

Guidance about medication personal plans, review, monitoring and record keeping in residential care services



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Medicines recording and personal/care plans

Purpose

Poor and ambiguous medication recording is a common issue identified by the Care Inspectorate during inspections or complaints activity. We have produced this guidance for Care Inspectorate staff and to help care service staff working in residential care services who record medication administration and develop personal plans.

This guidance gives common sense guidance on medication recording and personal plans. We also hope that organisations providing training in the safe handling and administration of medicines for care staff will find this guidance useful in developing their training programmes. The guidance also includes some observations about “times” on MAR records which we hope will be of interest to care services and healthcare professionals alike.

Care at home services

Care at home is where you receive a service in your own home. Traditionally, much home-based care has been provided by local authorities.

We recognise that some care at home services also use pre-printed MAR charts provided by the community pharmacy to record medicines administration. While there are a number of common areas where the guidance is transferable, generally there would have to be separate guidance for the care at home setting due to the various ways these services are provided in different Local Authority and NHS Board areas.

What is a medicine?

The Human Medicines Regulations 2012 defines a ‘medicinal product’ as:

“Any substance or combination of substances presented as having properties for treating or preventing disease in human beings;

Any substance or combination of substances which may be used in or administered to human beings either with a view to restoring, correcting or modifying physiological functions by exerting a pharmacological, immunological or metabolic action, or to making a medical diagnosis.”

National Care Standards

The National Care Standards (NCS) – Care Homes for Older People state:

“You are confident that the home keeps accurate, up-to-date records of all the medicines that have been ordered, taken or not taken, and disposed of” and “You are confident that staff will monitor your medication and the condition for which it has been prescribed. If there are any changes or concerns about the medication, including side effects, or your condition, they will seek your permission to get medical advice.”



Staff responsible for administering medicines in care services need to have more information than just a list of the medicines dispensed by the community pharmacy for the person in their care.



15885 "CONFIDENTIAL" AMS

Mrs Margaret Sinclair
Glasgow Tel: 0141 200 0000

Please give the Practice a minimum of 3 days notice prior to collecting your repeat drugs.
Prescription Line phone number: 0141 200 0000

There are 8 items on this re-order form 15/06/2012

1. Prednisolone 5mg gastro-resistant tablets
TAKE ONE TABLET(D) DAILY
Previous order dates: 23/03/2012, 16/06/2012, 13/06/2012.
2. Prednisolone 2.5mg gastro-resistant tablets
TAKE ONE TABLET(D) DAILY
Previous order dates: 11/04/2012, 03/06/2012, 11/06/2012.
3. Mirtazapine 30mg modified-release tablets
TAKE ONE TWICE DAILY
Previous order dates: 11/04/2012, 03/06/2012, 07/06/2012.
4. ADICAL 03 chewable tabs
TAKE ONE TWICE DAILY
Previous order dates: 11/04/2012, 03/06/2012, 07/06/2012.
5. Ranitidine 150mg capsules
TAKE ONE DAILY
Previous order dates: 11/04/2012, 03/06/2012, 07/06/2012.
6. Warfarin 3mg tablets
1 daily
Previous order dates: 11/04/2012, 16/06/2012, 11/06/2012.
7. Digoxin 250microgram tablets
1 MORN
Previous order dates: 11/04/2012, 03/06/2012, 07/06/2012.
8. Amloronic acid 75mg tablets
take one weekly (ON SUNDAY)
Previous order dates: 08/03/2012 13/06/2012 07/06/2012

It is vitally important that care staff understand the role of their community pharmacy service and the GPs who have patients living in the care service. There needs to be sound relationships between care services, GPs and pharmacists in ensuring best practice, good support and advice.

Pre-printed medicines administration recording (MAR) charts supplied by Community Pharmacists

Medication Administration Record	
Name: MARGARET SINCLAIR	DOB: 25/07/1934
Address: Mountain View Care Centre	Allergies: none known
GP: Dr B R Jackson, Main Street Health Centre	Start date: 4/7/2010 End Date: 31/7/2010
	Day/Week 1 Week 2 Week 3 Week 4
	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
Medication	Time Week 1 Week 2 Week 3 Week 4
28 Atenolol Tablets 50mg	b'fast
Take ONE in the morning	lunch
	tea
	bed
Qty per	by
Quantity: 28	Pac's: 1

Many care services use pre-printed MAR charts supplied by their community pharmacy.

