Frequently Asked Questions:

Novel coronavirus (COVID-19) standard operating procedure - Running a medicines re-use scheme in a care home or hospice setting

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881838/medicines-reuse-in-care-homes.pdf

	FAQs	Answer
When should the guidance be used?		
1.	When should this guidance be used?	The new medicines re-use scheme in a care home or hospice setting is time limited and would only apply during this period of emergency e.g. the COVID-19 pandemic. Medicines should continue to be supplied on a named patient basis through usual routes. This new process is only for those '**exceptional circumstances**' where that is not an option where: • No other stocks of the medicine are available in an appropriate timeframe (as informed by the supplying pharmacy) and there is an immediate patient need for the medicine • No suitable alternatives for an individual patient are available in a timely manner i.e. a new prescription cannot be issued, and the medicine(s) supplied against it in the conventional manner quickly enough • The benefits of using a medicine that is no longer needed by the person, for whom it was originally prescribed or bought, outweigh any risks for an individual patient receiving that unused medicine.
2.	The DH guidance says that one of the three key indicators which should inform the risk assessment and the subsequent decision of whether to re-purpose medication to a patient is when '*No other stocks of the medicine are available in an **appropriate timeframe** (as informed by the supplying pharmacy) and there is an immediate patient need for the medicine'.*	The DH guidance does not go into any detail on what an 'appropriate timeframe' should be, perhaps as this would depend on the individual patient circumstances. The CCG interpretation of this guidance is that it would be for those clinicians involved in the care of the individual patient (District Nurse, GP, etc.) to best appreciate the timeframe for which the medication in question is required and whether there is an immediate need. For example, patients with COVID can deteriorate quickly in an end of life situation and the medicine needs to be obtained in a timely manner. The clinicians

	What is an appropriate timeframe?	would need to consider the supplying pharmacy's information regarding medicine availability and assess whether this would compromise the patient's quality of life and whether re-using the medication would be the most appropriate route to obtain timely medication for the patient.
3.	The DH guidance says that the *'standard operating procedure (SOP) supports timely access to* ***essential prescribed medicines*** *during the COVID-19 pandemic for patients who are being cared for in a care home or hospice setting'* . What would be classed as an essential prescribed medicine?	The DH guidance does not specify what an 'essential prescribed medicine' would be. The DH guidance does however say that the guidance and SOP applies to all medicines, including liquid medicines, injections (analgesics, insulin), creams and inhalers, that are in sealed or unopened blister packs and when the criteria in Table 1 of the guidance are met. It is worth noting that WHO have a model list of essential medicines such as those medicines used for pain and palliative care, antiallergics and medicines used in anaphylaxis, anticonvulsants, antiepileptics and anti-infective medicines. It seems reasonable to interpret the DH guidance as referring to the prescribing of medicines such as these in their guidance. In the current pandemic, the CCG would envisage that the medicines usually used in supporting end of life care would be the main medication this guidance would relate to locally.
4.	Can the care home re-use a medication if the Out Of Hours (OOH) GP has prescribed medication for palliative care and there is a prescription, if they are aware that their local community pharmacies that hold end of life medications are closed in the time of need?	Yes, as long as the retained stock had been checked by a healthcare professional and agreed suitable for reuse at some point, either at the time of need or when it was put into re-use stock, and the appropriate permissions have been obtained from the patient/resident/ person with power of attorney /next of kin.
5.	Does the medication have to have supply issues before the nursing/ residential home can be allowed to keep deceased residents medication for potential re use? E.g. there is no supply issue with morphine sulphate injections but the medication is often used in End Of Life care.	No, the guidance is not specific to only retaining medication where there is supply issues and a deceased patient's medication could be retained. It could be used if they had difficulty obtaining supplies e.g. middle of the night. However previous consent should have been obtained and a HCP should check whether the medication meets the requirements to allow it to be re-used. Consideration also needs to be given to the length of time it is reasonable to retain medication.

