the resident has any allergies or contraindications to the medicine listed below, or possible interactions with their regular medicine.

We would be grateful if you could respond as soon as possible with any relevant information and advice.

Yours sincerely……(Print name)

Resident name and date of birth	Medicine dispensed (including strength and dose)	Date of dispensing	Pharmacy comments
Resident name and date of birth	**Medicine dispensed (including strength and dose)**	**Date of dispensing**	**Pharmacy comments**

10.0 Authorisation for the administration of medicine for residents with swallowing difficulties

Please note: use the difficult to swallow and covert administration pathway to determine the most appropriate solution for the resident. The resident must have the capacity to be part of, and agree with, this decision.

Resident's name:……**D.O.B:** …….

Has the GP been informed of the resident's difficulty in swallowing? Y / N

GP:…… **GP Practice:**…….

Has the resident been assessed as having difficulty in swallowing medicine?

Nurse	Y	N	Please note that if medicine has been changed to a liquid formulation, or crushed medicine to be given in a liquid, consideration should be given to the use of thickening agents.
GP	Y	N	
SALT	Y	N	

Have alternative medicines or formulations been considered?	Y	N

Has the availability and practicality of using alternative formulations been discussed with the pharmacist?	Y	N

This decision has been discussed and agreed with the resident and following individuals:(all individuals to sign):

	Date	Review 1 date	Review 2 date	Review 3 date	Review 4 date
Resident					
GP					
Care home					
Pharmacist					

Medicine to be administered	Method of administration i.e. crushed/sprinkle
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Please note you must not crush or alter the form of tablets/capsules without going through the above process. Doing so puts the resident at risk and makes you liable should any complications arise.

11.0 Covert administration of oral medication

Please note: use the difficult to swallow and covert administration pathway to determine the most appropriate solution for the resident

This plan must be used in conjunction with the care home's own covert administration policy.

Residents Name		Date of Birth	

Mental capacity assessment in relation to this decision (must be done by a registered health care professional including a physician, nurse practitioner, a registered nurse or a registered pharmacist suitably competent to complete assessment). **The capacity assessment must be discussed with a physician if the medicines include antipsychotics.**

Evidence supporting lack of capacity:

Assessors name, signature and date of assessment:

Medication Review

The resident's medication has been fully reviewed and the following medicines are considered essential by the health care professional (a pharmacist, GP or Practitioner). Medication should be reviewed every 12 months or before if there is a significant change of medication.

Health care professional role		Signature		Date	

Best Interest Decision

The decision to covertly administer medication has been discussed and agreed by the following people - the GP, appropriate member of care home staff, an informal person (relative) or an Independent Mental Capacity Associate (IMCA) if there are no family/friends available. This must be taken to the GP surgery for signing.

GP		Signature		Date	
Care home		Signature		Date	

Name of relative or IMCA that decision has been discussed with and date:

