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PrescQIPP
Community Interest Company

Care homes - Implementing NICE guidance and encouraging best practice

There is no single model for effective implementation of the National Institute for Health and Care Excellence (NICE) guidance in care homes. Putting NICE guidance into practice and using the NICE quality standards to drive improvements in quality has the potential to benefit the residents. Care homes can also use the implementation NICE guidance and NICE quality standards to support them in meeting requirements as set out in the Care Act and to demonstrate that they meet regulatory requirements as set out by Care Quality Commission (CQC).

A number of evidence-based guidelines exist to help care homes provide appropriate care to residents and there is a need to identify ways to incorporate evidence into practice. This document highlights some key NICE guidance relevant to the care home setting and ways of implementing their recommendations.

General principles for implementing guidance

- Have a system in place for keeping abreast of guidance that has been published, this may involve signing up to weekly or monthly updates (both internal and external).
- Assess the relevance of the published guidance, liaise with your quality team on the action plan for dissemination and implementation.
- Raise awareness amongst staff, via team meetings, newsletter etc.
- Discuss with staff how recommendations fit with current practice.
- Audit current practice against guideline recommendations; baseline assessment tools are sometimes provided to facilitate this or you may use those developed by your organisation (CCG/commissioner/ care home).
- Report findings to the care team and develop an action plan. Remember to identify any key partners to support implementation for example the GP, community pharmacist, social services or local Clinical Commissioning Group (CCG) medicines management team and engage them in the process. It would be useful to maintain a list of key contacts for each stakeholder group.
- If training and education has been identified as part of the action plan remember to:
- Ensure all staff are available for training sessions, particularly those working night shifts.
- Ensure that staff competency is assessed and maintained.
- Ensure that training is documented and updated.
- Identify whether care home staff are able to implement training, with no barriers.

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Managing medicines in care homes (SC1)

https://www.nice.org.uk/guidance/sc1/resources/managing-medicines-in-care-homes-61677133765

The guideline considers all aspects of managing medicines in care homes and recommends that all care home providers have a care home medicines policy. The policy should ensure that processes are in place for safe and effective use of medicines in the care home.

Resources		
Resources available with NICE SC1	• Baseline assessment tool • Checklist for care home medicine policy	https://www.nice.org.uk/guidance/sc1/resources
NICE Quality Standards QS85	See statements 1,2,3,5 and 6	https://www.nice.org.uk/guidance/qs85
Relevant PrescQIPP bulletins	• Covert administration • Homely remedies • Reducing waste in care homes • Medicine reconciliation • Controlled drugs • Use of when required medication • Medication review	All available on the care homes webkit https://www.prescqipp.info/carehomes

Managing medicines in care homes (SC1)		
Key areas		**Strategies and potential challenges**
1	Person-centred care - particularly important when considering safeguarding and mental capacity issues; the following issues are considered in the guideline in relation to medicines: • Care home residents and health professionals (for care under the NHS) have rights and responsibilities as set out in the NHS Constitution for England, and NICE guidelines are written to reflect these. Treatment and care should take into account individual needs and preferences. • Care home residents should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals and social care practitioners. • If someone does not have capacity to make decisions, health professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.	• With regards to person-centred care ensure adherence to the mental capacity act. • Ensure medicine management audits includes that of MAR charts, controlled drugs and the storage of medication.

<table>
<tr><th colspan="2">Managing medicines in care homes (SC1)</th><th></th></tr>
<tr><th colspan="2">Key areas</th><th>Strategies and potential challenges</th></tr>
<tr><td>2</td><td>There are 17 areas covered by the recommendations:
• Developing and reviewing policies for safe and effective use of medicines.
• Supporting residents to make informed decisions and recording these decisions.
• Sharing information about resident's medicines.
• Ensuring records are kept up to date
• Identifying, reporting and reviewing medicines - related problems.
• Keeping residents safe (safeguarding).
• Accurately listing a resident's medicines (medicines reconciliation).
• Reviewing medicines.
• Prescribing medicines.
• Ordering medicines.
• Dispensing and supplying medicines
• Receiving, storing and disposing of medicines.
• Helping residents to look after and take medicines themselves (self – administration).
• Care home staff administering medicines to residents.
• Care home staff giving medicines to residents without their knowledge (covert administration).
• Care home staff giving products non –prescription and over the counter products to residents (homely remedies).
• Training and skills (competency) of care home staff.</td><td>Consider
• How the recommendations link to the CQC guidance for providers on meeting the fundamental standards. http://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf
• If you support residents to make informed decisions.
• How you ensure the confidentiality of the resident.
• How you currently engage with the GPs that look after your residents and how the medication review process is undertaken. Encourage them to nominate a professional responsible for medication reviews. See recommendation 1.8.4.
Do you
• Assume residents cannot administer their medicines themselves?
• Supply medicines for each resident based on the resident's health and care needs with the aim of maintaining the resident's independence wherever possible?</td></tr>
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Medicines optimisation: The safe and effective use of medicines to enable the best possible outcomes (NG5)