However, we still regularly find poor recording during inspections and complaint investigations. Examples of poor recording practice have been published in:

"Remember, I'm still me" 2009

http://reports.mwscot.org.uk/Visiting_monitoring/RememberImStillMe/Remember_Still_me.aspx

"Handling Medicines in Social Care" 2007

www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf and

Care Inspectorate Health Guidance: Maintenance of Medication Records

www.scswis.com/index.php?option=com_docman&task=doc_details&gid=213&Itemid=720

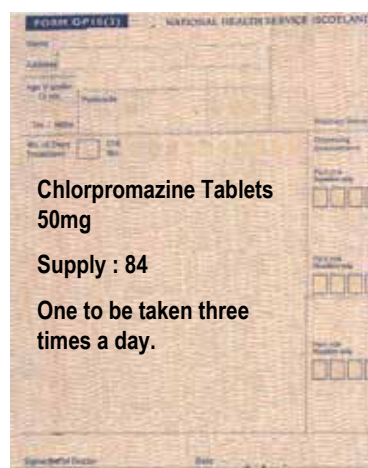
This guidance takes into account areas of concern that the Care Inspectorate, and the former Care Commission, has identified over the last 10 years of regulating care homes and other residential services.

The most common MAR chart used in care services is the type produced by community pharmacies which covers a 28 day period. This guidance explains how to use this type of chart to accurately record medication covering a 28 day period and includes

- recording any medication left over from the previous 28 day period
- recording all medicines received
- carrying forward to next record any medicines left at the end of the previous 28 day period
- recording all medicines administered
- recording all medicines not given including the reason why
- knowing who makes a change to the record, the date it was changed and the reason why.
- practice tips to support better understanding and joint working between care services, community pharmacies and GP practice.

The MAR chart is NOT a prescription sheet. It is a document used to record administration of medicines. **The NHS prescription or a written “direction” from the prescriber is the authority for care workers to administer medicines.**

Any document used to record administration of medicines to people who use care services should reflect the prescriber’s instructions. This is why care services should keep copies or scans of the original NHS prescriptions.



Any item supplied for a named patient on an NHS prescription is the property of that person and must not be used for someone else.

Timings on MAR Charts

When the community pharmacy dispenses medicines the label should include:

- the name of the product or its common name
- directions for use
- precautions relating to the use of the product.



So, if the instructions on the NHS prescription are “Take one three times a day” or “Take two at night” we would expect the instruction on the dispensing label and the narrative on the MAR chart to correspond with this instruction. This gives care staff the flexibility to administer the medicines at times and regular intervals to suit the person’s daily routine.

Commenced	05/12/2000	route	oral	med.
				7.30
			84 DIPHENHYDRAMINE tablets 100mg	10:00 1
			ONE to be taken THREE times daily	14:00 1
				18:00
				20:00 1
Dr Sig.		Carried forward		

Medicines administration, like other aspects of care should be provided in a person-centred way. A person prescribed Amoxicillin 250mg three times a day should be given this medication at regular intervals throughout the day when the person is awake. It is important that medicines are spaced as evenly as possible throughout the day to ensure maximum benefit. So if they wake up at 8am and go to bed about 11pm then it is preferable the antibiotic is given at around 8am, 4pm and just before bedtime rather than at 10.00; 14.00 and 18.00 because these are the times pre-printed on the MAR chart.

If the instruction on the NHS Prescription are "Take one at 2pm and one at 10pm" then we would expect the instruction on the dispensing label and narrative on the MAR chart to have these specific times. Care staff should administer these medicines at as close a time as possible to the time the prescriber has instructed. Such medicines would include treatments for Parkinson's disease, epilepsy or behavioural symptoms, and other medications linked to medication and food where the timing of administration is important to keep the person mobile, stable and symptom free as much as possible.

Some practice examples

A care home resident was prescribed Diazepam 2mg at 9am and 6pm and these times were printed on the MAR chart and the medicine was labelled with these instructions. The resident was asleep at 6pm so the medication was not given. The resident's relative asked for a dose to be given later in the evening and the staff member refused as it was prescribed to be given at 6pm.

If the Diazepam had been prescribed as "Take one twice a day" or "One in the morning and evening" the care worker could have given the second dose that evening.

A GP prescribed Chlorpromazine tabs 50mg – Take one three times a day. The community pharmacy labelled the medicine as "One to be taken at 10am; 2pm and 6pm" and this instruction was printed on the narrative of the MAR chart. So the dilemma for staff was whether or not this meant that they had to administer the Chlorpromazine at these set times, meaning that the resident got all three doses of the Chlorpromazine within an 8 hour period.

This resident's lifestyle was that he tended to get up mid morning but didn't go to bed till after midnight.

A GP prescribed Quetiapine as "One to be taken twice a day". The pharmacy labelled the medication with this instruction and the narrative on the MAR was the same. At the "time / dose" column on the MAR the pharmacy had indicated that the times of administration should be 9am and 9pm. During inspection we were trying to ascertain the reason the Quetiapine had been prescribed. We spoke to the community psychiatric nurse who explained the person's behaviour tended to manifest itself in the late afternoon so it should be given at 2pm and 6pm. This is the sort of information about the person's behaviour we should have found written in the resident's personal plan.