		The guidance applies to all medicines, including liquid medicines, injections (analgesics, insulin), creams and inhalers, that are in sealed or blister packs and when the criteria in Table 1 are met. (i.e.) • Medicine is in an unopened pack or blister that has not been tampered with • Are in date • Been stored in line with the manufacturer's instructions, including any need for refrigeration • A licensed medicine that has either been prescribed by a registered healthcare professional with prescribing rights or bought 'over the counter' (DH guidance includes 'homely remedies') Schedule 2 or 3 Controlled Drugs should only be retained for re-use if they can be stored securely in line with safe custody requirements for controlled drugs. Store Controlled Drugs that might be re used in a sealed container marked as 'resident/patient returns' in the CD cupboard ensuring they are segregated from any other CD medicines in the CD cupboard. The CD cabinet should only be used to store controlled drugs.
Training		
6.	What training/guidance is available for staff involved with care homes and hospice settings on this DH guidance?	A range of resources have been produced to support the implementation of this guidance in care homes and hospices by Opus, a medicines training company. These resources are free and include checklists, template forms and procedures.
What medicines can or can't be re-used?		
7.	Can you re-use medicines that a patient has brought in from their own home to the care home or hospice setting?	No, the SOP applies to medicines that have been supplied to patients while in a care home or a hospice, that have not been removed from that setting (other than for short periods e.g. an outpatient appointment) and have been stored in accordance with good practice guidance on storing medicines in a managed setting.
8.	Can medicines be re-purposed for all residents in the care home (i.e. not just from those who have died)?	The medicines re-use pathway in the DH guidance refers to residents who no longer need their medicine. This could be interpreted as those patients that have died and no longer

		require their medication or it may be current residents who no longer need the medication due to a change in circumstance. Patients, who have a continued need for their medication, should not have their medication re-purposed.
9.	Can medicines be re-used which have been in a dosette box/MDS?	No, a dosette or MDS would not meet these criteria as this medication has come from another pack and so no longer classed as an unopened medication. This guidance would therefore not include medicines that are in a dosette box and they should be disposed of following existing disposal procedures.
Medication assessment		
10.	Who can assess the medicines for re-use?	The medicine must be checked by a registered healthcare professional that has current registration with one of the UK's professional regulatory bodies regulated by the Professional Standards Authority. This includes pharmacists, pharmacy technicians, general practitioners, and nurses. In a care home with nursing, this would usually be undertaken by a registered nurse working in the care home. In a care home without nursing, where there are no registered healthcare professionals (HCP) on site (e.g. in a care home that only offers personal care and has no registered nurses on site), registered healthcare professionals (e.g. pharmacists, pharmacy technicians, general practitioners, community nurses) from other local organisations, such as general practices or community healthcare providers, can perform that check (this may be done virtually) and confirm that the medicine is suitable for re-use. Locally a HCP could be the local GP linked to the care home, GP practice based pharmacists, local community pharmacists and health care professionals working within the Care Home Support Team. For example it could be District Nurse or GP that has come to the home to administer a drug that re-purposes an old medicine. i.e. in a residential home, a HCP will have to attend in order for medication to be administered.

Consent		
11.	Who needs to give consent to allow a named patient's medication to be re-purposed/ re-used?	If a medicine is thought to be suitable for re-use, permission should, if possible, be obtained for re-use from the patient for whom it was prescribed or (if the patient lacks capacity) from a person with power of attorney, or (if the patient has died) from their next of kin. The DH guidance suggests that care homes and hospices proactively seek written permission from all patients[1] for: ➢ their medicines (if no longer needed) to be made available for other patients and/or ➢ them to receive a re-used medicine, provided they are deemed safe for re-use. Care homes and hospices are encouraged to have timely conversations with all their patients with the full involvement of their families and/or carers, about their preferences and priorities on the re-use of prescribed medicines. This should include a discussion to explain: ➢ that the medicine, once it is in the patient's safe keeping, is the property of the patient, and some would say that it becomes their property as early as when it leaves the pharmacy. An approach is being taken that is compatible with a range of opinions on this issue. ➢ that as a result of COVID-19 there may be interruptions to the medicine supply chain, which may mean surplus medicines need to be given to other patients, subject to the original patient's permission ➢ if they wish, they need to agree this in writing and the date of agreement noted in the column in the table provided in the guidance ➢ if the supply of their medicine is interrupted, they may, subject to their written agreement, receive another patient's surplus medicine.
Processes and documentation		

[1] An example of a template letter for residents in relation to the re-use of medicines is available via Opus, a commercial training company. See: https://opuspharmserve.com/covid-19-support/