https://www.nice.org.uk/guidance/ng5

Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines. Medicines optimisation applies to people who may or may not take their medicines effectively.

Resources		
Resources available with NG5	Baseline assessment tool	https://www.nice.org.uk/guidance/ng5/resources
NICE Quality Standards QS120	See statements 1,2,3 and 6	https://www.nice.org.uk/guidance/qs120
National Care Forum	My medicines my choices	http://www.nationalcareforum.org.uk/medsafetyresources.asp
NICE CG76	Medicines Adherence resources information sheet	https://www.nice.org.uk/guidance/cg76/resources
Relevant PrescQIPP bulletins	• Medicine reconciliation. • Medication review. • Transfer of care. • Supporting self-administration of medication in the care home setting.	https://www.prescqipp.info/carehomes

<table>
<tr><th colspan="3">Medicines optimisation: The safe and effective use of medicines to enable the best possible outcomes (NG5)</th></tr>
<tr><th colspan="2">Key areas</th><th>Strategies and potential challenges</th></tr>
<tr><td>1</td><td>Having systems for identifying, reporting and learning from medicine related patient safety incidents.
• Reduce preventable medicine related patient safety incidents by reviewing your systems and processes. (See section above on managing medicines).</td><td rowspan="3">• Engage with professionals across health and social care to ensure residents are reviewed periodically including their medicines.
• Encourage residents to be involved in decisions about their medicines. When the resident first comes into the care home get an understanding of their knowledge, beliefs and concerns about medicines.
Consider whether
• Complete and accurate information about their medicines is available in a format they can understand.
• Additional support for people who need it is available.
•</td></tr>
<tr><td>2</td><td>Having effective communication systems about residents' medicines especially as they move across care settings.
• Sharing information about the resident's medicine in a secure and timely manner.
• Target risky times when medicines related problems are most likely to occur ,e.g. medicines reconciliation, medication review and post hospital discharge.</td></tr>
<tr><td>3</td><td>Accurately listing residents' medicines - medicines reconciliation.</td></tr>
</table>

Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence (CG76)

https://www.nice.org.uk/guidance/cg76

Applying this approach in practice requires a patient – centred approach that encourages informed adherence.

The guideline makes recommendations about how healthcare professionals can help patients to make informed decisions. The patient has the right to decide who should be involved in their care. With the patient's consent, carers should have access to appropriate levels of information and support.

Resources		
National Care Forum	My medicines my choices	http://www.nationalcareforum.org.uk/medsafetyresources.asp
NICE CG76	Medicines Adherence resources information sheet	https://www.nice.org.uk/guidance/cg76/resources
Relevant PrescQIPP bulletins	• Medicine reconciliation • Medication review • Transfer of care. • Supporting self-administration of medication in the care home setting	https://www.prescqipp.info/carehomes

Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence (CG76)		
Key areas		**Strategies and potential challenges**
1	Ensure the resident is involved in decisions about medicines. Information should be accessible and understandable.	• Involving residents in decision making, effective ways of communicating with residents include the use of pictures, symbols, large print, having information available in different languages, the use of an Interpreter or patient advocate. • Adherence should be assessed routinely in a non-judgemental way. Residents may need support in order to make effective use of their medicines. **Consider whether** • Interventions are tailored addressing the needs of the individual and any concerns they may have. • You are able to identify and address residents' concerns about medicines. • Additional support for people who need it is available such as written information or opportunities to discuss practical changes, e.g. the type of medicine or the regimen •
2	There should be adherence support, but there should also be the understanding that residents do not always take their medicines exactly as prescribed.	
3	Resident's medicines should be reviewed periodically.	
4	There should be an effective system of communication between the care home and healthcare professionals involved in the prescribing, dispensing and reviewing of medicines, especially when difficulties with adherence are observed	

Drug allergy: diagnosis and management (CG183)

https://www.nice.org.uk/guidance/cg183

All drugs can cause side effects (or 'adverse drug reactions'). The NICE guideline covers drug allergies, an allergic reaction caused by the person's immune system.

