A care system support organisation

Medicine Matters

March 2022

Medicines information for care staff in a social setting

Missed and delayed doses of medicines.

In the event of a dose of medication being missed or late due to a delay, refusal or having been completely forgotten, it is important to know what action to take if you identify that this has happened. Patient information leaflets contained within the medication packaging, or available to download (https://www.medicines.org.uk/emc) should guide staff on what to do for an occasional missed or delayed dose. However, if this happens on several occasions, or if there is harm caused due to the delayed or missed dose, then this would be considered a medication error and would need to be reported as such via your usual channels.

Advice on this topic was published in November 2021 by both PrescQIPP (attached Briefing document) and Specialist Pharmacy Service (SPS) (https://www.sps.nhs.uk/articles/what-should-people-do-if-they-miss-a-dose-of-their-medicine/).
This guidance is intended to support people and care home staff on what to do in these situations and help staff to identify if they can safely administer the missed or delayed dose, or if further actions are required.

Please note: this advice applies to residents where occasional doses of medicines are delayed or missed. If this happens on several occasions, or if harm is caused by the omission of medication doses, this is a safeguarding issue and is required to be reported to your local authority and/or regulator.

If the dose is **less than 2 hours late**:
Take the missed dose as soon as it is remembered.
Generally, for the vast majority of medicines it is acceptable to take a dose up to 2 hours late.
Additional advice:

- *As a one-off, you can usually disregard any warnings about taking the medicine before or after meals.*
- *Watch for side effects – taking medicines at shorter intervals than usual may cause more side effects.*
- *take into consideration any minimum gap between doses that is stated on the label or leaflet.*

If the dose is **more than 2 hours late**:
The advice depends on how often the person usually takes the medicine:

Once or twice each day
Take the missed dose as soon as it is remembered if the next dose is not due within a few hours, then continue at usual times

More often than twice a day
Omit the missed dose and wait until the next dose is due.
Then continue at the usual times.

- Once or twice each day - take the dose as soon as possible, providing the next dose is not due within a few hours. Residents should then continue taking the medicine at the usual times.
- the next dose is due, then continue as normal.

What about **HIGH-RISK** medicines?
The general advice still applies – check the Patient Information Leaflet for specific instructions on missed or forgotten doses. You may need to seek further advice from a pharmacist, doctor or specialist nurse/clinic if there are any concerns or any doubt as to what to do for the following.

- Epilepsy medicines
- Warfarin
- Insulin
- Medicines for Parkinson's Disease
- Oral contraceptives

NEVER TAKE A DOUBLE DOSE TO MAKE UP FOR A FORGOTTEN DOSE UNLESS SPECIFICALLY ADVISED

Drug Allergies

Prescribers urged to double-check penicillin allergy is genuine
Millions of people in the UK have penicillin allergy recorded in their medical notes. Many of them are not truly allergic. New research highlights the importance of both doctors and patients discussing recorded penicillin allergies.
Penicillins are first-line treatment for many infections. People with a penicillin allergy listed in their medical records will not receive them. This keeps people with a true allergy safe. However, it means that people who are not allergic will receive second choice antibiotics if their notes are incorrect. This can mean longer hospital stays and more risk of antibiotic-resistant bacteria.
Further information: NIHR Evidence - Are you sure you are allergic to penicillin? Professionals and patients are urged to double-check - Informative and accessible health and care research

Document drug allergy status in medical records using one of the following:

- 'drug allergy'
- 'none known'
- 'unable to ascertain' (document it as soon as the information is available).

Please encourage your team to discuss and review allergies, where possible, detailing the nature of the allergy

NECS Medicines Optimisation Website: Information, guidance documents and various medicine related tools are accessible via our website. These can be downloaded and many may be adjusted to suit your needs :https://medicines.necsu.nhs.uk/category/resources/care-homes/

Medicine Matters: March 2022

Lessons Learnt: Enteral feeds and Medicine administration

In recent months, we have visited a number of care homes and a common area found to be requiring improvement was the documentation and practice for medicine administration via PEG. One particular incident involved all medicines being administered at once. Fortunately, no harm was caused. After investigations, it was clear the cause was both lack of a detailed care plan and inadequate training and competencies for staff. Action plans have been implemented, and lessons learnt on this occasion.

If residents require medicines to be administered via PEG, a detailed regime should be in place and available at point of administration.

What are the recommendations?

CQC guidance https://www.cqc.org.uk/guidance-providers/adult-social-care/enteral-feeding-medicines-administration states *"You should administer medicines individually. You should give a flush of water given before and after administration, and between each medicine. This will prevent any incompatibilities between the different medicines, or the feed being given. You should clearly record the volume of flush needed each time."*

Training & Competency

Staff must be appropriately trained to prepare and administer medicines via enteral feeding tubes before they undertake this task. This should include a regular competency assessment.

Records

Information should be available to staff on how to prepare and administer each medicine safely, including oral liquid medicines. The person's care plan should cover medicines administration via an enteral tube. It must include all the relevant issues, including when to seek advice or refer to specialist help.

Make a clear record of administration (including the route) on the MAR (medication administration record) or equivalent

Make sure people have a regular review of their medicines to check if it is still required or if a more suitable or alternative medicine is available.

Considerations for care homes

Care homes need to ensure staff are suitably trained and regularly have their competency assessed for administration of medicines via PEG.

Care homes should seek guidance on each medicine from the prescriber and, also, a pharmacist. Some medicines are not suitable to be given via a feeding tube as they may block or bind to the tube.

A detailed regime should be in place and available to support staff who administer medication via PEG. This is particularly important for new staff and agency nurses who are not familiar with the residents.

'Is my resident unwell?' communication tool

The Academic Health Science Network for the North East and North Cumbria (AHSN NENC) work across the region, supporting innovation in all its forms within the NHS and Social Care.

As part of their work on a Managing Deterioration project and the Well-Connected Care Homes programme a communication tool/resource has been developed which aims to assist staff in care homes in recognising signs and will assist in recording a set of observations of residents. The regional resource is a structured communication tool which looks at and records soft signs, NEWS2, SBAR etc. It is hoped that the tool will be incorporated into the system and will be something that all care home staff in the North East and North Cumbria region will use

"Early feedback from care homes that have been piloting the tool has been positive and we're looking forward to seeing even more care homes using the tool in the coming weeks and months. This is just the beginning of the journey and we welcome feedback on the tool." (Dave Belshaw, AHSN NENC Health Programme Manager)

Further information is available at: https://ahsn-nenc.org.uk/ahsn-nenc-launch-is-my-resident-unwell-communication-tool/

New Information Standard aims to reduce medication errors and improve patient safety

A new Information Standard has been published to support improved medication and allergy/intolerance information sharing across healthcare services in England.

The new standard aims to standardise medication message content, enabling transfer of prescription information across health and care settings in England to help reduce medicines related errors and improve patient safety. It will enable medicines information to be more efficiently shared between NHS and social care organisations, including primary and secondary care – from hospitals and GP practices to residential care homes, mental health trusts, and pharmacies and will be particularly beneficial in reducing medication errors when patients transfer between care locations.

For further information: New Information Standard aims to reduce medication errors and improve patient safety - NHS Digital

What can care homes do to support this?

- **Ensure that medicine documents and care plans have up to date information regarding to resident's allergy status**
- **Ensure allergy status is included in the information shared when a resident is transferred between services**

If you have any questions regarding this newsletter or if you have an idea for an article to be included in a future issue, please contact us via necsu.moadmin@nhs.net where you will be forwarded to the most appropriate member of the team

Please don't forget to share this newsletter with your colleagues!