Administering Medication Safely in Residential Care Home Sector

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Joint East Riding of Yorkshire and Hull Medication Policy

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AMENDMENTS

Amendments to the policy may be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Internet

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SECTION 1 - POLICY

1. INTRODUCTION

1.1. The administration of medicines is a regulated activity under the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This policy should be used in conjunction with CQC guidance for providers on meeting the regulations (March 2015) available from: https://www.cqc.org.uk/sites/default/files/2015024%20Guidance%20for%20providers%20on%20meeting%20the%20regulations.pdf

1.2. "Managing medicines in care homes" (SC1, March 2014) a guideline published by National institute for Health and Care Excellence (NICE), covers good practice for managing medications in care homes. It aims to promote the safe and effective use of medicines in care homes by advising on processes for prescribing, handing and administering medicines. It also recommends how care and services relating to medicines should be provided to people living in care homes.

1.3. The Joint East Riding of Yorkshire and Hull Medication Policy on Administering Medication Safely in Residential Care Home Sector has been reviewed and updated to take account of recommendations made in the NICE guideline.

2. ENGAGEMENT

2.1. This policy has been developed with input from the following stakeholders:

- East Riding of Yorkshire Council (ERYC)
- City Health Care Partnership (CHCP)
- Clinical Commissioning Group East Riding of Yorkshire (CCG ERY)
- Clinical Commissioning Group Hull (CCG Hull)
- Community Pharmacy Humber (Humber LPC)
- Hull City Council (HullCC)
- Hull & East Riding Care Association
- Humber Teaching NHS Foundation Trust
- North of England Commissioning Support Group (NECS)

3. SCOPE

3.1. This Policy applies to all stakeholders involved in the safe administration of medicines to the service users of East Riding of Yorkshire and Hull. This includes Care Home Providers, General Practitioner (GP) practices and Dispensers (Community Pharmacies, Dispensing Practices, Acute and Mental Health Providers) who are involved in any aspect of medicine management in the delivery of care packages commissioned by East Riding of Yorkshire Council and Hull City Council.

This Policy does not apply to non-commissioned packages of care i.e., people funding their own care or receiving personal budgets (unless these are commissioned by the Council).

3.2. This policy applies to medicines prescribed for the service user and medical appliances that are administered in the same way as medicines.

3.3. This policy cannot cover every possible situation that may arise. Where care home workers have any doubt about the action to take, the care home manager, a Health Care Professional (HCP), and the service user or a nominated person (e.g., next of kin), should always be consulted.

4. POLICY PURPOSE & AIMS

4.1. To enable, promote and maximise service users' independence safely. It is important that responsibility for managing a service user's medicines is not taken away from them unless an assessment indicates a need.

4.2. To give clear guidance to HCPs and Care Home Providers commissioned to provide medicine support for adults residing in care homes.

4.3. To ensure unified procedures are undertaken where medication is administered to ERYC and HullCC service users.

4.4. To meet all legal requirements and the Good Practice Standards prescribed by the Care Quality Commission (CQC) and other relevant agencies.

4.5. To meet the recommendations published by NICE Social care guideline [SC1] "Managing medicines in care homes".

5. DEFINITIONS

Administration of medicines - One, all, or a combination of the Care Home Provider (CHP) doing the following:

- deciding which medicine(s) have to be taken or applied and when this should be done
- being responsible for selecting the medicines
- giving a person medicines to swallow, apply or inhale, where the service user (SU) receiving them does not have the capacity to know what the medicine is for or identify it
- giving medicines (even at the request of the person receiving care) where a degree of skill is required by the Care Home Worker (CHW) to ensure it is given in the correct way.

SU Service User

CH Care Home

CHP Care Home Provider

CHW Care Home Worker

CP Community Pharmacist

CQC Care Quality Commission

DN District Nurse

ERYC East Riding of Yorkshire Council

ERYCCG East Riding of Yorkshire Clinical Commissioning Group

HullCC Hull City Council

HullCCG Hull City Clinical Commissioning Group

GP General Practitioner

HCP Health care professional, defined as a member of the medical, dental, pharmacy and nursing professions and any other persons who during their professional activities may administer, prescribe, purchase, recommend or supply a medicine

MAR Medication Administration Record

NICE National Institute of Health and Care Excellence

6. ROLES / RESPONSIBILITIES / DUTIES

GOOD COMMUNICATION BETWEEN ALL STAKEHOLDERS IS KEY TO ENSURING POLICY IMPLEMENTATION, PROVISION OF HIGH-QUALITY PATIENT CARE AND MINIMISED RISK.

6.1. SERVICE USER

6.1.1. The level of responsibility for medication assumed by an individual service user will depend on their ability to manage this aspect of their life.

6.1.2. If assistance with medication is required then the service user must provide CHP with access to the prescription, medicine, and other relevant information if they have capacity, consent must be given to assist with medication. If service user does not have capacity, decisions should be made in line with the Mental Capacity Act 2005.