In another care home we found several medicines prescribed as “take one three times a day”. When the medicine was dispensed in an original pack, for example a liquid or dispersible tablet then both the dispensing label and the MAR chart narrative had the instruction “Take one three times a day”. So staff could give the medicine three times during the period when the person is awake.

However when the pharmacy dispensed the medicine in a MDS Blister pack then each of the three MDS packs were labelled differently – one labelled “take at 10am” ; next as “Take at 2pm” and last as “Take at 6pm”. The narrative on the MAR chart stated “Take one three times a day”. So the dilemma for staff here is does this mean they have to administer at these set times or give the three doses at regular intervals throughout the day when the person is awake?

A care home resident was prescribed Haloperidol twice a day and the MAR chart had the times 9am and 6pm printed on it. A member of staff gave a dose at 9am then realised there was no more stock. They arranged for a further supply and when this came in the staff member administered the 6pm dose and recorded it on the existing MAR chart. However when the new supply of Haloperidol came in, the pharmacy had sent another MAR chart with the times for administration as 9am and 9pm. The night shift then administered another dose of Haloperidol at 9pm based on the instruction on the new MAR chart.

A community pharmacist has told us of a heated discussion with a nurse in a care home who was refusing to administer warfarin at 8.00pm because the MAR sheet said 6.00pm but at 6pm the keys for the trolley had been missing!

Community Pharmacists need to consider their practice of printing set times on MAR charts and making the decision about what time doses should be given. The pharmacy staff are unlikely to know the routine of each of the residents in the care service so it is not appropriate for them to be specifying administration times on MAR charts unless the prescriber has stated specific times on the prescription or direction. Pharmacists should review with the care service the practice of medicines prescribed “daily” defaulting to a labelling instruction to give in the morning.

It may be more appropriate for the “time/dose” column in the MAR charts to identify time periods, for example:

- 8am to 9am; 12noon to 1pm; 4pm to 5pm; 8pm to 9pm; and leave any other times blank for staff to decide
- times printed as “morning”, “lunch”, “tea-time”, “bed-time” [or suitable abbreviations] and the care service decides what this means for each individual resident. For example
 - Morning means 8:30 to 10:00
 - Lunch means 13.30 to 14.00
 - Teatime means 18.00 to 19:30
 - Bedtime means 22:00 to 23:30.

The time bands can be individualised for each resident and the information kept alongside their medication records, beside their medication storage or within their personal plan.

When medicines are given out with these times, staff should record the actual time they do it using the reverse of the MAR or a supplementary document.

The care worker can then choose what the most appropriate times are for each of the person's medicines to ensure they are given regularly throughout the day when the person is awake. This allows flexibility to meet the needs of the individual and enables care staff to record this accurately. When making decisions about the best times to give individual residents their medicines to suit their daily routine it is always worth looking at the patient information leaflet for the advice the manufacturer gives about how to take the medication. This might include information that although prescribed as twice a day it should be taken at 12 hourly intervals.

How to use a MAR chart

Receipts

When a new MAR chart is received from the pharmacy it should have printed the quantity dispensed on that occasion. This is sometimes printed to the left of the name of the medicines [for example, 56 Adalat Retard tablets 10mg] or below the narrative in a "quantity box". When none of an item is supplied the quantity printed will be "0" and sometimes it says "none supplied this month".

The care worker checking in the items supplied by the pharmacy should record the **quantity they actually receive**, even though in most cases this will be the same as the quantity printed by the pharmacy. The care worker should also **sign/initial that they have received this amount** and ideally **record the date** they checked the medicines in.

Medication		Week 1							Week 2							Week 3							Week 4							
		Time	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
ZOPICLONE 3.75MG TABS																														
One to be taken at night																														
Medicines make you sleepy....																														
Not supplied this month																														
Qty f/w	15	by		DM																										
Quantity		Rec'd	0																											

None received	15 carried forward	2 doses administered	13 to be returned
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If there is some of an item left over from the previous month which is still prescribed and in date, then this quantity should be carried forward into the stock for the next month. **This will be items like "when required" painkillers; creams, ointments, needles, dressings and short-term acute medicines like antibiotics or medicines for diarrhoea or vomiting.**

Some MAR charts have a “carried forward” box to record this information, ‘if not, then the received box(es) can be used’

When someone is admitted to the care service and brings in medicines or a new item comes in mid-cycle, then the quantity received must also be recorded and dated.

Remember most MAR charts offer the facility to record additional information on the reverse. If the MAR charts that your care service uses do not have this, then you can develop a separate sheet to record the additional information for the period covered by the MAR chart.