12.	Overview of the prescribing and prescription process	As mentioned in question 1, there is clear guidance about the situations when re used medicines could be used. A medicines re-use pathway has been included in the DH guidance / SOP[2]. 1. A prescriber issues a prescription for a care home or hospice resident 2. If the medicines are out of stock and there is an immediate need for them, an alternative preparation should be prescribed and dispensed, as is usual practice where possible. 3. If the situation arises where it is the middle of the night and the pharmacy is closed and there is an immediate need for a medication, a prescriber should be contacted in the first instance to discuss next steps. 4. Where stock is not available, the supplying pharmacy (when open) should contact the care home or hospice to establish whether a medicine re-use scheme is in place and stock of the required medicine is available in the home. 5. Re-used medicines may be administered to residents in a care home or hospice under the direction of a prescriber, and in line with this SOP, where an appropriate medicines re-use scheme is in operation and consent sought. 6. The direction would normally be in the form of a prescription. If a prescription is issued remotely, it should be scanned and emailed to the care home by the prescriber (for known medicines shortages) or the community pharmacy as appropriate in each individual case. 7. If stock of a re-used medicine is available in the care home or hospice, the community pharmacy team must share a copy of the prescription for that medicine with the home. Where the care home or hospice do not have a procedure in place to allow interim additions or amendments to MAR charts in their possession, the pharmacy could issue a new MAR chart for the product that is to be re-used. 8. A copy of the prescription could potentially be shared by sending an image of the prescription via NHSmail, where the care home has access to NHSmail. The supply of the medicine by the care home or hospice will need to be in accordance with that prescription; they cannot rely on a report of its contents.

[2] Refer to pages 10-12 of the Department of Heath guidance.

		9. Appropriate checks must be made to inform the decision to reuse another patient or resident medicine.
13.	What documentation is needed for *prescribing* and *issuing* these medicines?	Any re-used medicine would need to be administered according to the direction of a relevant prescriber (*This can be a verbal direction initially with a written prescription to follow either by email or hard copy.*) and recorded by care home or hospice staff in the relevant administration chart. Controlled drugs legislation should be followed as per standard practice. Unless the product is being supplied under a patient group direction (PGD) or a patient specific direction (PSD), a new prescription must be obtained prior to administration to the new patient. If it is for a **controlled drug**, the extra requirements in relation to controlled drugs prescriptions must be satisfied. New remote prescriptions should be scanned and emailed before the first dose is given, and a copy of the prescription kept with the patient's records in line with current processes. The administration chart (paper or electronic) should be updated by the care home or hospice, in line with the direction from the prescriber (in most cases this would be the prescription e.g. FP10). The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. The prescriber does not need to sign the MAR chart. Following the administration of a re used medicine, a re-used medicines log (see Annex 2 of the DH guidance for an example log returns sheet) should be kept at the care home or hospice and updated. This should include the date of administration, patient's name, dose, quantity used and reason for re using medication as a minimum. Where the medicine to be re-used is a **controlled drug**, the extra requirements in relation to the storage, recording and administration of CDs must be followed (see question 14 below).
14.	What documentation is needed for re-use of controlled drugs and how should these drugs be stored?	A current prescription must be in place for a Controlled Drug, whether the resident is receiving re-used Controlled Drugs or their own dispensed supply.

		Schedule 2 or 3 Controlled Drugs should only be retained for re-use if they can be stored securely in line with safe custody requirements for controlled drugs. Store Controlled Drugs that might be re used in a sealed container marked as 'resident/patient returns' in the CD cupboard ensuring they are segregated from any other CD medicines in the CD cupboard. The CD cabinet should only be used to store controlled drugs. Keep all records of Controlled Drugs in line with standard legislation and requirements. Schedule 2 controlled drugs should be recorded in the CD register, however schedule 3 controlled drugs are not required to be recorded in the CD register (although some services may choose to do this). A separate section of the CD register must be used for re used Controlled Drugs and a separate page of the CD register should be used for each re used Controlled Drug. An entry should also be included in the re used medicines log as well as the controlled drug register prior to administration so there is a clear record of who was the original owner of the medication, as well as after any administration of re-used medicines. Care homes should also refer to their existing policies and procedures in relation to controlled drugs management including the action to take if a stock discrepancy arises.
15.	Is it OK to issue an FP10 prescription to cover medication issued from reused stock or should we really be using patient specific directions?	Use the SOP completing all the necessary documentation. The SOP is clear that any re-used medicine would need to be administered according to the direction of a relevant prescriber (this can be a verbal direction initially with a written prescription (e.g. FP10) to follow either by email or hard copy) and recorded by care home or hospice staff in the relevant administration chart. Unless the product is being supplied under a PGD or a patient specific direction, a new prescription must be obtained prior to supply to the new patient. If it is for a **controlled**

