QUESTIONS RAISED BY ATTENDEES OF THE RE-USE OF MEDICINES WEBINAR 1/6/20

GAINING CONSENT

Q1 Do we need to ask Next of Kin re consent if the resident does not have capacity?

It is important to remember that the term 'Next of Kin' has no legal meaning. If there is doubt about a persons a capacity for the two decisions; ***I give consent for my medicines to be re-used*** *and* ***I give consent to receive re-used medicines***, a capacity assessment should be undertaken by the relevant decision maker, which in this case should be the Care Home manager or delegated staff. If the person does not have capacity for these decisions a Best Interest decision must be made by the decision maker. The best interest decision should take into account current/ previous views from the resident, anyone interested in the person's welfare (family/ friends) and any relevant professionals involved in the care. (NB - If the person has a valid Lasting Power of Attorney [LPA] for Health & Welfare, then the LPA should make the best interest decision.) The capacity assessment and best interest decision should be documented.

Q2 Do we need to ask the Next of Kin for consent if the person has just died?

If at all possible, the gaining of consent for re-use of medicines should be considered well before the resident is at the end of their life. This does not mean these conversations cannot happen after the person has died in certain circumstances, for instance if requested by the resident's family/ executor or where a specific need to re-use their medicines is identified. This would be an individual decision at the time which must be done with sensitivity.

Q3 What would happen if a person with Lasting Power of Attorney for Health & Welfare does not want to be involved in making the decision?

If an LPA does not want to be involved in these decisions, then (depending on circumstance) it might be worthwhile to sensitively remind the LPA of their duties under the Mental Capacity Act Code of Practice, which they should be aware of. If they continue to decline involvement, then the Care Home Manager should become the decision maker as per Q1 and document the reasons why the LPA declined involvement. If however the LPA doesn't want the medicines to be used, that decision must be respected and the medicines cannot be re-used

Q4 Sounds like each resident at the End of Life must be asked for consent to share medicines post death as almost always there are injectables left over?

As above (Q2), we would recommend the conversation around consent to start as soon as possible, ideally before the person is at the end of their life. To allow best use of the re-use of medicines scheme, it would be advisable to obtain consent from all residents, and look to make this part of the care home admission process. Care Homes should review the quantity of a medicine that is left over and decide whether it is sensible to store that medicine for re-use, to make best use of the storage available.

LIST OF MEDICINES TO BE STORED FOR RE-USE

Q5 With regards the list of medicines to be stored for re-use in the care home, who produces this list and distributes to care homes and GP practices looking after that care home?

The list is owned by the care home but the creation and review of the list will need input from the healthcare professionals supporting the care home.

Q6 Why does each care home need to create their own list as I presume the medicines in short supply will be the same throughout the borough?

We have shown a suggested list (on the slides) but it will need to be amended for each care home to remove any medicine(s) from the list which should not be kept because it is unlikely that the medicine(s) will be needed (maybe no residents at the end of life with COVID-19 are anticipated), or

there are clinical reasons not to store certain medicines (such as haloperidol if a high incidence of Lewy Body dementia in the care home). It is important that communication about medicines that are in short supply should be ongoing between GP practice, community pharmacy and care home to allow additions to the list as needed if there are residents prescribed these. The amount of storage area available for controlled drugs and non-controlled drugs in each care home will also affect the volume and number of different medicines stored for re-use.

Q7 How will the care home know which medicines are in short supply?

Now, more than ever, communication around supply of medicines to residents in care homes needs to be good. We encourage healthcare professionals supporting care homes to ensure all parties are kept up-to-date with supply problems.

ASSESSING AND STORING MEDICINES FOR RE-USE

Q8 Do we have to wait 7 days before using the medicine?

The medicines need to be kept for 7 days after a resident dies as per usual practice, in case of Coroner's request. If the medicine was stopped and the resident has known or suspected COVID-19, it is recommended to quarantine the medicines for 3 days to reduce any risks of contamination.