6.1.3. If support is required for ordering repeat medications, and the CHP has been identified as giving that support, then consideration should be given to allow the care provider to order medications as well as appliances and equipment for DN use, on-line from the service user's GP. This would require the service user to allow third party access to their patient record including Proxy access if applicable.

6.2. EAST RIDING OF YORKSHIRE COUNCIL AND HULL CITY COUNCIL BUSINESS MANAGEMENT AND COMMISSIONING UNIT

6.2.1. The Council's Authorised Officer or their representative(s) may seek assurance that the CHP is compliant with this policy. This will be done as part of routine quality assurance, monitoring and evaluation, as outlined in the Local Authorities Care Home provision agreement.

6.2.2. The Council's Authorised Officer or their representative(s) may seek assurance that all CHW who deal with medication have sufficient relevant and appropriate training and competencies to undertake medicines management.

6.2.3. The Council's Authorised Officer or their representative(s) may seek assurance that CHP is meeting service user's medication care and support needs as agreed and set out in individual SU care planning.

6.2.4. The Council's Authorised Officer or their representative(s) may seek assurance that CHP have properly documented systems of quality assurance and effective audits to ensure that medication practice is safe and compliant with Regulations and best practice guidance.

6.3. CARE HOME PROVIDERS

6.3.1. Ensures that this Policy is implemented in their service.

6.3.2. Facilitates training for CHWs by ensuring that the CHW follows a recognised training in accordance with this policy and associated Standard Operating Procedures (SOPs).

6.3.3. Maintains records of staff training and competencies for the safe administration of medication.

6.3.4. Provides the agreed and documented level of assistance to the service user on a day-to-day basis.

6.3.5. Ensures that medication is administered from the original pharmacy filled container and that this is recorded on a MAR by trained and competent CHW.

6.3.6. Ensures that, if a medication is prescribed mid cycle, this is (in order of preference and risk):

1. Additional MAR is obtained **or**
2. Where the above is not possible, for example Out of Hours when the pharmacy is closed: the senior CHW will handwrite the medication onto the SU MAR which is currently in use, ensuring a second CHW is present to verify the accuracy of the transcription by following the agreed process (see Appendix 1). Alternatively, additional blank MAR can be used to handwrite the medication if no space in the MAR chart currently in use.

6.3.7. Has robust processes in place for handling urgent changes to a service user's medicines from a prescriber, received preferably via NHS Mail, (medication letters or verbally in an emergency), including:

- Recording details of the requested change (including who requested the change, date and time of request and who received the request)
- Ensuring that a second member of staff is present to verify transcription/transfer of information the request.

And where instructions are given verbally:

- Reading back the information that has been recorded to the prescriber requesting the change to confirm it is correct (including spelling of the medicine)
- Ensuring where possible that a second member of staff is present to verify the information e.g.by speakerphone.

6.3.8. Monitors and reviews the service provided via regular audit of MAR charts.

6.3.9. Informs the HCPs of any significant change/s that may trigger the need for a review.

6.3.10. Ensures that incidents and 'near-misses' are recorded appropriately and used as a learning tool to improve the service. See example of incident reporting form Appendix 3.

6.3.11. Takes responsibility for resolving problems and investigating incidents. When necessary specialist support should be involved in these investigations and learnings disseminated to all parties.

6.3.12. Takes responsibility for reporting to CQC and Safeguarding where appropriate.

6.3.13. Involve (and document the involvement of) service users and/or their representatives in all decisions and care planning regarding their medications.

6.3.14. Deploy suitably qualified, competent, skilled and experienced staff to meet service users anticipated medication support needs at all times, including overnight. To always include consideration and arrangements for onsite support to help with the administration of PRN medications and changes to, or newly prescribed medication Out of Hours.

6.3.15. Is aware of any changes to the service user's support needs in relation to medication that could prompt a review by relevant HCP (side effects, declining prescribed medication, swallowing difficulties, changes to levels of independence, cognition etc).

6.6. GENERAL PRACTITIONERS(GPs)

6.6.1. GPs have a duty of care for all their listed patients to provide general health and medical care or refer for specialist health care or social care.

6.6.2. In looking after an individual's health and wellbeing, the GP or other non-medical prescriber will prescribe medication to their patient to prevent, treat or relieve medical conditions. It should be noted that SU might also receive medication prescribed by specialists who might have been supplied to them in hospital, clinic or other healthcare setting. Within primary care, other professionals may be involved in prescribing for service users – e.g., Dentists, suitably qualified nurses, pharmacists or physiotherapists.

6.6.3. GPs should record details of the CHP in SU's medical record, when notified that the person is residing in CH. The details should be immediately obvious to anyone accessing the patient's record by adding an alert, reminder or "Pop-up box".

Such support should be Read coded – **SystmOne: Lives in Care Home (XaMFG) Emis Web: Lives in Registered Adult Care Home**.

