Care Home Charter for Swallowing Medicines

Audit checklists

The following standards are provided as suggestions only and should be amended in line with local guidelines and accepted best practice.

Involvement of resident in decision making

1. There is a mental capacity assessment for all residents for whom medication is administered by staff (Law changed 1st April 2017).
2. Possible to locate an up to date record of resident's wishes and beliefs about medicines
3. Evidence available to demonstrate that resident's wishes and beliefs have been listened to and responded to appropriately e.g. refusal to take a medicine or medicines by residents with capacity is accepted
4. Evidence available which demonstrates residents or people important to them are routinely involved in making decisions regarding medicines
5. Medication records indicate where medication is prescribed when needed, it is not administered routinely
6. Evidence of Multidisciplinary meetings to review medication includes the residents where they have capacity, or their representatives. And these cover covert administration and swallowing difficulties.

Medicines monitoring and review

1. The intended purpose for all of my medicines is recorded
2. Plans for monitoring the effectiveness of resident treatment are in place
3. Evidence available which demonstrates that the effectiveness of resident medicines is routinely monitored i.e. staff are aware of what to monitor and routinely ensure that this is undertaken for example, antibiotics, PRN (when required medication) and pain relief
4. Staff are aware of common and serious side effects of resident medicines which need to be monitored for. And the most serious side effects are recorded in the care plan
5. Evidence available which demonstrates that the safety of resident medicines is routinely monitored e.g. test results are followed up and recorded in resident notes
6. Evidence that medicines are regularly reviewed by the general practitioner or pharmacist is available. To be done annually as routine for all other medications, at least every 6 months for covert administration, antipsychotics and difficulties in swallowing.

Covert administration

1. Repeated refusal by residents to receive administered medicines results in timely case review and an appropriate response
2. Evidence that covertly prescribed medication is still offered at first before being administered covertly
3. In residents without capacity where medication refusal is identified then evidence of MCA assessment and best interests meeting is available
4. General practitioner, care home representative and appropriate resident representatives are all present at best interests meeting
5. Frequency of review of best interest meeting decision recorded. And evidence to demonstrate least restrictive options are considered i.e. is the medication still life changing or can it be discontinued?
6. Where residents lack capacity, there is evidence of DoLS referral and formal authorisation from the relevant Local Authority.

7. Where covert administration is the chosen course of action evidence that:
8. medication review has been undertaken to ensure that dosage form and route of administration has been appropriate considered
9. Advice has been sought to ensure that where dosage form manipulation is identified as the only option this is in line with best practice

Advanced care plans

1. Advanced care plan in place for all residents
2. Evidence that advanced care plans are reviewed each time resident condition changes
3. Evidence that advance care plans are implemented in line with resident wishes

Swallowing deficits

1. Presence or not of swallowing deficit recorded in resident notes
2. Evidence of MCA assessment for crashing medication is undertaken and best interest process in place
3. Resident GP made aware of identified swallowing deficit
4. Result of discussion with GP regarding whether resident requires referral to speech and language therapist is recorded
5. Where speech and language referral recommended evidence of assessment in resident notes
6. Nature of swallowing deficit recorded in a manner which enables the selection of appropriate food, liquid and medicines texture to be determined
7. Evidence that medication reviewed within one month of swallowing deficit identification
8. Where swallowing deficit identified evidence that medication route and formulation were considered within medication review

Medicines administration

1. Evidence that staff who administer medicine have training and competencies in medication administration, and signs or symptoms of dysphagia
2. Evidence for all residents being administered medication to have MCA assessments
3. Signs and symptoms of dysphagia are routinely recorded
4. All residents demonstrating signs or symptoms of dysphagia during the medication administration round have been reviewed for possibility of dysphagia
5. No medicines are mixed or hidden in foods or thickeners unless the resident is aware and consent has been provided (resident's with capacity) or a best interests meeting has chosen covert administration (residents without capacity)
6. Routine mixing of medicines in foods or liquids for residents with capacity is recorded in the resident's care plan
7. Where medicines are altered prior to administration e.g. crushed or dispersed, evidence supporting this decision and the safety of the process is available
8. Authorisation for dosage form alteration for each individual resident where this occurs has been provided by the resident's prescriber

Oral health

1. Resident has dental check-up within the last 12 months
2. Toothbrush is of suitable quality
3. Evidence that teeth/dentures are cleared twice daily for each resident
4. Staff are trained in oral care