		drug, the extra requirements in relation to controlled drugs prescriptions must be satisfied. New remote prescriptions should be scanned and emailed before the first dose is given, and a copy of the prescription kept with the patient's records in line with current processes.
16.	An FP10 prescription does not seem appropriate but the SOP says we need a prescription and homes will consider this to be an FP10. I am concerned about the potential for diversion of drugs if we have FP10s floating around that could be presented for dispensing.	The care home needs sight of the prescriber's direction so they can safely and legally administer. It is not the intention that the original prescription form goes back to them, but if it does it should be clearly marked 'Not dispensed' by the pharmacy. Normally it would be an EPS prescription and a token could be shared, but the intention is that an image of the prescription is sent via NHSnet. If this prescription is the only one on the form, the form could be shredded - a record still exists with the prescriber. If there are other prescriptions on the form, then it would need to be passed for payment.
Storage		
17.	Where and how should the medicines which are to be re-used be stored?	Any medicines that might be re-used should be placed in a sealed container and marked as 'resident/patient returns', to make it clear that the stock should only be re-used when stock cannot be obtained from the legitimate supply chain. The additional obligations in respect of storage of controlled drugs must be adhered to. Once a medicine has been assessed as being suitable for re-use, the usual processes and governance, as recommended by NICE guideline SC1: Managing medicines in care homes, apply. Medicines identified for re-use should not be transferred to another care home or hospice, even when they are part of the same parent organisation. A log should be maintained of all re-used stock. The log should include the generic drug name, batch number, strength, formulation, expiry date quantity and details of the

		registered healthcare professional that assessed the medicine, as a minimum. When the stock is re-used, the quantity used should be entered. All medicines should be stored in line with the manufacturer's recommendations. If a **controlled drug** is to be re-used, the extra requirements in relation to controlled drugs must be adhered to (also see question 14).
18.	How long can a residential home keep controlled drugs as they normally give to the community pharmacy to destroy straight away?	All care homes nursing and residential would normally retain medication for 7 days following the death of a resident or until the coroner said they could dispose of it. There is no clear guidance regarding whether this medication can be used within this 7 day period and this may be subject to whether this was an expected death and the medication was not implicated in the death.
Infection control		
19.	What infection control procedures need to be considered when re-purposing medication in a care home or hospice setting?	Adequate infection prevention and control precautions should be taken when re-purposing medication in a care home or hospice. The DH guidance highlights that medicine that has been retrieved from a patient infected with COVID-19 should be sealed (double bagged) and quarantined for three days. A 'do not process before' date should be fixed to the bag before the bag is stored safely and away from any other medicines before it can be re-purposed to another patient. If a medicine belonging to a COVID-19 patient has been stored in a separate room and has not come into contact with patients and potential COVID risk, this should be discussed with the HCP assessing the medicine as being suitable for re-use as per the SOP.
Other		
20.	How is a residential home meant to keep the medication under the supervision of a healthcare professional when there isn't a healthcare professional at the residential home?	They should discuss with a Heath Care Professional (HCP) whether the medication is appropriate to keep and the correct storage requirements e.g. Controlled Drugs in CD cabinet, other medicines locked away safely and kept separate from all other medicines and clearly labelled. If the criteria as stated in the SOP applies and the medicine has been assessed by the HCP as being suitable for re-use, and are stored and logged appropriately then that would be in line with guidance.
21.	How does the healthcare professional sign the	After thorough discussion with the Heath Care Professional (HCP)involved in assessing

	assessment form when they are probably working virtually?	the medication the HCP would need to sign the form electronically (if an electronic signature isn't available- they could potentially add their name and details) to ensure a clear audit trail and good governance.

Local Contact Info:

- **BNSSG CCG Wraparound Support Team for care providers through a Single Point of Access (SPA) telephone line for healthcare related support and advice (non-emergency clinical support)**
  - calls will be directed to either the Sirona medicines advice line or the BNSSG Medicines Optimisation Care Home team (MOCH team)
  - **24/7 Telephone:** 0300 125 6789

- **BNSSG Medicines Optimisation team email:** bnssg.medicines-optimisation@nhs.net