6.6.4. Prescribers should communicate any changes to service user's medication (e.g., when stopping or starting a medicine) by:

- Informing SU and/or when appropriate their named next-of-kin as well as CHP
- Providing written instructions of the change and/or issuing a new prescription
- Informing community pharmacy and CHP. Any changes in medication, where there is a need to avoid delays in treatment or avoid confusion, should be made preferably by NHS mail (verbally in an emergency)
- Ensure GP patient records are updated in a timely fashion to reflect medication changes.

6.6.5. GP Practices could consider identifying at least 2 members of the administration team to be responsible for managing the prescription process for CHP requiring MAR charts.

6.6.6. Provide clear written directions on the prescription to show how each prescribed medicine should be taken or administered, including:

- What dose should be administered?
- The frequency of administration
- For 'when required' medicines when there is no alternative: What the medicine is for and when it should be given to the service user?
- What exact dose should be administered (for example, avoid 1 or 2 tablets) as CHW are not suitably qualified to decide what the dose should be unless the patient can direct the CHW to the dose needed
- For external medicines, on what area of the body to be applied
- The minimum time interval between doses
- The maximum dose to be taken in a 24-hour period.

6.6.7. It is recommended that SU have a structured medication review (SMR) where appropriate, on admission to CH, at least annually or sooner if needed and communicate any changes as above. This may be conducted by practice, PCN or community provider pharmacist or suitably qualified clinician.

Consider if any changes or extra support may be helpful for example by checking if the SU's medication regimen can be simplified, if any medications can be stopped or if there are any formulation changes needed. This includes Just in Case medication boxes which are recommended to reviewed on at least six-monthly bases.

6.7. DISPENSERS (INCLUDING COMMUNITY, HOSPITAL AND GP DISPENSARIES)

6.7.1. Dispensers have a professional responsibility to supply medication prescribed by GPs and other recognised prescribers and in a timely manner.

6.7.2. The medication must be of a suitable quality and comply with legal and ethical requirements for the packaging and labelling, ensuring the expiry date is included on all cut or loose foil strips.

6.7.3. Additionally, pharmacists have a responsibility to ensure that a service user or CHP receives appropriate information and advice to support them in gaining the best effect from any medicines supplied. This will include annotating the MAR on the best time of day to administer the medication, for example morning, lunch, tea, evening to aid compliance.

6.7.4. Liaise with the prescriber where prescription details are ambiguous and do not give sufficient information to the carer to safely administer the medication.

6.7.5. For a mid-month medication, for a patient who the pharmacy is aware already has a MAR in place a new chart should be printed for each additional medication provided outside of the regular monthly cycle. Each additional chart should be marked as a "Supplementary Chart" on the front to ensure that the CHW is aware that this is an additional chart for the service user.

6.7.6. For a mid-month medication, liaise with the CHPs, ensure that the new medication is collected in time, or delivered by the pharmacy where there is an agreement to do so.

6.7.7. Supply a patient information leaflet for every dispensed medication in line with the Human Medicines Regulations 2012.

6.7.8. Provide ongoing advice and support about a person's medicines including non-prescribed medication.

6.7.9. Complete an incident form when necessary and appropriate e.g., where a CHP has been informed that there is a medicine to collect, and they have not done so in an appropriate timescale.

6.8. NURSING PERSONNEL

6.8.1. Provide nursing and clinical care to individual CHR, e.g., caring for wounds, pressure sores and the change of dressings or with invasive procedure such as injections and bladder irrigations and matters relating to feeding tubes.

6.8.2. During the above provision, monitor the health status of the individual and report any change in circumstances to the GP.

6.8.3. Specialist nurses e.g., stoma nurses, palliative care nurses or continence advisors will similarly provide nursing and clinical care to individual service user and support to their family. These specialist nurses will support and educate CHPs and CHWs in coping with their particular condition and assist them in dealing with equipment or the drug treatment or therapy necessary to the condition.

6.8.4. There may be some instances when some procedures normally done by nursing personal can be done by carers. These are classed as Specialised Techniques (see Section 2 – 1.3.3) and would be specific to the patient and carer. The health care practitioner would need to train the carer to undertake the task, e.g., shared care management of skin tears.

7. IMPLEMENTATION

7.1. This policy will be disseminated to GPs, CPs, Hospital Pharmacies, Adult Social Care, and CHPs via email. It is expected that relevant line managers will make the policy available on their respective websites and communicated to staff via team briefings and training. All outdated copies will be removed from websites and replaced by the new version.

8. TRAINING & AWARENESS

Relevant line managers are responsible for ensuring staff involved in implementing this policy are aware and have the relevant training.

9. MONITORING & AUDIT

East Riding of Yorkshire Council and Hull City Council Business Management and Commissioning Unit are responsible for supporting CHP to effectively adopt and apply this policy ensuring the policy is implemented effectively by CHPs as detailed in section 6.3.