Administration

The MAR chart should be primarily used to record administration of medicines. It also holds information about other items supplied by the community pharmacy. **There is no need to use the MAR to record that a needle has been used to inject insulin; a lancet and strip to check blood glucose; a volumatic device being attached to an inhaler or a leg bag changed.**

The care worker should record administration **once they have confirmed that the person has taken their medicine.** They should then initial the box on the MAR for the date and the most appropriate time band.

If the medicine has been refused or not given for a specific reason, then consider having a policy that staff record this with a different coloured pen, for example the service’s policy might be to use **red ink** so that it is easy to see when the dose was **not** given. Use the codes printed on the bottom of the MAR to explain the reason why it was not given and remember that the reverse of the MAR can be used to record full details.

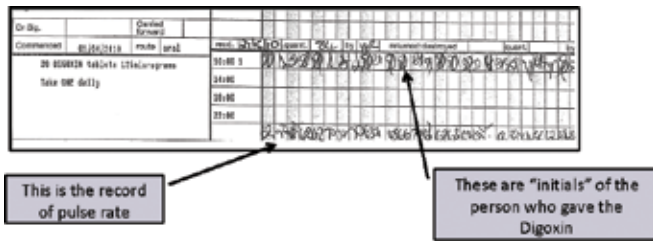
Medication	Time	Week 1						
		1	2	3	4	5	6	7
Chlorpromazine Tablets 50mg	10:00	S	S	S	S	S	S	S
	14:00	AR	AR	DM	DM	AR	DM	AR
Take on at 10am; 2pm and 6pm	18:00	AR	AR	DM	DM	AR	DM	AR
	22:00							
<i>Received 22/08/11</i>								

If a medication is prescribed as, for example “when required” or “when necessary” then **positively record**. So only record when you actually administer it. You don’t need to make a record when the person doesn’t take a “when required” or “when necessary” medicine. This is so that it is easy to look at the records and see when the person has needed to have this medication. If you want to record each time you offer someone a “when required” medicine develop a separate document and use the MAR chart to record the doses which are actually taken.

It is a good idea to ask the person if they want their medicines before you take them out of the pack. If a medicine is refused after it has been removed from the pack, spat out or dropped this should be recorded and disposed of according to the services procedures.

The NMC standards for administration of medicines expect nurses to administer or withhold a medication depending on the patient’s condition (for example, Digoxin not usually to be given if pulse below 60)

If your services policy is to check someone’s pulse before administering Digoxin then do NOT record this on the MAR chart – develop another type of record. The boxes on the MAR chart are too small to try to record the pulse.



If the prescriber’s instruction is “take one or two” or “take 5ml or 10ml” then use the reverse of the MAR or an extra sheet to record how much was given on each occasion. Do not try to squeeze your initials and the quantity given into the small box on the MAR chart. The boxes are not big enough and the records need to be easily read.

If your policy is to have two staff administering some medicines, for example Temazepam then only one staff member should use the MAR to record administration. The boxes on the MAR chart are too small for double signatures so we suggest you develop a separate sheet for the second person to record.

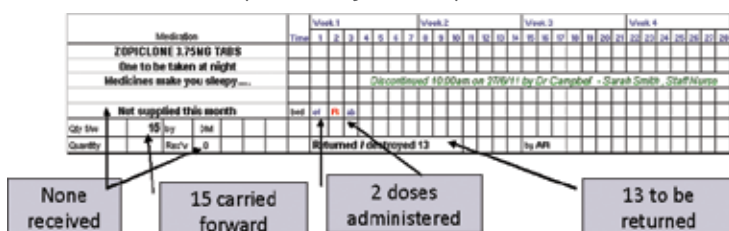
If there are double signatures within the CD register for administration of Schedule 2 Controlled Drugs then your policy does not need to be that there is also a double signature on the MAR record as well. It could just be the person who actually administered the medicine and not the witness who signs the MAR record.

Consider what items the MAR chart is not appropriate for, for example Warfarin; variable insulin; SIP feeds; dressings; depot injections; Hydroxycobalamin injection, emollients (skin moisturisers), and so on, and develop your own recording sheet. If you are using a separate recording sheet then annotate the entry on the MAR to let colleagues know to record the information elsewhere, for example “See Topical MAR record”; “See Warfarin record”.

Consider detailing the types of medicines not recorded on the MAR within your procedures documents along with examples of how to record these specific medicines.

Returns

At the end of the 28 day cycle use the MAR chart to record the quantity of any remaining items which can be carried forward to use for the next month if they are still prescribed and anything which has to be returned to the pharmacy for disposal.



Medicines are valuable and costly, even though most people do not have to buy their medicines or pay prescription charges, there is a cost to the NHS.

