Care Home Prescription Management Guidance

TARGET AUDIENCE	Care home staff Primary care staff proving care to patients in care, nursing or residential home settings Community Pharmacy teams supplying medication to care home residents.
PATIENT GROUP	Patients living in care, nursing or residential homes in Lanarkshire.

Clinical Guidelines Summary

- A robust medication ordering system for care home residents will ensure that the correct medicines are supplied in a timely manner to meet their needs with minimum waste.
- This guide outlines the ordering process, addresses key areas that can be problematic and details 'Good Practice Points' for each discipline to aid a more efficient process and accurate medicines supply for care home residents with the objective of safe and cost effective use of NHS resources.

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1. Prescription Procedures

1.1 Ordering repeat prescriptions

It is important that the practice, care home and pharmacy have good procedures in place and that these procedures are reviewed and discussed regularly. This is important to avoid over-ordering and to save professionals' time by avoiding numerous phone calls between practice, home and pharmacy to address problems.

The care home should have a written procedure for ordering prescriptions which should be reviewed on a regular basis. A suitably trained member of the care home team (and a deputy) should be responsible for ordering and control of medication in the home, but other staff should be familiar with the procedures in order to cover leave/sickness.

Prescription requests should always be initiated by care home staff, the resident or a relative and not the supplying community pharmacy.

Medication should be ordered at **28 day** intervals. Allow sufficient time for prescriptions to be issued, checked, dispensed and delivered (see appendix 1 – flowchart of monthly prescription ordering process).

Stock levels of medication, in particular 'as required' (PRNs) and topical products, must be checked before they are re-ordered, so that items are not ordered unnecessarily.

Carry forward quantities of any medicines that can still be used. For example – an inhaler prescribed for PRN use or where the dosage means the inhaler should last for 2 months before replacement. Record the quantity carried forward on the MAR sheet for the next 28-day cycle.

Care home staff should see the NHS prescription forms for the orders they have placed before they are sent to community pharmacy to be dispensed, and should check the prescriptions against the record of the order, taking account of any recent changes to check for discrepancies. Staff should ensure for each resident that all medication ordered has been correctly prescribed, that discontinued medication has not been supplied and that any unexpected items have not been prescribed in error. This process does not apply to acute prescriptions resulting from consultations, as this may cause a delay to the patient starting a new medication e.g. an antibiotic.

Discrepancies should be queried with the GP practice within 24 business hours via secure email. **An item that is prescribed on a GP10 prescription but is not required can be scored through with a line and marked 'ND' (not dispensed) by care home staff.** If incorrectly

prescribed items are to be scored off a prescription form, the GP practice must be informed so that electronic records can be updated.

1.2 Medication Administration Record (MAR) sheet orders

Some types of MAR sheets can be used as an alternative to the normal GP practice 'tick list' to complete the monthly drug order in the care home. MAR sheet ordering aids communication between the care home, the GP practice and the community pharmacy, as well as reducing risk of errors, providing an audit trail and potentially reducing waste.

It should be noted on the MAR order form whether a particular medicine is to continue or has been discontinued by the prescriber. The reason why the medicine has to be removed from the MAR should be written on the MAR order form e.g. discontinued by GP or finished course.

It should be noted on the MAR order form if a medicine is to continue but no supply is required (this means it will continue to be printed on the MAR sheet by the community pharmacist but no prescription is required). Specific quantities can also be requested to synchronise any medications started or doses changed mid cycle. This avoids unnecessary supply and reduces waste.

Some GP practices link in with a member of care home staff with responsibility for ordering medication to the practice on a monthly basis. They discuss the MAR sheet medication order, ensuring that medication records are up-to-date and that only required items are prescribed. This has proved efficient for both care home staff and practice staff and has reduced over-ordering and discrepancies.

1.3 Medication ordering planner

Community pharmacists often produce a year planner of the medication ordering cycle for a care home. It would be useful to share a copy of this document with the GP practice so all parties are aware of the timescale for medicine supply.