ERY CCG and Hull CCG Quality, Performance and Finance Committee and will be responsible for ensuring that primary care implements the policy effectively, including monitoring and audit of any additional services commissioned to support delivery.

10. POLICY REVIEW

10.1. This policy will be reviewed in 3 years. Earlier review may be required in response to exceptional circumstances, organisational change, or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this policy.

11. REFERENCES

Care Inspectorate, and a Royal Pharmaceutical Society (Scotland) and Social Work Scotland working group, Prompting, assisting and administration of medication in a care setting: guidance for professionals, 2015

http://www.careinspectorate.com/images/documents/2786/prompting-assisting- and-administration-of-medication-in-a-care-setting-guidance-for-professionals.pdf

Care Quality Commission, Guidance for providers on meeting the regulations, 2015

http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

National institute for Health and Care Excellence (NICE), Managing medicines in care homes (SC1), 2014

https://www.nice.org.uk/Guidance/SC1

NHS England, Network Contract Directed Enhanced Service, Structured medication reviews and medicines optimisation: guidance, 2020

https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf

12. ASSOCIATED DOCUMENTATION

12.1. The appendices to this policy provide further information and Standard Operating Procedures to support policy implementation.

13. IMPACT ANALYSES

13.1. EQUALITY

The ERYC and HullCC as well as ERY CCG and Hull CCG are committed to creating an environment where everyone is treated equitably and the potential for discrimination is identified and mitigated. No positive or negative impacts were identified.

The results of the assessment are displayed on the internet with this policy.

SUSTAINABILITY

A Sustainability Impact Assessment has been undertaken. No positive or negative impacts were identified against the twelve sustainability themes. The results of the assessment are displayed on the internet with this policy.

14. BRIBERY ACT 2010

14.1. ERYC and HullCC as well as ERY CCG and Hull CCG follow good business practice as outlined in their respective Business Conduct Policy and the Conflicts of Interest Policy and have robust controls in place to prevent fraud, bribery and corruption.

Under the Bribery Act 2010 there are four criminal offences:

- Bribing or offering to bribe another person (Section 1)
- Requesting, agreeing to receive or accepting a bribe (Section 2)
- Bribing, or offering to bribe, a foreign public official (Section 6)
- Failing to prevent bribery (Section 7).

14.2. Due consideration has been given to the Bribery Act 2010 in the development (or review, as appropriate) of this policy document and no specific risks were identified.

SECTION 2 – PROCEDURES

1. ASSESSMENT

GUIDING PRINCIPLE

THE RESPONSIBILITY FOR MANAGING MEDICINES SHOULD NOT BE TAKEN AWAY FROM SERVICE USER UNLESS THE ASSESSMENT INDICATES THE NEED.

1.1. PROCESS

1.1.1. Assess a service user medicines support needs as part of the overall assessment of needs and preferences for care and treatment.

1.1.2. Engage with a service user (and family members /representatives if this has been agreed with SU and appropriate) when assessing a service user's medicines support needs. Focus on how the person can be supported considering:

- Their needs and preferences, including social, cultural, emotional, religious, and spiritual needs
- Their expectations for confidentiality and advance care planning
- Their understanding of why they are taking their medicines
- What they are able to do and what support is needed e.g., reading medicine labels, using inhalers, or applying creams
- How they currently re-order, take and storage their medicines
- Whether they have any problems taking their medicines, particularly if they are taking multiple medicines
- Who to contact about their medicines (ideally the person themselves, if they choose to and are able to, or a family member/representative)
- Any special needs that must be considered.

1.1.3. Service user may have certain preferences relating to equality and diversity. These should be recognised at the assessment stage and arrangements made to accommodate them where possible, considering pharmaceutical/medical advice/guidance which must be sought and agreed during the assessment stage.

1.1.4. In an instance of fluctuating capacity or cognitive decline ensure that the service user and family members/representatives are actively involved in discussions and decision making. Record the person's view and preferences to help make decisions in the service user's best interest if they lack capacity to make decisions in the future (also see Section 2).

1.1.5. Record date of review of assessment pre-admission then 4 weekly or more often if any changes in circumstances, to ensure correct support is being given.

1.1.6. Mental Capacity and Best Interests Decision making

1.1.6.1. The Five statutory Principles in The Mental Capacity Act (2005) Code of Practice are as follows:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to support the person to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because they make an unwise decision
- An act done, or the decision made must be in the persons best interests
- The act or decision must be the least restrictive option in relation to the persons rights and freedom of action.

1.1.6.2. Decisions about the administration of medication, in the best interests of a service user who lacks capacity, should involve the prescribing practitioner and relevant people such as other professionals, family and CHP. Where the prescribing practitioner refuses or is unable to be involved in making the decision and there is an appropriate range of family, CHWs and suitably qualified HCPs available to contribute to making the decision, then it can be made without the prescribing practitioner.