Q9 Should we black out the name on the label?

The label should be kept intact so that all additional information about how to use the medicine is available to the person administering. The original resident's name should be left visible so that it can be recorded as the source at the time of administering to the new resident. One option is to cross with one line through the whole label, leaving the information readable, to show it is not being used for the person named on the label.

Q10 Can we use disinfectant wipes (such as Clinell® wipes) to allow reuse medicines to be used straight away?

No. The DHSC guidance states that medicines from residents with known or suspected COVID-19 should be quarantined for 3 days.

Q11 Will there be central policy around the stock levels that should be stored for re-use?

Not as far as we are aware. This would be for local discussion and will depend on anticipated need and storage availability.

GENERAL

Q12 Can medicines that are supplied by the hospital be re-used?

If needed, medicines that have been supplied by the hospital during an inpatient stay and come directly to the care home with the resident can be re-used as we can be assured of the storage of these medicines.

Q13 Can other medicines that would be wasted be kept as part of this process? For example high cost/high volume items such as nutritional supplements?

No. The DHSC is clear that this change in guidance only applies when medicines are urgently needed by a resident, the medicine is unavailable or supply is not possible within the time frame via the usual supply process, and there is no alternative available. It is unlikely that nutritional supplements would fall into this definition so they cannot be stored for re-use.

Q14 This seems like a lot of paperwork for care homes?

The re-use of medicines scheme is a big change in practice and the documentation of the steps taken is important to ensure it is carried out safely. It is very likely that each step of the process will

be undertaken on a different day so it will not be overly onerous in practice e.g. during a single shift for instance

Q15 If the GP generates a prescription for re-use for say 10 ampoules and there are only 7 available for re-use, what do we do?

The prescription is being used as the authorisation to administer from the stock of the re-use medicines. It is not about the total quantity to take out, so the total quantity indicated on the prescription does not have to be used. The prescriber may wish to add a timeframe such as, *"To allow re-use stock to be administered for up to 24 hours until labelled supply can be obtained".* Re-used stock should only be used for as long as is necessary, and labelled supply should be obtained at the earliest opportunity.

Q16 Will there be central policy as well as local "guidance" documents around the re-use of medicines?

As far as we know, the DHSC are not releasing any further documents around this. Our local guidance support care homes to implement the DHSC re-use scheme in line with the central policy.

Q17 How often do you think this policy and process will occur in care homes per week and per year per care home when an actual medicine is re-used?

This process should be in exceptional circumstances only. The safest way for medicines to be supplied is with labelled medicines dispensed for the individual resident. How often re-used medicines are used in an individual care home will depend on many variables including the size of the care home, the type of residents, and any medicines supply issues that arise over the coming months.

Q18 If you store a whole box of 10 ampoules for re-use then use 4 ampoules, do you then dispose of the remainder?

No, intact ampoules can be stored even if the box is not full. So the 6 ampoules would be returned to the re-use stock cupboard and paperwork (running balance) should reflect this.

Q19 Why can the care home not keep stock of anticipatory medicines?

The legislation has not been changed to allow care homes to keep stock of anticipatory medicines outside the DHSC re-use of medicines guidance. Care Homes with nursing can keep stock of controlled drugs providing the appropriate Home Office license is held but care homes without nursing cannot do this.

Q20 Why does a prescription need to be issued rather than amending a MAR chart?

Legally the care home needs to be provided with a written authorisation to administer medicines to their residents (except medicines bought over the counter). In most cases, a prescription would be the easiest way of providing this, however other forms of communication can be used such as a letter. Amending the MAR chart does not comply with this requirement; as the MAR chart is a record of what medicines have been administered to the patient rather than an authorisation to administer. More information on this can be found here: https://www.sps.nhs.uk/articles/direction-to-administer-forms-use-of-electronic-signatures-during-covid-19/

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