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 supplies.



When medicines are supplied dispensed into monitored dosage blister packs the shelf life is reduced to 8 weeks so it is not appropriate to have “when required” or rarely used medicines supplied in these packs. Do not ask the community pharmacy to supply these medicines in MDS packs.

Some medicines are not stable when taken out of their original packs, if your community pharmacy advises you that it is better not to re-dispense into MDS, please accept this.

We have also been given anecdotal information that some care services have been advised by their community pharmacy that they need to discard tubs of emollients/moisturisers, lotions, creams etc. every month and order new ones. Provided the product is still needed, is still within it’s expiry date and the manufacturers literature does not include anything about a short shelf-life when the product is opened there is no need to do this.

The situations when medicines might need to returned to the pharmacy include:

- **Surplus to requirements, for example** a person’s treatment is changed or discontinued – the remaining supplies of it should be disposed of safely (with the person’s consent).
- **Expired stock** - The medicine reaches its expiry date. Some medicine expiry dates are shortened when the product has been opened and is in use, for example, eye drops.
- **Deceased resident** – keep their medicines under lock and key within the service for at least 7 days in case there are any police investigations into the death.

Once the details of the items for disposal are recorded on the MAR, these medicines must be stored securely in a tamper proof container in a locked cupboard until they are collected by or taken to the pharmacy. Do not leave “returns” lying in an open box in the medication room.

The care service should keep a record of the name of the person they gave the tamper-proof box to. The record should also include the name of the staff member who handed over the box(es); who they gave them to, the date, time and the name of the pharmacy. This procedure applies to returns of any item supplied by the community pharmacy or items brought into the care service by residents, including SIP Feeds, dressings, lancets etc.

Handling medication changes

There will always be changes to medicines so the care service needs to have guidance for their staff about how to handle these situations. **You can make hand-written entries but these must always be dated, clearly written and identify who wrote the amendment, including their designation and also reference to the prescriber who authorised the change.** For example, that the dose of Furosemide was reduced from 80mg to 40mg in the morning by Dr Smith [GP] on dd/mm/yy.

Never make a change using a dispensing label supplied by the community pharmacy. Staff must be prepared to challenge any unclear or ambiguous changes made to medication records. This applies to changes made by other colleagues, doctors or pharmacists. If doctors or pharmacists are making changes to information on MAR charts then the service should have clear guidance for them to explain how these should be written which includes being able to identify who wrote the change. Do not accept Latin abbreviations like "PRN", "tid and get them to write the information in CAPITALS not joined up writing]

New medicine

New admissions – use a blank MAR chart and transcribe the information about the medicines from the dispensing label on each item. Where possible, the service should seek to corroborate the information on the dispensing label from another source eg. verbal feedback from relative, information from the community pharmacy, hospital discharge letter, copy of prescription, written authority from the GP.

Medication Administration Record																													
Name																D.O.B.													
Address																Allergies													
GP																Start date							End Date						
Medication		Dose/Day		Week 1					Week 2					Week 3					Week 4										
		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	
		Time	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
		by																											
		checked																											
		by																											
		checked																											

Make sure there is a record of the name of the person who transcribed the information and anyone who checked the transcription [TIP you can use the reverse of the MAR to do this]. 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.

Record the quantity you received for each item.

Mid-cycle item

Clearly transcribe the name of the medication and the instructions from the copy of the NHS Prescription and/or the dispensing label. **Do not use Latin abbreviations like "PRN", "tid".**
[TIP – write this information in CAPITALS not *joined up writing*]

Include the name of the person who did the transcribing, the date and make reference to prescription or written "direction". For example "Prescribed by Dr Smith, GP – see entry in professional visits/ personal plan dated dd/mm/yy".

If a further supply comes in, record the quantity.

Discontinued item

Draw a vertical line through any recording boxes left on the day the medicine is discontinued and then clearly transcribe the reason why it has been discontinued, for example "course complete", "see note over", "discontinued by Dr Jones, Geriatrician", "see entry in professional visits/ personal plan dated dd/mm/yy".

If the prescriber gives a verbal instruction to stop the item then ask them to back this up in writing or follow the services procedures for verbal instructions.

Ensure these entries are dated and identify the staff member who made the change. Record how much stock is left.

Change of dose

When there has been a change of dose (particularly if the dose is increased) it is likely that the prescriber will need to write a new prescription so that additional stock can be supplied. If the dose is decreased there might be sufficient stock. If the prescriber gives a verbal instruction to change the dose then ask them to back this up in writing. If the dose is decreased ask for a written direction to do this.

Discontinue the entry as described above and also reference to "see new record".

