**Nursing Care / Residential Home Drug Policy Guidance**

This is a quick guide to the management of medication within Care and Nursing homes.

These guidelines are based on what the regulator The Care Quality Commission would expect to find as ‘best practice’.

Other issues with regards to Controlled Drugs would be covered by the Misuse of Drugs Act (Safe Custody regulations).

1. **Policies and Procedures:**

All homes should have their own Policies and Procedures that should include all aspects of medication which will include ordering, storage and administration.

All homes should review their policies on an annual basis.

Care home providers should have a “Medicines Policy” which they review to make sure it’s up to date and is based on current legislation.

1. **Ordering and Management of Medication**:

Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medication, in the case of a Nursing Home this would be qualified nurses, although ordering of the medication can be done by one member of staff, ideally (although not always possible) the booking in of medication when it arrives at the home should be done by a different person other than did the original order.

The premise will be registered with the Care Quality Commission (CQC) and subject to CQC inspection. The CQC also set the National Standards (telephone 0333 405 33 33).

Care home providers should retain responsibility for ordering medicines from the GP practice and should **not** delegate this to the supplying pharmacy.

Care home providers should ensure that records are kept either in written or electronic format of medicines ordered; medicines delivered to the home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly; this will also include checking liquid medication to ensure the amount sent is enough to last the full cycle.

Other records that should be found would be individual residents **care plans**, these would indicate general wellbeing including weight, nutrition and other welfare issues.

Care home providers must ensure that any “short fall” of medication is dealt with as quickly as possible to prevent medication from being used from the following cycle.

Care home providers must ensure that medicines prescribed for a resident are not used by other residents.

Care home providers must check stock levels before doing their monthly order to ensure excess stock not being kept, and therefore reducing medication waste.

1. **Dispensing, supplying and storage of medicines**:

All monthly prescription requests should be with the GP practice within a timely manner to ensure all residents have their medication on time.

Pharmacies supplying medicines to care home providers should ensure they have robust systems in place for checking medication, particularly medication issued in monitored dosage systems.

All medication should be stored within a lockable room or cupboard, especially where the temperature is relevant.

Fridge items need to be checked as some items such as eye drops need to be stored in the fridge before opening.

Medicines intended for internal and external use should be stored separately.

Items with a short shelf life must be dated when first opened, i.e. items such as eye drops and creams have a short life once opened.

1. **Receiving Medication**:

Care home providers must ensure that all medication received is checked against the order and ensure the correct medication has been delivered for each resident in particular the strength of the medication.

Medication must be stored in a secure location with only authorised staff having access, medication must be checked and put away as soon as possible after it has been delivered. Staff must ensure that fridge line items have been put in the fridge as soon as possible after it has been delivered.

Controlled drugs MUST be checked and locked in a suitably approved controlled drugs cabinet as soon as they are brought in to the home.

Any discrepancies must be dealt with as soon as possible, this will allow staff at the home to deal with any discrepancies before the medication cycle begins.

1. **Controlled Drugs**:

Controlled Drugs although covered by the MDA 1971 are also readily available in a pharmaceutical form as Prescription only Drugs (POM).

These drugs vary from strong Opiate based analgesics used in end of life medication to anxiolytics and hypnotics, for example the Benzodiazepines.

In the care environment controls are often kept on drugs of potential abuse or concern although not covered by Class A, B or C of the MDA 1971.

These must be stored in a suitable metal cupboard and comply with Controlled Drugs Regulations; this will include information such as the cupboard must be fitted securely onto a solid wall or floor with at least two substantial fixings.

Only authorised trained staff should have access to this cupboard

All CDs must be checked and written in the controlled drugs book and signed by two members of staff.

Each time Controlled Drugs are administered this must be recorded in the controlled drugs register and have another member of staff to witness.

The controlled drugs register and Medicines Administration Record chart must be signed (by 2 people in the controlled drugs register) once it has been witnessed and the medication has been given to the resident.

If a second member of staff did not witness the administration of the Controlled Drug then they should not be signing the book.

Regular medication count checks should be done to ensure the amount remaining in the cupboard is correct against the amount administered, this should also be signed by two people, and it is recommended this be done on a weekly basis.

Any errors written in the controlled drugs book should have one single line across the error and marked with an asterix, the correct information should be recorded below.

Any discrepancies with controlled drugs must be reported to the home manager ASAP who should then be informing their Safeguarding Team, NHS England Local Area Team, the local Clinical Commissioning Group and the Police.

Keys to the Controlled drugs cabinet should be kept safely and securely.

In a Residential Care home where there is unlikely to be nursing care, medication could be under the control of the resident as it is the residents own property.

1. **Disposal of medication**:

When disposing of medicine and removing medicines classed as clinical waste, care home providers should have a process in place for the prompt removal of items such as:

1. **Medicine that is no longer required**:

This could include unwanted or unused medicines including medicines of any resident who has died.

1. **Expired medicines:**

Wasted controlled drugs must be recorded and dealt with using an appropriate audit trail, nursing homes cannot send any medication waste back to the pharmacy; they must have an arrangement in place for a waste company to collect this who must sign the correct documentation. Copies of this paperwork must be kept for any audit trails.

Medicines for disposal should be stored securely in a tamper proof container and ideally kept within a cupboard until they have been collected OR taken away by the pharmacy.

All returned or wasted medication should be recorded in a “**returns book**” which should include the residents name, the name and strength of the drug, how much is being returned /destroyed and the reason why, again this information would be needed for any full investigation or audit that may be required.

Where residents have passed away all medication **must** be kept for **seven** days after death in the event of any investigation by the Police or Coroner.

1. **Medicines Administration Record Charts**: **(MAR)**

MAR charts that are printed and supplied by the pharmacy will include all the relevant information; however MAR charts that are hand written must include the following information:

All residents should be identified by an up to date photograph.

The residents name, date of birth, address and named GP, (this should be included on each chart in use).

The start date of the chart including the year should be clearly marked; any known allergies should be recorded.

The name, strength and form of medication should be copied from the dispensing label onto the appropriate space on the chart along with the full dosage instructions (exactly as they appear on the label) and any additional instructions, such as avoid taking with cranberry juice etc. The quantity received must be completed as well as any medication that it is be carried forward.

For any medication that is not administered on a daily basis an **\*** should be marked in the signature column against each day the medication WILL NOT be given, this will reduce any errors of staff administering this medication on the wrong day.

Each time medication has been administered staff must always sign the MAR chart.

When variable dose has been prescribed e.g. take one or two tablets the amount given or administered must be recorded on the chart.

If homeopathic remedies or over the counter medication have been given, the following information must be recorded on the MAR chart, the back of the MAR chart should be used to capture this information.

**The name of the resident**

**What medication has been given?**

**How much medication has been give i.e. 1 or 2**

**The time the medication was given**

**The effects must be monitored and recorded and must include the signature of the staff giving the medication.**

MAR charts must be legible at all times, and completed with a black pen. Correction fluid **MUST** never be used.

All hand written details on a MAR Chart Must have two signature; this is to ensure the information written on the MAR chart is correct.

When staff have taken details of medication OR change to medication over the phone, they **MUST** request this is followed up by a fax or a letter.

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