



# Medicine Matters

The Newsletter for Care Homes



November 2022

Issue 15

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[Click here](#) to access the Frimley ICB Good Practice Guidance for care homes

## Medicines Safety Culture in Care Homes Project

Today Medicines Safety Culture differs between the NHS and Health and Social Care. There is widespread reporting in Hospitals which have:

- a no blame culture,
- don't punish people, and
- seek to learn from mistakes
- good reporting of safety incidents.

But this is very different in Health and Social Care where low numbers of medication errors are reported.

The aims of Medicines Safety Culture Project in Care Homes are:

- for all care homes to have a nominated 'Medicines Safety Champion' to:
  - lead on managing medication problems, and
  - be responsible for sharing good practice with medicines safety
- to raise awareness around the medicines classed as 'high risk' in terms of adverse effects and errors associated with them

- to raise awareness around the risks of medication problems (medication incidents/ errors/ near misses and concerns) so that care home staff are more able to identify an incident/error/near miss and know how to manage them.

Benefits for care homes include supporting regulation, improving standards, improving patient safety, improving risk awareness, reduction in potential hospital admissions secondary to medication errors, reduction in avoidable harm, and reduced costs associated with avoidable harm.

The project is open to all care homes in **Frimley ICS**.

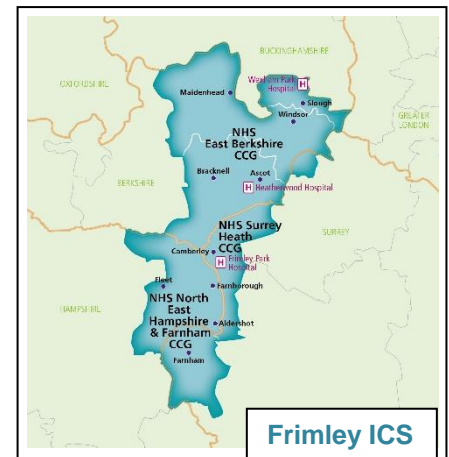
Ideally we would like to have a member of care staff from:

- 1 Nursing Home                    }
- 1 Residential Home                } per place = 15 care homes
- 1 Learning Disability               }

If more care homes are interested and wish to be involved they are very welcome.

The MOCH team will produce a resource/ toolkit to support you.

A Medicines Safety Corner featuring an anonymised scenario with reflection and learning points will become a regular feature in the **Medicine Matters** Care Homes' newsletter.



## Medicines Safety Corner



### Controlled Drugs in Care Homes



Controlled Drugs (CDs) are subject to register and storage requirements depending on their schedule. The Controlled Drugs Register must only be written in and signed by suitably trained and authorised members of staff.

When handling CDs the following must be taken into consideration:

- When CDs are received, they should be entered into the Controlled Drugs Register and store in the CD cabinet **immediately**.  
**Do not leave CDs out on the side or in the cupboard to be entered later.** When you sign the CDs in from the delivery driver **you** are taking responsibility for those medicines.
- Stock checks must be done regularly and as a minimum requirement once a week for each drug, but ideally each time a CD is received, administered, returned to the supplying pharmacy for destruction (care homes without nursing) or destroyed (care homes with nursing).
- Two authorised members of staff, suitably trained and competent with CDs should be involved and sign for CDs when making entries into the Controlled Drugs Register and for:
  - receiving
  - transferring (e.g. transfer of care)
  - checking suitability (e.g. not expired, dispensing label is visible and the contents are not damaged)
  - administering
  - disposing/ returning for destruction.
- Errors made in the Controlled Drugs Register must **never** be crossed out (see example below).

NAME, FORM OF PREPARATION AND STRENGTH *morphine sulfate 5mg modified release tablets*

AMOUNTS OBTAINED									
Amount	Date Received	Serial No. of Registration	Date	Time	Patient's Name	Amount Given	Given by (Signature)	Witnessed by (Signature)	STOCK BALANCE
			31/01/22	8:30	A. Example	1x 5mg	OP	SS	54
			31/01/22	20:05	A. Example	1x 5mg	OP	SS	53
			4/01/22	8:35	A. Example	1x 5mg	OT	PP	52
			4/01/22	20:01	A. Example	1x 5mg	PT	SS	51
			5/10/22	8:40	A. Example	1x 5mg	PP	OP	<del>49</del>
			5/10/22	20:08	A. Example	1x 5mg	PP	OP	50

Errors made in the controlled drugs register must never be crossed out

- If an error is made in the Controlled Drugs Register, complete the following actions:
  - the incorrect entry should be put in brackets and an asterisk with a note made:
    - at the bottom of the page with the phrase 'entered in error', **or**
    - 'entered in error' can be written on a new line below the incorrect entry
  - the incorrect entry should be signed by authorised staff, witnessed, and dated
  - the correct entry should be made using a new line on the relevant page in the CD register (see picture below)

NAME, FORM OF PREPARATION AND STRENGTH *morphine sulfate 5mg modified release tablets*

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			5/10/22	8:40	A. Example	1x 5mg	OP	SS	<del>49</del> *
			5/10/22	8:40	A. Example	1x 5mg	OP	SS	50

\* entered in error. see 5/10/22

Example of good practice

Ensure care staff know the difference between milligrams (mg) and millilitres (ml). The dose should be documented clearly in the care plan and on the MAR chart, especially for injections or liquids where doses need to be measured or titrated. If you are unsure about the dose, obtain advice from the GP or supplying pharmacy prior to administering.