CHLORPROMAZINE 25MG TABS ONE to be taken when required for agitation WARNING THIS MEDICINE MAY MAKE YOU FEEL SLEEPY. IF THIS HAPPENS, DO NOT DRIVE OR USE TOOLS OR LJ AX	M	1000	1	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	
	N	1400																						
	T	1800																						
	B	2200																						

Should have been discontinued and a new entry made when changed from 'when required'

Create a new instruction on a blank space on the MAR as you would do for a new medicine. Carry forward the quantity of stock from the discontinued entry if it can be used and any new stock which is received.

Change of times or frequency of administration

Discontinue the original instruction and write a new one. Do **not** score out or change a time on the original entry and continue using it. If the original prescription says "One three times a day" and the person now wants to go to bed earlier than they used to, then you can bring the dose forward a bit to fit in their new routine. The GP would not necessarily have to be involved in this decision if the original prescription doesn't have a specific time on it. We would not expect to see lots of entries at 22:00 recorded as "not taken" because the person was asleep. The time of administration should have been brought forward.

If the frequency is being changed then ask the prescriber to confirm this in writing or follow the services procedure for verbal instructions.

Change to "When required" or for regular administration

Discontinue the original instruction and write a new one. Do **not** score out or change a time on the original entry and continue using the same record. Do not write "PRN" or "when required" on the original.

Ask the prescriber to confirm this in writing or follow the services procedure for verbal instructions.

Instructions on dispensing labels

The MAR chart is the document which will be kept for a period of time as the record of what medication has been given. These records may be needed as evidence in any scrutiny inspection, complaint investigation or legal proceedings. 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.

This might be because the dose was originally to "Take two in the morning" and it has now been changed to "Take one in the morning". As the dose was reduced there is sufficient supply for the person so there is no need to get another prescription dispensed. There is no need to get the medicine re-labelled to reflect the new dosage instructions if the MAR chart explains the reason for the change. Once the medicine is finished the pack with the dispensing label which says the "Take two in the morning" will likely end up in the bin and the MAR chart is the piece of paper kept for legal reasons.

Reviewing MAR charts

The care service needs to have a system in place to ensure that all medications kept for the use of service users or administered are currently prescribed.

When an item is discontinued, the pharmacy must be notified so that the item is not printed on the next 28 day MAR chart. On a monthly basis the MAR charts need to be reviewed to check if creams, ointments, dressings are still being used for the condition they were prescribed for. If no longer

used, the pharmacy should be asked to remove the item from the MAR chart and any remaining stock returned to the pharmacy for disposal. The personal plan should be checked for duration of treatments to ensure that medicines are not continued inappropriately.

Staff should not be administering a medicine just because it is still on the MAR and the care service has kept the remaining stock. Examples of this would be:

- a box of 12 Microlax Enema's to treat an acute impaction in April 2011 being kept "just in case" It happens again
- topical steroid creams/ointments prescribed for a skin condition kept "just in case"
- medicated dressings kept once the wound has healed
- remainder of a supply of Loperamide for a bout of diarrhoea kept on the MAR and in stock "just in case".

The MAR charts need to be checked for duplicate and discontinued items when they come from the pharmacy at the beginning of a cycle.

Examples of what to look for here would be:
Tiotropium inhalation powder capsule with device 18 micrograms
and,
Tiotropium inhalation powder capsule (refill) 18 micrograms

We found 20 months of MAR charts for a person which had both these items printed on them. Some months staff recorded administration against both entries although it was clearly the same medication.

Reviewing medication

A medication review has been described as “a structured critical examination of a patient’s medicine to reach agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste”.

“Room for Review” A guide to medication review published in 2002 describes three types of medication review:

Level 1 – Prescription reviews normally take place without access to the patient’s clinical notes and do not usually include a review of the full repeat prescription. The patient may be present, but not always.

Level 2 – Treatment reviews normally take place under the direction of a doctor, nurse or pharmacist, but often without the patient – for instance, removal of unwanted items from the repeat medicines list, and dose adjustments. This may arise from a review of patients with a particular condition such as asthma or taking a group of drugs such as proton pump inhibitors. The review may include the complete repeat prescription or focus on one therapeutic area (eg hypertension), drug (eg lithium) or group of drugs (eg NSAIDs). Recommendations may be passed to the prescriber for implementation.

Level 3 – Clinical medication reviews require access to the patient’s notes, full record of prescriptions and non-drug care and results from laboratory tests etc. The review should include the complete repeat prescription as well as over-the-counter and complementary remedies. In clinical medication reviews, medicines would not be examined in isolation but considered depending on the patient’s condition and the way they live their lives. Clinical medication review should therefore involve the patient as a full partner. This means listening to the patient’s views and beliefs about their medicines, reaching an honest understanding of their medicine taking behaviour, and taking full account of their preferences in any decisions about treatment.