2. Interim prescriptions/mid-cycle changes

If a new repeat medicine is started or dose increased during the medication cycle, the prescriber should provide a prescription for the remainder of the current 28-day cycle, as well as a further 28 days' supply if the monthly medication order has already been placed.

If a dose is decreased, a new instruction can be recorded on the MAR sheet by the prescriber or by a nurse/senior carer. A new prescription is not always necessary. The previous entry and any remaining space for recording of administration should be scored through and a new entry added. **Changes should not be made to an existing entry on a MAR sheet.**

If a prescriber writes on the MAR sheet this becomes a written direction signed by the prescriber. To allow a member of care home staff to write the instruction on the MAR, the prescriber should provide the care home with some other form of written direction for change (as per NMC guidance) e.g. secure email. If an instruction is given verbally, the care home must have a robust verbal communication procedure in place. The NHS Lanarkshire Medication Dosage Amendment forms (Appendix 2) can be used to document verbal instructions.

When a change is made to a prescription, e.g. when a resident is discharged from hospital or seen at out of hours, care home staff can make hand-written entries on a MAR sheet but these must always be dated, clearly written and identify who has written the amendment, including their designation, and also reference to the prescriber who authorised the change. The entry should be written in capital letters and full directions should be used e.g. write 'when required' **not** 'PRN'.

Amendments to MAR sheets should **not** be made using dispensing labels supplied by the community pharmacy. Labels can become 'unstuck' thus rendering the entry incomplete.

A new printed MAR sheet from the community pharmacy is not always required for newly prescribed medicines, as detailed above, and can cause excess paperwork and discontinuity of audit trail. However, changes should be communicated with the community pharmacy.

If the instruction on the MAR chart is different from the instruction on the dispensing label, then the information on the MAR should explain why. The dispensing label can be annotated 'dose changed – see MAR sheet' to avoid dosing errors.

Further advice for care home staff can be found 'Guidance about medication, personal plans, review, monitoring and record keeping in residential care services': Care Inspectorate 2012.

Practices may need to provide prescriptions to cover the remainder of a 28-day cycle, particularly where changes are made by out-of-hours GPs.

It is important that all changes to medication are recorded on the GP prescribing system at the practice as soon as possible and always within 24 hours. N.B. Once a new/amended prescription item has been recorded on Vision it must be queued to print (i.e. either an acute or a repeat ticked and the print button pressed once) before it will show in the Emergency Care Summary (ECS). It is not necessary to actually print the prescription if it has already been handwritten at the care home.

3. Shortages

When medicines are dropped or spilled, or refused by a resident and requested later on, care home staff **may** need to request further prescriptions to cover the shortage in the month's supply. In the first instance the care home staff should contact the practice pharmacist or nurse to seek advice on the clinical significance of the missed dose and establish if a further prescription to replace the missed dose is required. Requests for such prescriptions should be made promptly and before the end of the medicine cycle so that the resident does not run out of medication, but, if these requests are frequent, care home staff may consider making such requests on a weekly basis in order to reduce calls to the GP practice.

The prescriber may wish to consider whether a medicine needs to be continued if a patient is missing or refusing it on a regular basis, so it is essential that repeated missed doses are communicated to the prescriber. The government framework My Health, My Care, My Home advises all residents receive a polypharmacy review, ideally pharmacist led, on admission to the care home and then at least annually thereafter. Proactive management and communication of medicine related issues can reduce harm or deterioration.

4. New Care Home Admissions

When a new resident is admitted and they have a supply of medicine e.g. patient's own drugs or hospital discharge drugs, care home staff should use a blank MAR sheet (supplies of which can usually be obtained from the community pharmacy) and transcribe the information about the medicines from the dispensing label on each item**. Where possible, staff should seek to corroborate the information on the dispensing label from another source e.g. verbal feedback from a relative, information from the community pharmacy(s) who dispensed them, the hospital discharge letter, copy of prescription or a written authorisation from the GP.**

Staff should make sure there is a record of the name of the person who transcribed the information, anyone who checked the transcription and the sources of information used to confirm current medications (this can be noted on the reverse of the MAR). Make sure all of the person's details are written on the header including the start date of the record and fill in the dates the record is going to cover. The quantity of each item received should be recorded.