1.1.6.3. If a service user is assessed as lacking capacity to make decisions regarding their health and welfare but they have a Lasting Power of Attorney (LPA) or court appointed Deputy who is able to legally make health and welfare decisions on their behalf, then they are the best interest decision makers in relation to care and support matters. The LPA or Deputy must meet the requirements set out in the Act and must follow the statutory principles of best interests.

1.1.6.4. A decision in relation to the administration of medication to a SU who has been assessed as lacking capacity to make this decision for themselves should be taken by the appropriate health care professional with appropriate documentation to be in place. The HCP should involve the person, informal carers and other professionals in their decision making and must follow the statutory principles.

1.2. PROVIDERS SUPPORT PLAN

1.2.1. Record discussions and decisions about the service user medicines support needs in the CHP personalised care plan, including:

- The person's preferences and expectations for confidentiality and advance care planning
- How consent for decisions about medicines will be sought
- Details of who to contact about their medicines (the person or named contact)
- Support needed for each medicine and how it will be given – this is especially important if the administration is e.g., cream only or oral medication only. The dosage or frequency should not be written on the personalised care plan
- Who will be responsible for providing medicines support, particularly when it is agreed that more than one HCP is involved
- When the support will be reviewed
- If an assessment identifies that the service user is at risk of overdose specific arrangements, such as secure storage, if self-administering should be in place for their prescribed medication(s). These arrangements should be documented in the personalised care plan and appropriately risk assessed.

1.3. TYPES OF SUPPORT

1.3.1. General Support for assisted self-administration

1.3.1.2. General support is given when the service user takes responsibility for their own medication. The support given may include some or all the following:

- Requesting repeat prescriptions from the GP, using the surgery on-line system including Proxy ordering
- Collecting medicines from the community pharmacy
- Disposing of unwanted medicine safely (when requested and required)
- An occasional reminder from the CHW to take medicine as indicated in the support plan. A persistent need for a reminder (for example daily for more than 7 days) may indicate that a service user does not have the ability to take responsibility for their own medicine and should prompt an urgent review of the personalised care plan
- Where alternatives are not available (as assessed by a pharmacist) the opening of a container under the direction of the service user who has capacity, for example, opening a bottle of liquid medication or popping tablets out of a manufacturer's blister pack
- Assistance with prescribed hosiery as well as appliance application aids and if CHW carry out any of the above, it must be recorded appropriately.

1.3.2. Administration of Medication

1.3.2.1. Administration of medication may include some or all the following (please refer to point 1.3.1.2.) plus CHW:

- Selects and prepares tablets/capsules/powder medication for immediate administration
- Selects and measures a dose of liquid medication for service user to take
- Applies a medicated cream/ointment
- Inserts drops to ears, nose, or eye
- Assembles/prepares an inhaler for self-administration by service user themselves
- Selects and administers an inhaler via a spacer or a nebuliser for a person who is unable to self-administer (preventer inhalers only) to prevent a condition from worsening
- Applies a transdermal patch
- Addition of thickeners to fluids
- Applies a cream to treat/prevent moisture lesions.

1.3.2.2. If the service user lacks the capacity to consent to support with administration of medication, it is still possible to administer the medication if it is considered to be in their best interests. But only following a best interest meeting with appropriate documentation completed to support the decision.

1.3.2.3. CHWs should administer medication from the original container, as dispensed and labelled by a pharmacy. Pharmacy filled monitor dose systems (MDS) are acceptable if designed for CH use but under no circumstances should they to be used for 'when required' medications.

1.3.3. Administration of medication by specialised techniques

1.3.3.1. In exceptional circumstances and following an assessment by an appropriate healthcare professional, a CHW may be asked to administer medication by a specialist technique. In those circumstances HCP e.g., a registered nurse must provide the required extra training following guidance from the Nursing and Midwifery Council. A CHW may be trained under their guidance and be signed off as competent to carry out the specialist health related task. This training is specific to both the service user and the CHW and refresher training should take place at least annually. The HCP delivering the training will not remain responsible for the competency of the CHW.

1.3.3.2. It is important that:

- The assessor explains the type of assistance proposed to the service user. The SU consent (when they have the capacity to do so) should be recorded in the support plan. Consent may be given in writing, verbally or a physical gesture.
- The SU consents on each occasion medication is to be administered by specialised techniques.
- The CHW should feel competent to carry out the specialist task and agrees to give the procedure and can refuse to do so if not.
- Clear roles and responsibilities are agreed by the CHP and the HCP.

1.3.3.3. Specialised techniques may include:

- Rectal administration, e.g., suppositories, diazepam (for epileptic seizures)
- Any action regarding Insulin including preparation, injection and testing of blood sugars
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG) or Percutaneous Endoscopic Jejunostomy (PEJ)
- Simple dressings or first aid (more information can be found in ERY Homely Remedy Protocol)
- Oxygen procedures
- Use of an Epipen
- Buccal administration of midazolam.