People can be allergic to any drug, those bought over the counter and those prescribed. They can have an allergic reaction to a drug even if they have taken the drug before. The reaction can occur within minutes of taking the drug or it may take days or weeks for symptoms to appear. The guideline highlights that a lack of clinical documentation of drug allergy and a lack of patient information as major issues.

Resources		
Resources available with NICE CG183	Baseline assessment tool - See relevant section on documenting and sharing information with other healthcare professionals	https://www.nice.org.uk/guidance/cg183/resources
NICE Quality Standards QS97	See statements 1,2,4 and 5	https://www.nice.org.uk/guidance/qs97

Drug allergy: diagnosis and management (CG183)		
Key areas		Strategies and potential challenges
1	The accurate documentation and sharing of information with healthcare professionals and other care settings is vital.	• Drug allergy status should be recorded as follows – drug allergy, no known drug allergy, unable to ascertain (make sure to document it as soon as the information is available). This section on the MAR chart should not be left blank. • Records should be maintained documenting any new suspected drug allergic reactions. • Drug allergy information should be shared where appropriate to do so. • It is important to check the resident's allergy status before any drug is administered. **Consider** • How to record this information. When a resident transfers into a care home in addition to recording the resident's current medication it is also best practice to record any known allergies. This would include reactions to medicines or individual ingredients in medicines. It is also important to record the type of reaction experienced if known. The gathering of information on allergies should involve the resident, carer, GP practice and community pharmacy. Information may also be given via hospital discharge letters or transfer information from other care homes or intermediate care providers. • How you will ensure all the information is shared with relevant healthcare professionals and is kept up to date? Having up to date allergy information on MAR charts is a safety check for care home staff when administering medication to a resident. Checking for residents' allergies is also an important safety check at the point of prescribing and dispensing of new and existing medication for a resident.

Nutrition support for adults: oral nutrition, enteral tube feeding and parental nutrition (CG32)

https://www.nice.org.uk/guidance/cg32

NICE defines malnutrition as: "A state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function (including social and psychological) and clinical outcome." (NICE, 2012)

Resources		
BAPEN	E-learning tool on nutritional screening in care homes (a fee is payable)	http://www.bapen.org.uk/e-learning-portal/nutritional-screening-using-must/virtual-learning-environment
NICE Quality Standards QS24	See statements 1,2,3, 4 and 5	https://www.nice.org.uk/guidance/qs24
PrescQIPP bulletin	Fabulous fortified feasts	https://www.prescqipp.info/resources/send/67-nutrition-toolkit/529-fabulous-fortified-feasts-hd

<table>
<tr><th colspan="3">Nutrition support for adults: oral nutrition, enteral tube feeding and parental nutrition (CG32)</th></tr>
<tr><th colspan="2">Key areas</th><th>Strategies and potential challenges</th></tr>
<tr><td>1</td><td>Screening for malnutrition and the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training.</td><td rowspan="2">• An appropriate screening tool such as Malnutrition Universal Screening Tool (MUST) should be identified and used.
• Residents should be screened on admission and nutritional management plans should be implemented including monthly screening for all residents and food fortification strategies for residents at medium and high risk according to 'MUST'.
• There should be a system for referrals to a Dietitian, in accordance with local guidance, (usually if no improvement was seen in a resident after 4-6 weeks).
• Food fortification training should be made available to kitchen staff and should also involve carers learning how to recognise and monitor residents for signs of malnutrition.
• Interventions to improve nutritional status should include reviewing mealtime ambience and providing assistance to residents who may have difficulty feeding themselves.
• For each resident that is identified to be malnourished or at risk of malnutrition the overall aim/goal of treatment should be identified and documented as well as a monitoring plan.
Consider
• For residents with dysphagia, the perceived palatability and appearance of food or drink as well as the risks and benefits of modified oral nutrition support.
• The role of the multidisciplinary team in residents whose condition it may be more difficult to manage such as those with enteral feeding tubes.</td></tr>
<tr><td>2</td><td>Nutrition support should be considered in people who are malnourished as defined by any of the following:
Body mass index (BMI) of less than 18.5kgm² .
Unintentional weight loss greater than 10% within the last 3–6 months.
Body mass index (BMI) of less than 20 kgm² and unintentional weight loss greater than 5% within the last 3–6 months.
and those at risk of malnutrition as:
• Eaten little or nothing for more than 5 days and or are likely to eat little or nothing for 5 days or longer
• A poor absorptive capacity and/or high nutrient losses and increased nutritional needs from causes such as catabolism, gastro–intestinal disorders, cancer.</td></tr>
</table>