5. Respite Care

For residents admitted for respite care before returning home from hospital with a supply of hospital discharge drugs, the advice for new admissions applies (see section 4). For planned respite, use the person's own drugs as in section 4, or, consider requesting a prescription in advance from the person's GP to cover the period of respite, which can then be dispensed by the care home's usual community pharmacist. For planned respite, medication arrangements should be made timeously to ensure that stock is available and that any queries can be dealt with in advance.

6. Medication Returns

All medicines returned to a pharmacy are destroyed. They cannot be used for anyone else. It is unacceptable to return unused medicines supplied in an original pack and at the same time request more. Cupboards should not routinely be emptied at the end of each 28-day cycle. Instead, review stock at the point of ordering and carry forward quantities of any medication/treatments that the resident is still prescribed and can still be used. For PRN/when required medications, check quantities remaining and if there is enough left for the next 28 day-cycle do not reorder. If there is an overstock of these medicines, contact

the GP practice and ask them to adjust the quantity supplied. Medicines should only be returned to the pharmacy in the following situations:

- **Discontinued** medication-where medication has been discontinued or there has been a change to the regime by the prescriber.
- Date expired- the medicine has reached its expiry date.
- **Deceased** – resident has passed away.

A record of all medicines to be returned should be kept by the care home. This can be recorded on the MAR, in the returns book supplied by the community pharmacy or on the NHS Lanarkshire Medication Returns form (Appendix 3).

7. Good practice points

7.1 Good practice points for GPs and Practice Staff

- Good communication and co-operation between GP practices, pharmacies and care homes is essential. It is useful to have a named contact at the practice and at the care home for prescription enquiries.
- To aid workflow, practices can agree a set time for the care home to contact the surgery each day rather than the surgery getting calls from different units or different staff about the same issue.
- Prescriptions for care homes should be for 28 days' supply.
- Prescription quantities should be aligned to 28 days' supply to avoid unnecessary calls mid-month for further supplies of medication. Interim/mid-cycle prescriptions should be made for a quantity that will bring the new medicine in line with the current medicine cycle and for a further 28 days if the next month's supply has already been requested.
- Annotate new prescriptions with a review date, stop date, number of days' prescribed or long-term prescription status to reduce the incidence of inappropriate requests for repeats of acute prescriptions.
- The repeat prescription list should only contain medications which are taken on a regular basis and "as required" medications which are needed on a frequent basis.
- Avoid adding to the repeat prescription list; dressings, topical steroids and other items that may be subject to frequent review.
- Duplicate or inactive drugs on a patient's repeat list should be removed to avoid inadvertent prescribing/administration of discontinued medicines.
- Regular medication and compliance review to ensure appropriate prescribing for care home residents will ensure that unnecessary prescriptions are not being generated and so reduce waste.
- **Update changes to medication on Vision within 24 hours.**

7.2 Good practice points for Care Home staff

- Good communication and co-operation between GP practices, pharmacies and care homes is essential.

- The care home should have a written procedure for managing changes to medication.

  The care home should track all stages of the ordering and receipt of medication. Records should be kept for each stage to provide an audit trail.

- Discrepancies in the monthly order should be communicated to the community pharmacy/GP immediately.

- If an item on the monthly prescriptions is not required or has been prescribed in error, this can be scored off by care home staff. This must be documented and communicated to the GP so electronic records can be updated.

- Discontinued medicines should be annotated as discontinued on the prescription request form or removed from a resident's electronic MAR sheet to avoid inadvertent administration/ordering.