1.4. COVERT ADMINISTRATION

1.4.1. A person must be assumed to have the mental capacity to make decisions and a refusal of medication by a service user who has capacity should be respected.

1.4.2. Disguising medication e.g., mixing with food or drink in the absence of consent (covert administration) may be regarded as deception, as the person is being led to believe that they are not receiving medication when in fact they are.

1.4.3. Covert administration should only be considered as a last resort and the decision to administer covertly, should only be made by during best interest meeting which needs to be documented appropriately.

1.4.4. Best interest meeting should involve CHWs, HCP(s) prescribing for the service user, pharmacist and family member or advocate to agree whether administering medicines without the SU knowing (covertly) is in their best interests.

1.4.5. The information recorded would include the agreement to the decision of the action to be taken and the names of all parties concerned (including the SU GP and relatives/advocate as well as other HCP and CHWs) and documented in the personalised care plans. The decision and medications administered covertly should be reviewed on a regular basis and always when a change in circumstances is recognised.

1.5. SECURE STORAGE

1.5.1. The decision of where to store the medicines in care home should take into account the size of the home and nature of the medicines supplied to the home. Medicines could be stored centrally in a designated room or in an appropriate locked cupboard in the SU's room if self-administering and appropriate risk assessment has been put in place.

1.5.2. Most medicines should be stored below 25 degrees C and away from sources of heat and moisture. The directions on the product packaging, dispensing label or patient information leaflet (PIL) should be followed regarding the storage conditions for each medication. Where CHW are not sure, or there are problems with the storage, the pharmacist can be contacted for advice.

Examples of places NOT suitable for the storage of medicines include kitchens, bathrooms, toilets or next to heaters.

1.5.3. Medications must be date checked on a regular basis and out of date medication disposed of appropriately. New supplies should be placed behind older supplies when medication is received, so that the older supplies are used first.

1.5.4. Medicines for internal use must be stored in the locked cabinet/cupboard or trolley provided. Cabinets/cupboards used for medication storage must be of a robust construction, big enough to store the medication appropriately and have a good quality lock. If a trolley is used to store medication, it must be locked and tethered to a wall, or kept in a locked room to which only authorised staff have access, when not being used to administer medication.

Adequate lockable storage must be provided at all times for all medication, including those supplied in a monitored dosage system (MDS). This also applies to the new medication received at the changeover period.

1.5.5. Medicines for external use must be stored in a separate locked cupboard or physically separated from internal medicines on separate shelves in the main medicines' cupboard.

Additional consideration should be given to storying thickeners. Whilst it is important that products remain accessible, all relevant CHW need to be aware of potential risks to the safety of service user. An appropriate storage and administration of thickening powder needs to be embedded within the wider context of protocols in the care home.

1.5.6. The security of medicines must not be compromised by cupboards being used for non-clinical purposes, for example, storing money or valuables. Also, pharmaceutical advice should be taken before any changes to storage arrangements are made.

1.5.7. Controlled drugs (CDs), that require safe custody and are not being self-administered, must be stored in a CD cabinet which meets the requirements specified in the Misuse of Drugs (Safe Custody) Regulations.

The cabinet should be raw bolted to a solid wall. If CDs are incorporated into a monitored dosage system, then the whole system which contains the CD must be kept in the CD cabinet. Service users who are self-administering their prescribed CDs can hold their own individually dispensed supply of controlled drugs in their personal lockable, non-portable cupboard/drawer in their room.

1.5.8. Medicines requiring cold storage must be stored in a dedicated, locked medication refrigerator. The temperature of the medication refrigerator should be monitored daily using the maximum and minimum thermometer and the maximum and minimum temperatures recorded*. The thermometer must be reset after each reading. The required temperature range is between 2– 8 degrees C.

1.5.9. If the temperature of the refrigerator is found to be outside of the required range the following actions must be taken as a matter of priority:

- A pharmacist must be contacted to obtain information on individual products as some of the medication may need to be destroyed and replaced.
- The advice given should be recorded, including the name of the pharmacist.
- Medication which can no longer be used should be removed from stock and disposed of. Arrangements for a new supply of the medication should be made with the relevant GP's practice as a matter of urgency.
- Any medication that can remain in use should be marked with any shortened shelf life advised by the pharmacist. Where necessary, a different refrigerator, monitored the same way as the medication refrigerator, should be used to store the medication until the reason for the temperature fluctuation can be identified and corrected.
- Arrangements should be made to have the refrigerator checked and repaired or replaced as soon as possible.
- The refrigerator must be cleaned and defrosted regularly. This should be documented on the refrigerator records.

1.5.10. The keys for the medicines trolley, cupboards, CD cabinet, refrigerator and clinical area must be kept separate from other keys and not part of the master key system.

The carer in charge of the medication on that shift must hold the keys. All medicine keys must be handed directly from one designated member of staff to the next designated member of staff and not left in a 'safe place' or given to anyone else for safe-keeping.