Pressure ulcers: prevention and management of pressure ulcers (CG179)

https://www.nice.org.uk/guidance/cg179

Pressure ulcers are often preventable, the guideline provides recommendations for their prevention which focuses identification and risk assessment.

Resources		
CG179	Baseline assessment tool	https://www.nice.org.uk/guidance/cg179/resources
NICE Quality Standards QS89	See statements 1,3,4, 5,6,7 and 8	https://www.nice.org.uk/guidance/qs89

<table>
<tr><th colspan="3">Pressure ulcers: prevention and management of pressure ulcers (CG179)</th></tr>
<tr><th colspan="2">Key areas</th><th>Strategies and potential challenges</th></tr>
<tr><td>1</td><td>Risk assessment</td><td rowspan="6">• Ensure care home staff are aware of how to risk assess residents and the importance of appropriate categorisation, in order to support management and referral where appropriate.
• Skin assessment should be conducted by an appropriately trained healthcare professional.
• Individualised care plans which reflect the needs of the resident should be developed and implemented.
• Identify the local referral process and follow up with the tissue viability team where necessary.
• Liaise with the prescriber and pharmacy to ensure there are clear directions on prescriptions in order to optimise use, as different preparations can vary on frequency and amount applied.
• Ensure staff are aware of the importance of nutrition and hydration.
• Do staff know who to contact for further information and action?
Consider whether
• Staff actively encourage residents who have been assessed to be at risk, to change their position frequently and at least every 6 hours. Are sufficient staff available to reposition residents who are unable to do this themselves?
• High specification mattresses are available for those at high risk.
• Training covers risk and skin assessment as well as steps to prevent new or further pressure damage.</td></tr>
<tr><td>2</td><td>Skin assessment</td></tr>
<tr><td>3</td><td>Care planning</td></tr>
<tr><td>4</td><td>Repositioning</td></tr>
<tr><td>5</td><td>Devices for prevention of pressure ulcers</td></tr>
<tr><td>6</td><td>Training and education</td></tr>
</table>

Falls in older people: Assessing risk and prevention (CG161)

https://www.nice.org.uk/guidance/cg161

The guideline recommends that older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.

A multifactorial falls risk assessment should be conducted, this may include; cognitive impairment, continence problems, falls history, including causes and consequences (such as injury and fear of falling), footwear that is unsuitable or missing, health problems that may increase their risk of falling, medication, postural instability, mobility problems and/or balance problems, syncope syndrome and visual impairment. This assessment should be part of an individualised, multifactorial intervention.

Resources		
NICE Quality Standards QS86	See statements 4 and 5	https://www.nice.org.uk/guidance/qs86
PrescQIPP resources	Medication and falls	https://www.prescqipp.info/carehomes

Falls in older people: Assessing risk and prevention (CG161)		
Key areas		**Strategies and potential challenges**
1	Preventing falls in older people • All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention. • Falls assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.	• Check the resident's falls history on admission to the care home. • Conduct a falls assessment for all residents and review periodically. • Ensure medication review (with modification or withdrawal) is part of the assessment. • Check environmental factors such as lighting, the height of chairs, access to hand rails and positioning of furniture within the care home. • Consider the resident's risk of fragility fractures and liaise with their GP accordingly. This may mean the addition or cessation of bone protection therapy.

Dementia: supporting people with dementia and their carers in health and social care (CG42)

https://www.nice.org.uk/guidance/cg42

This guideline makes recommendations for the identification, treatment and care of people with dementia and the support of carers. It highlights three issues, namely:

- Wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers.
- Good communication between care providers and people with dementia and their families and carers is essential, so that people with dementia receive the information and support they require.
- If a person has dementia this doesn't mean they don't have capacity to make decisions. Treatment and care should take into account patients' needs and preferences. People with dementia should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, (having conducted an assessment) healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act.