- Prescription requests can take up to 48 hours to process at the GP practice. Ensure that GP practice staff are fully aware when a request is urgent.

- Acute prescriptions should be started by the resident as soon as possible and at least within 24 hours. Contact your community pharmacy to ensure that supply can be made within this timeframe. If your regular community pharmacy cannot make the medicines supply, then you should seek supply from an alternative community pharmacy. If no pharmacy can make the medicines supply, you must let the prescriber know so that an alternative can be prescribed.

- If a medication supply for a resident does not arrive as expected always check with the community pharmacy whether they have received the prescription, especially when the GP practice has sent the prescription in an emergency.

- Communicate any information about expected prescriptions or delays to supply at each shift change.

- Let other staff know when you have contacted the GP practice or community pharmacy about a prescription query so that multiple calls are not made about the same query.

- Prescriptions may change when a resident is discharged from hospital or is seen by an out of hours GP. Communicate any changes to medication to the GP and to the regular community pharmacy.

- Let the community pharmacy know when items are discontinued so that the items can be removed from the next MAR sheet.

7.3. Good practice points for Community Pharmacy Staff

- Good communication and co-operation between GP practices, pharmacies and care homes is essential.

- Share a copy of the care home medication ordering planner with the GP practice.

- Acute prescriptions should be commenced within 24 hours. Make sure care home staff are aware if there will be a delay in supply. For long term shortages ensure that care home staff and the GP are aware so an alternative may be prescribed.

- When a prescriber has annotated a review date, stop date or noted the number of days' prescribed on the prescription, this information should appear on the MAR sheet.

- Liquid formulations are often prescribed for care home residents. The GP prescribing system does not always flag up when a 'special' is being prescribed. Ensure the GP is aware when they are prescribing an unlicensed product.

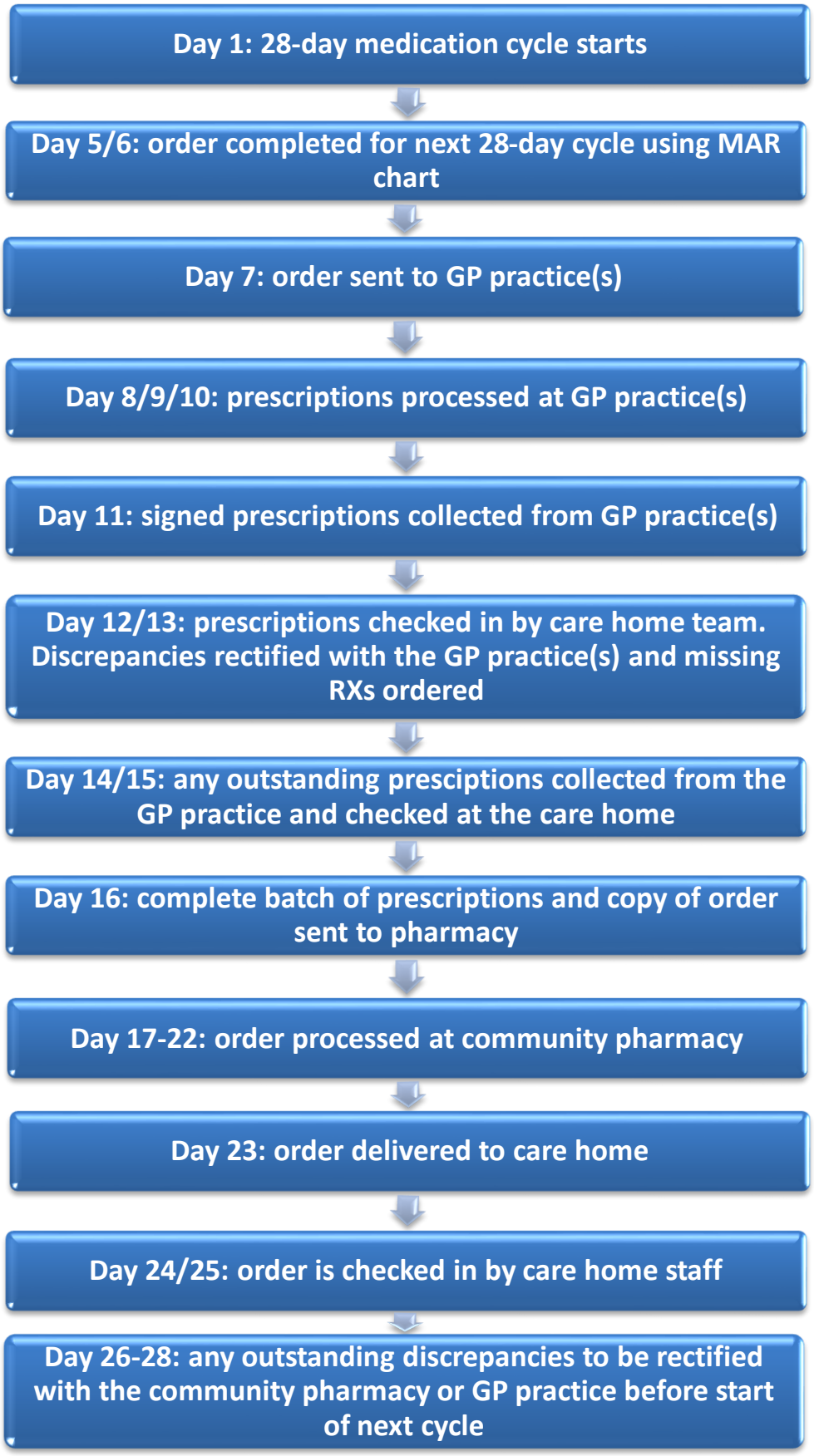
- Discontinued medicines should be removed from a resident's MAR sheet to avoid inadvertent prescribing/administration.