Any spare keys must be stored in an appropriate secure place where only designated staff have access to them.

1.5.11. If a person is prescribed oxygen the home must discuss storage and administration with the engineer from the company who supplies the oxygen. Their advice should be documented and followed.

1.5.12. A risk assessment must be completed for the storage and use of oxygen in line with health and safety procedures.

1.5.13. Oxygen cylinders should be stored securely, under cover and not subject to extreme temperatures. This should be in a dry, clean, well-ventilated area away from highly flammable liquids, combustibles and sources of heat and ignition. A statutory warning notice should be displayed in any room/area where oxygen is stored or used, stating "**Compressed gas. Oxygen: No Smoking. No naked lights.**"

1.5.14. Cylinders should be handled with care, never knocked violently, or allowed to fall over. They must be switched off when not in use. Cylinders should only be moved with a trolley specifically designed for the cylinder size unless it is a small portable cylinder.

1.5.15. Oxygen concentrators must be stored upright and plugged directly into the mains socket. Adequate ventilation must be provided around the concentrator. They must always be switched off when not in use.

1.5.16. In the case of fire, it is the responsibility of staff to inform the fire brigade that oxygen cylinders and/or concentrators are present and where they are located. When evacuating people from the home, oxygen concentrators or cylinders left in the home should be switched off, where it is safe to do so, as part of the evacuation process.

2. SUPPORT FOR PRESCRIBED MEDICATIONS

2.1. Arrangements for the supply of prescribed medications should be agreed with the service user or if lacking capacity to make decisions regarding their health and welfare appointed representative and documented in the personalised care plan by CHP.

2.2. Such arrangements should include the following:

- ordering prescriptions for regular medication
- collecting prescriptions from the GP surgery or other healthcare setting as required
- delivering prescriptions to the community pharmacy
- collection of medication from community pharmacy and taking to CH.

2.3. If agreed that the service user requires medicines administration, then it should be confirmed with community pharmacy to provide the Medicines Record Chart for CHP including the charts for non-routine medications. The arrangements for the provision of MARs should be noted in the personalised care plan.

2.4. Where the service user's normal pharmacy does not provide the Medicines Record Chart for CH, CHP should agree with the SU or their representative which pharmacy will be used to dispense prescriptions.

2.5. The usual arrangements for collection and delivery of prescriptions should be agreed with the pharmacy and recorded appropriately. Prescription ordering arrangements must not be delegated to the supplying CP as this will be classed as third-party ordering.

2.6. The CHP should liaise with the community pharmacy to agree medication delivery arrangements. Urgent prescriptions may need to be dispensed by an ‘out of hours’ or by a different pharmacy.

2.7. The CHP must ensure that the correct amounts of the medicines are available including 'when required' medications, in line with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

If the CHP has done all in its power to ensure that the medication is in place and for some reason, outside its control, there is not sufficient medication in place the CHP should ensure that this is documented, reported and escalated appropriately.

2.8. CHP must ensure their staff is be trained and competent to handle medication ordering. They should ensure that the CHWs have sufficient time allocated for checking which medicines are needed, liaising with the GP to order medicines and checking that the correct medicines and quantities have been supplied.

2.9. To minimise additional calls for the CHP, medications could be ordered by electronic means using the:

- Practice GP online service
- NHS App
- NHS-mail directly to the Practice.

This constitutes third-party or “Proxy” access. Both the SU (or where there is lack of capacity someone with POA for that person) and the GP will need to consent to access. CHP should liaise with the GP to agree the most appropriate way of ordering.

Historical methods of ordering such as telephoning the GP Practice or dropping off repeat prescription lists are no longer considered appropriate due to the additional time and workload involved.

2.10. When ordering/receiving a service user’s medicines CHPs should:

- Record on the MAR or other appropriate document when medicines have been ordered
- Record in when the medicines have been supplied (collected or delivered)
- Check for any discrepancies between the medicines ordered and those supplied
- Check the quantity supplied matches the quantity on the dispensing label
- Know what action to take if any discrepancies are noted.

2.11. Most Community Pharmacies will offer a delivery service. It is important to remember that such a service is not funded by the NHS and is at the discretion of each individual pharmacy. Delivery may be restricted to certain days, between certain times and in defined geographical areas and may be subject to change and charge. Where possible, it is preferable to use this service for monthly medication supplies to minimise additional burden. The arrangements for delivery should be risk assessed and agreed with the Community Pharmacy and documented appropriately.

2.12. Pharmacies should supply all medicines with patient information leaflets (PILs).

2.13. No more than 28 day's supply of medicines, including those on repeat prescriptions should normally be requested and prescribed for an individual at any one time.

2.14. Where a mid-month medication has been prescribed to replace an existing medication listed on the MAR chart, the CHP MUST make sure the chart has been annotated to indicate which medication has been stopped and by whom to prevent any further administration occurring.

2.15. Dispensed medicine becomes the property of the service user to whom it has been prescribed. It should not be used for the treatment of anyone else.