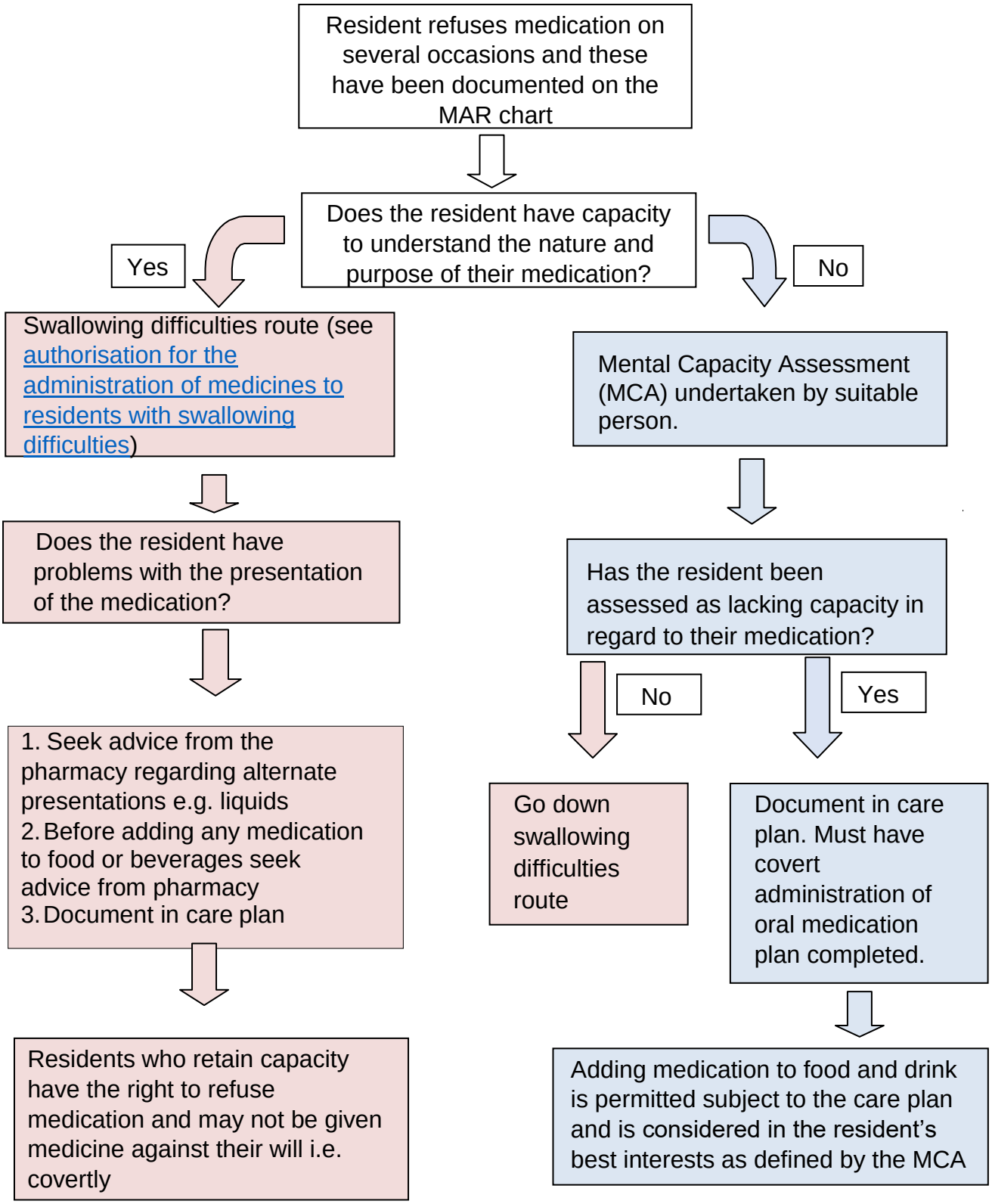
.....

11.1 Covert medication administration plan

For each medicine to be administered covertly, a plan for administration must be in place. The pharmacist can provide information about whether the medicine can be crushed or if liquids are available. This should be reviewed annually unless the resident's condition changes. Only the medicine(s) listed below can be given covertly, any new medicine(s) must be considered separately to see if it is in the resident's best interests for covert administration.

Medication to be administered covertly with plan (e.g. offer to resident first, if refuses wait 30 mins then try again)	Method of administration e.g crushed/sprinkle
1.	
2.	
3.	
4.	
5.	

12.0 Difficult to swallow and covert administration pathway



13.0 Care home visit checklist

The following list may be used by the community pharmacist / technician or health board pharmacist / technician when undertaking a care home visit.

Care home name			
Completed by		Date	

√	Area to be checked	Comments
	Check CD register and quantities.	
	Check for overstocks.	
	If on eMAR, check for stock that will run out before end of the cycle.	
	Running totals of medicine liable to abuse kept.	
	Medicine stock rotated and expiry dates checked and recorded.	
	Procedure for recording disposal of unused and expired medicine / clinical waste.	
	Medicine room temperature checked and recorded daily (below 25°C).	
	Maximum and minimum fridge (2°C to 8°C) temperatures recorded daily and the thermometer reset after each recording.	
	Segregation of internal and external medicine.	

√	Area to be checked	Comments
	CD stock levels checked regularly.	
	All entries in CD register countersigned.	
	BNF available and not more than 1 year old (or access to e-BNF available).	
	Creams, ointments and eye drops/ointments have the date opened recorded on the bottle or tube.	
	Fridge items being administered and stored outside the fridge have the date of opening on them.	
	All regular medicine has full dosing instructions on the MAR charts.	
	Alterations on MAR sheets are countersigned and dated by a second qualified member of staff after agreement with GP.	
	All relevant signatures (GP, care home and residents' representative) present on convert administration forms.	
	Consent form lists all medicine covered by the covert order.	
	Oversee at least part of a medicine's administration round.	