MEDICATION <small>(Name strength dose frequency)</small>	HOUR	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
<b>Medicines Management Corner</b>																																

## Record Keeping in Care Homes

It is essential that care homes keep secure, accurate, and up to date records for residents' care. This is required under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good record keeping is also a compliance with [CQC regulation 17](#), where records should be kept fit for purpose. Fit for purpose means it must:

- Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable.
- Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf.

Some examples of medication that require good record keeping include:

### Insulin

It is good practice to have a detailed insulin care plan in the resident's record. This should detail:

- An assessment of the support a person may need to manage their diabetes care and details of the person(s) providing the support
- Information to support safe administration of insulin
- Information about blood glucose monitoring, including frequency and acceptable range
- Person centred dietary requirements
- How often blood sugar levels should be tested and what to do if this is out of range
- Signs of hypoglycaemia or hyperglycaemia and actions to take if these occur
- The dose of insulin administered and records of the site of administration (which should always be rotated)



[Click here](#) to see the CQC Medicines information for adult social care services - Care Homes - Diabetes and insulin use

### Anticoagulants

Anticoagulants include warfarin, direct oral anticoagulants (DOAC's) such as Apixaban and Rivaroxaban and injectable anticoagulants such as Dalteparin (Fragmin®).

It is good practice to ensure records are kept of:

- How to use the anticoagulant treatment e.g. the current dose schedule of Warfarin.
- Possible side effects
- How anticoagulants may affect certain activities such as sport, or how it could affect dental treatment
- Monitoring information, e.g. for Warfarin, the INR information such as the target INR, current INR and when the next blood test is due
- When and how to seek medical help, e.g. if a dose is missed or side effects occur.

Written correspondence of changes should be kept in the resident's care plan.

[Click here](#) to see the CQC Medicines information for adult social Care services- Care Homes- Anticoagulants

### When required 'PRN' medication

PRN protocols should detail the reasons for administering the medication, signs and symptoms of when to offer the medication if the resident does not have capacity to request the medication (e.g. rocking or clenching as a sign of pain); maximum and minimum doses and when to refer to the GP. PRN protocols should be person-centred.

[Click here](#) to see the CQC Medicines information for adult social Care services - Care Homes - When required medicines

## Topical Preparations

For creams and ointments, care staff should be able to access information about:

- The frequency of application
- The amount of the cream/ointment to apply
- Location on the body the cream/ointment should be applied

Administration records should be kept of any creams/ointments applied by care staff.

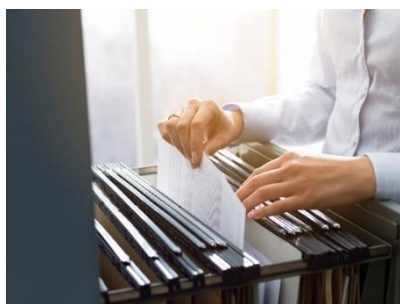
## Patches

The site of administration of patches should be rotated. The site of patch application should be changed each time a new patch is administered and not the same site twice in a row. Refer to the patient information leaflet to determine how long to avoid the same application site and record the site of administration on a body map. Recording where the patch is administered helps in identifying if a patch is still in place.

[Click here](#) to see the CQC Medicines information for adult social Care services - Care Homes - External medicines such as creams and patches.

## Top tips for record keeping:

- When checking a resident's medication from hospital discharge/another care home/resident's own home, ensure you have checked and recorded all details. This should include and is not limited to; known allergies and reactions, current medication the resident is taking, details of when required medication (last taken, any particular order when required medication must be taken), dates of any tests and health professional contact details.



- Fridge and room temperatures should be recorded daily. It is advisable to record the maximum, minimum and current temperature using a minimum/maximum thermometer. The thermometer should be reset after every reading.
- Ensure correspondence from other professionals is documented clearly in the care plans. It is good practice to record the name, title and contact details of the professional and follow up with any written confirmation where necessary.
- A handwritten MAR chart entry should be produced in exceptional circumstances. It must be created by care staff that have had the training for managing medicines. The record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.
- If using homely remedies, the GP should verify the suitability of the homely remedies used for each individual resident within the home. If using an authorisation sheet, this should be for each individual resident. If the GP has suggested an over-the-counter medication, instructions for its use should be recorded in the individuals care plan.

## Medicines Re-use Scheme Update

***Novel coronavirus (COVID-19) standard operating procedure: running a medicines re-use scheme in a care home or hospice setting*** was withdrawn on **6 April 2022**.

### **ACTION for Care Homes:**

- **STOP using medicines re-use scheme with immediate effect.**
- Retain all medicines re-use scheme records (consent forms, suitability checks & administration records) and archive with corresponding resident's MAR charts as per usual records retention period.
- Dispose of Medicines re-use scheme stock according to your care home medicines disposal policy and process. Keep records as stated in the disposal of medicines policy.
- All Medicines re-use scheme Controlled Drugs (CDs) stock must be disposed of as per CDs disposal care home policy and process. Records of CDs disposal must also be recorded in the CD register.