When care staff are responsible for managing a residents medication we would expect them to input into these reviews.

In terms of general repeat prescription house-keeping, care staff need to make sure the GP practice is aware when medicines are no longer needed. Examples would be to let the GP know that a skin condition has cleared up so the Daktacort prescribed is no longer needed.

Care staff need to keep the GP informed about any residents who are refusing to take their medication.

The National Care Standards expect care staff to monitor medication and the condition for which it has been prescribed. In a level 3 review care staff have an important role in ensuring that the GP is made aware of any concerns, side effects etc. The care staff should record details of when the review took place, the people involved and the outcomes.

The resident's list of regular repeat prescriptions and items on the MAR chart should be kept as short as possible. The repeat prescription list should only contain those medications which are taken on a regular daily basis and those "as required" medications which are needed on a frequent basis. Information about medicines on repeat prescriptions can be found on the tear off section of the NHS GP10 prescription

"As required" medications which are needed infrequently should not be included on the repeat prescription list, nor should short term items like topical steroids, medicated dressings, antibiotics, or items which are only needed every few months, e.g. depot medications or hydroxocobalamin. However, it is important that the care home records when items such as hydroxocobalamin are due to be given again in order that these items are not overlooked.



Care and support of people who have dementia

The Dementia Standards published by the Scottish Government in June 2011 say that NHS Boards will ensure that when psychoactive medication (including anti-depressants and tranquillisers) and in particular antipsychotic medication is prescribed for people with dementia, the prescribing doctor will need to be satisfied that there is a clear benefit for the person with dementia and there is no reasonable alternative.

The doctor will set a date to review its continued use and put in place a plan to ensure that carers and staff are aware of any potential side effects and where to report any concerns they have.

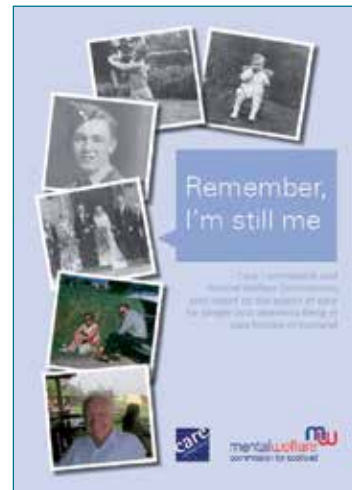
There is a commitment to achieve improvements in the early diagnosis and management of people with dementia. This is supported by physical and mental health reviews every 15 months along with an assessment of carer's needs which includes an appraisal of the impact of caring on the care giver.



Care staff need to be aware of the information the prescribing doctor includes in the plan and incorporate this information into the residents personal plan.

In “Remember, I’m Still me” 2009, medicines used to treat people with dementia were defined as:

1. Medicines used to treat symptoms such as poor memory, not being able to concentrate well, and difficulty in going about daily living. These can improve mental function for some people. We refer to these as “cognitive enhancers”.
2. Medicines used to treat behavioural symptoms, like agitation, verbal and physical aggression, wandering and not sleeping. We refer to these as “**psychoactive**” medicines.



Five types of psychoactive medicines are commonly used to treat these behavioural symptoms:

- **antipsychotic** (also called neuroleptic) medicines used to treat symptoms such as agitation, delusions or hallucinations
- **antidepressant** medicines used to treat depression
- **anxiolytic or tranquiliser** medicines used to relieve anxiety and reduce tension and irritability
- **anticonvulsant** medicines used to prevent fits and seizures or to calm mood
- **hypnotic** medicines used to help people get to sleep at bedtime.

Many of these medicines have side effects which can make a person sleepy, confused, lack co-ordination, develop a tremor or become agitated.

A list of commonly used “psychoactive” and “cognitive enhancer” medicines found during the inspections which resulted in the publication of “Remember, I’m Still me” can be found in Annex A.

Personal plans

Care home staff who administer medicines need to have access to adequate information to allow them to monitor resident’s medication and the condition it has been prescribed for. This might include when a medicine is started, who prescribed it, what it is for, where it has to be applied (ointment, eye drops etc), how long it has to be used for, when it should be **reviewed**, any tests or monitoring needed or if an accompanying behavioural monitoring charts, pain assessment chart etc. is needed.

This information should be included in the personal plan. A personal plan is created for each long term condition and includes any medication prescribed. When a medicine is prescribed for short-term [acute] use then a short-term/ acute plan would be drawn up, for example for a chest infection.

These plans also need to be updated when a change is made to any medication.

The timing of administration relating to the needs of the individual resident and the way the medicine is best given should be considered in the plan. This would include advice taken from the prescriber, specialist or pharmacist. The plan can also be used to evaluate the usefulness of the medication, for example medicines prescribed for insomnia or behavioural problems.