- Ensure that care home staff are aware of opening hours/delivery schedule and what they should do if they require a supply of medication outwith normal delivery times e.g. they can present at the community pharmacy with a prescription or at another community pharmacy if necessary.

- The pharmacist should let the care home know under which circumstances they can issue medicines out of hours via the national PGD.

- Care home staff should be directed to a palliative care safety net pharmacy if this would allow a more timeous supply of an urgent prescription.

Appendix 1 – Suggested Care Homes Monthly Prescription Ordering Flowchart



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Appendix 2 - General Medication Dosage Amendment Form

This form should not be used for Warfarin or Insulin Dosage Amendments

Instruction for dosage amendments for medication can be given verbally or electronically

NB Verbal instructions to change a prescription can only be done in the following circumstances

a) To discontinue a medication
b) To increase or decrease the dosage of a current prescription

Verbal instructions cannot be taken for a new prescription or for any changes in controlled drug prescriptions

All verbal instructions must be witnessed by 2 staff members

NAME OF RESIDENT **CHI**

Date	Time	Name of Medication	Current Dose	New Dose	Method of Instruction	Name of person receiving instruction	Name of witness to instruction

Appendix 3 Medication Returns Form

Resident's Name	Medication and Strength	Quantity Returned	Reason for Return

Care Home ……..

Signed…… Job Title……

Date Returned……

ONE COPY TO BE KEPT IN CARE HOME, ONE COPY TO BE SENT WITH RETURNS TO PHARMACY.

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Lead Author	**Claire Osprey**	**Date approved**	
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References/Evidence

Royal Pharmaceutical Society of Great Britain. Principles of Safe and Appropriate Production of Medicine Administration Charts. February 2009.

Care Inspectorate. Guidance about medication, personal plans, review, monitoring and record keeping in residential care services. 2012.

Scottish Government. My Health, My Care, My Home, Hea;thcare Framework for Adults Living in Care Homes. 2022

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Appendices

1. **Governance information for Guidance document**

Care Home Prescription Management Guidance

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