Resources		
Alzheimer's Society and Royal College of Nursing	'This is me' – A tool developed for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.	https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf
PrescQIPP resources	• Reducing antipsychotics in dementia • Supporting self-administration of medication in the care home setting • Covert administration	https://www.prescqipp.info/carehomes

Dementia: supporting people with dementia and their carers in health and social care (CG42)	
Key areas	
1	**Non-discrimination** People with dementia should not be excluded from any services because of their diagnosis, age (whether designated too young or too old) or coexisting learning disabilities.
2	**Valid consent** Health and social care professionals should always seek valid consent from people with dementia. This should entail informing the person of options, and checking that he or she understands, that there is no coercion and that he or she continues to consent over time. If the person lacks the capacity to make a decision, the provisions of the Mental Capacity Act 2005 must be followed.
3	**Coordination and integration of health and social care** Health and social care managers should coordinate and integrate working across all agencies involved in the treatment and care of people with dementia. This should involve: a combined care plan agreed by health and social services that takes into account the changing needs of the person with dementia and his or her carers, assignment of named health and/or social care staff to operate the care plan, endorsement of the care plan by the person with dementia and/or carers, formal reviews of the care plan at a frequency agreed between professionals involved and the person with dementia and/or carers and recorded in the notes diagnosis.

Dementia: supporting people with dementia and their carers in health and social care (CG42)	
Key areas	
4	**Behaviour that challenges** • People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour. Individually tailored care plans that help carers and staff address the behaviour that challenges should be developed, recorded in the notes and reviewed regularly. The frequency of the review should be agreed by the carers and staff involved and written in the notes.
5	**Training** • All staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities.

Dementia: supporting people with dementia and their carers in health and social care (CG42)

Strategies and potential challenges

- Care home staff should treat people with dementia with respect at all times.
- Identify the specific needs of people with dementia arising from diversity, including gender, ethnicity, age (younger or older), religion and personal care. Record them in the care plans and address these needs.
- Identify the specific needs of people with dementia arising from ill health, physical disability, sensory impairment, communication difficulties, problems with nutrition, poor oral health and learning disabilities. Care plans should record and address these needs.
- Identify and, wherever possible, accommodate the preferences of people with dementia, including diet, sexuality and religion. Care plans should record and address these preferences.
- Ensure care staff supporting people with dementia receive information and training about, and abide by, the local multi-agency policy on adult protection. People with dementia are vulnerable to abuse and neglect.
- Aim to promote and maintain the independence, including mobility, of people with dementia. Care plans should address activities of daily living (ADLs) that maximise independent activity, enhance function, adapt and develop skills, and minimise the need for support. When writing care plans, the varying needs of people with different types of dementia should be addressed.
- Care home staff who care for people with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others.

Consider

- How residents may access non –pharmacological interventions to manage behaviour that challenges such as aromatherapy, multisensory stimulation, therapeutic use of music and/or dancing, animal-assisted therapy and massage.
- Care home staff should be trained in dementia awareness.

Older people with social care needs and multiple long term conditions (NG22)

https://www.nice.org.uk/guidance/ng22

Resources

PrescQIPP resources	Supporting self-administration of medication in the care home setting	https://www.prescqipp.info/carehomes

Older people with social care needs and multiple long term conditions (NG22)		
Key areas		**Strategies and potential challenges**
1	• Ensure a person-centred assessment is undertaken, focused on ensuring the resident has choice and control over their care and support.	• Ensure that care plans enable older people with social care needs and multiple long-term conditions to participate in different aspects of daily life, as appropriate, including: self-care, taking medicines, hobbies and interests. • Identify ways to address particular nutritional and hydration requirements. • Ensure people have a choice of things to eat and drink and varied snacks throughout the day, including outside regular meal times.
2	• Work with other health and social care professionals; joined-up care and support helps to deliver better experiences and outcomes for older people with social care needs and multiple long term conditions.	
3.	• Encourage social contact and provide opportunities for education, entertainment and meaningful occupation. Offer opportunities for movement.	• Ensure older people are enabled to communicate and interact with others have the tools available to help them. • Involve the wider community in the life of the care home through befriending schemes and intergenerational projects which can be enabled through including voluntary and community sector organisations that can support older people with social care needs and multiple long term conditions.

Information compiled by Cherise Howson, PrescQIPP Programme and reviewed by Sue Smith, Senior Medicines Evidence Reviewer, April 2017.

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Contact help@prescqipp.info **with any queries or comments related to the content of this document.**

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