Personal plans for conditions like Type 1 Diabetes would include the frequency of blood monitoring, the type of needles, lancets, blood strips etc. used.

Monitoring of medication would include things like:

- the frequency of measurement of blood pressure for anti-hypertensive drugs; measurement of pulse for Digoxin;



- how often are bloods checked for lithium or warfarin;
- evaluation of behaviour when psychoactive medicines are prescribed including information about review dates and monitoring of adverse effects,
- assessment of pain for analgesics.

The personal plans should record when a depot or vitamin injection is due, when it is administered and the bit of body where the injection is given. The personal plans can also record when a catheter should be replaced; how often medicinal patches should be checked, where applied and when changed.

Entries in, for example, personal plans or progress notes like "give medicines as per kardex"; "antibiotics prescribed", "discontinued by GP" and so on, are not appropriate. Accurate information with the name and designation of prescriber and name of medicine must be kept.

The personal plan should clarify for each medicine what "when required" means, for example: "Take three times a day when required". This means when the condition needs to be treated that the medication should be taken three times a day.

Examples:

- a flair up of athlete's foot means the antifungal cream should be applied at the frequency prescribed for several days till it clears up
- when Lactulose is prescribed as "when required" this means that it has to be given at the frequency prescribed for several days to be effective
- "Take one when required up to three times a day". This means one can be taken whenever at recommended intervals but not more than three times in 24 hours.

The advice in the patient information leaflet (PIL) supplied when the medicine is dispensed by the pharmacy/GP dispensing practice is helpful when developing personal plans.



Tissue Viability

Information about tissue viability personal plans and recording dressings and sundries can be found at www.scswis.com/index.php?option=com_docman&task=doc_details&gid=708&Itemid=720

Controlled Drugs

Information relating to controlled drugs including recording can be found in

“A guide to good practice in the management of controlled drugs in primary care - Scotland 2012”

<http://tinyurl.com/8t93xwo>

Conclusion

This guidance provides the perfect opportunity for care services to review their medication policies and procedures to ensure they cover all legal requirements and best practice relating to medication recording, reviews, monitoring and personal planning.

We feel the information within the guidance is a useful starting block to open up dialogue between care services, their supplying pharmacy, GP's, relatives and carer and training organisations to improve the quality of medicines management within the service. This should be part of a joint commitment to improving quality and care.

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Annex A: Psychoactive medicines

Medicines (generic name)	Class of Medicine
Amisulpride	Antipsychotic
Amitriptyline	Antidepressant
Aripiprazole	Antipsychotic
Benperidol	Antipsychotic
Carbamazepine	Anticonvulsant
Chlordiazepoxide	Anxiolytic
Chlorpromazine	Antipsychotic
Citalopram	Antidepressant
Clobazam	Anticonvulsant
Clomethiazole	Hypnotic
Clonazepam	Anticonvulsant
Clonipramine	Antidepressant
Diazepam	Anxiolytic
Donepezil (Aricept)	Cognitive Enhancer
Dosulepin	Antidepressant
Doxepin	Antidepressant
Escitalopram	Antidepressant
Fluoxetine	Antidepressant
Flupenthixol	Antipsychotic
Fluphenazine Decanoate	Antipsychotic
Fluvoxamine	Antidepressant
Galantamine (Reminyl)	Cognitive Enhancer
Haloperidol	Antipsychotic
Lithium	Antidepressant
Lofepramine	Antidepressant
Lorazepam	Anxiolytic
Lormetazepam	Hypnotic
Memantine (Ebixa)	Cognitive Enhancer
Mirtazapine	Antidepressant
Nitrazepam	Hypnotic
Nortriptyline	Antidepressant
Oxazepam	Anxiolytic
Paroxetine	Antidepressant
Pericyazine	Antipsychotic
Phenobarbitone	Anticonvulsant
Phenytoin	Anticonvulsant
Primidone	Anticonvulsant
Promazine	Antipsychotic
Quetiapine	Antipsychotic
Risperidone	Antipsychotic
Rivastigmine (Exelon)	Cognitive Enhancer

Medicines (generic name)	Class of Medicine
Sertaline	Antidepressant
Sodium Valproate	Anticonvulsant
Sulpiride	Antipsychotic
Temazepam	Hypnotic
Trazodone	Antidepressant
Trifluoperazine	Antipsychotic
Valproic Acid	Antidepressant
Venlafaxine	Antidepressant
Zolpidem	Hypnotic
Zopiclone	Hypnotic
Zuclopenthixol Acetate	Antipsychotic
Zuclopenthixol Decanoate	Antipsychotic
Zuclopenthixol Dihydrochloride	Antipsychotic

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অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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