3. SUPPORT FOR SELF CARE (NON-PRESCRIBED OR OVER THE COUNTER MEDICATION)

3.1. Some service users may request the CHP to support them with non-prescribed medicines as well as homely remedies e.g., vitamin tablets/cod liver oil capsules. The CHW should refer the request to manager for discussion with the SU's pharmacist or GP to ensure that this medication is safe to take with their other prescribed medication. Once it has been agreed that it is safe to administer this should be recorded in the care plan including the name, role and profession of the person giving this advice.

The CHP should ensure that the SU understands and accepts any risk associated with taking the medicine. A CHP may comply with any request to purchase a specific OTC or complementary treatments only if the SU understands and accepts the associated risks.

3.2. CHPs should purchase only the product specified by the service user and should only buy an alternative brand or product where the SU has asked them to do so.

3.3. The CHWs can only administer from the original pack as purchased and must follow the directions on the pack. This medication would need to be handwritten onto the MAR chart as above including the name strength and quantity of medicine (see Appendix 1).

3.4. All administration would need to be recorded on the MAR chart. CHPs must not offer advice to a service user on OTC medication or complementary treatments, nor should they purchase any such medicines based on symptoms described by SU or the family.

3.5. In the case of moisturising creams (including facial moisturisers) these can be applied as requested by the service user as part of the personal care if this is written into the support plan. An example of this would be E45 cream. Many SUs use this as a general moisturiser. However, if the SU has severe dry skin or a rash it would be appropriate to refer to the appropriate HCP who may decide to prescribe a cream for the condition.

4. ADMINISTERING AND RECORDING MEDICATION

GUIDING PRINCIPLE

CHWs MAY, WITH THE CONSENT OF THE SERVICE USER, ADMINISTER PRESCRIBED MEDICATION, SO LONG AS THIS IS IN ACCORDANCE WITH THE PRESCRIBER'S DIRECTIONS (Human Medicines Regulations 2012).

4.1. This Policy is based on ‘6 R's'.

- The right SU receives……..
- The right medicine……..
- At the right dose……..
- Via the right route……..
- At the right time and frequency……..
- And has the right to refuse.

At times seventh 'R' is added and refers to 'the right documentation'.

4.2. Advice on medicines can be obtained from:

- Any community pharmacist (CP)
- The service user’s GP or Non-Medical Prescriber (e.g. Advanced Care Practitioner, Nurse Prescriber, Pharmacist Prescriber, Consultant)
- NHS 111 (24 hours).

4.4. CAPACITY AND MEDICINES ADMINISTRATION

4.4.1. The CHW administering the medication can assume that any actions taken under the support plan are agreed to be in the SU best interests. However, they have a key role in assessing capacity and best interests at the time of administering the medication.

4.4.2. If there are variations in the circumstances covered by the support plan e.g. where a service user who lacks capacity but has previously complied with taking medication now refuses to take that medication, or where a CHR who previously had capacity to agree to assistance with administration of medication now appears to lack the capacity to agree to that assistance, the CHW should not proceed with administering the medication but must seek medical advice as the cessation of medication may place an individual at risk.

4.4.3. The medication refusal should be discussed with the patients GP or other appropriately qualified prescriber and any advice or actions requested by them must be documented and retained in the CH. Records must include the date the situation arose, date discussed with GP, name of person raising the query, a timeline with an appropriate date for re-review.

4.5. MEDICATION ADMINISTRATION RECORD

4.5.1. Electronic Medication administration record (eMARs):

A variety of electronic solutions are now available for CHP. Many include the functionality to produce eMARs, which will remove the requirement for paper MARs.

Currently there are two systems:

- CP enters the SU medication via a portal, after performing a clinical check of the medication – this is the preferred system as it mirrors the current paper MAR, ensuring that the eMAR is completed by a clinical professional
- CHWs enter the medication onto the system - this is classed as transcription and, as with handwritten MAR, is only allowed in exceptional circumstances under this policy. Where

a CHP wishes to use staff to enter medication onto a service users eMAR, the staff must be trained to do so, completing annual updates, with a regular audit in place to confirm no medication errors have occurred.

Due to the wide range of eMAR systems on the market the CHP may need to support visiting professionals to access any records they need to see. The CHP will need to provide access to records in a way that meets their own governance requirements. The CHP may do this by providing guest log-in details. CHP may need to make a member of staff available to support the person to access and navigate records.

4.5.2. Pre-printed Medication Administration Record MARs

Supplying pharmacies should produce medicines administration records wherever possible.

4.5.3. There may be some circumstances where the service user can successfully manage to take all their oral medicines but needs help with the application of external medication. In these instances, the CHP would need to identify the support required within the care plan considering for example who is responsible for ordering, storing, administration and confirm consent with the SU that they would be responsible for all other medications.

4.5.4. The support needed should be clearly documented in the service user support plan as 'CHW to administer e.g., creams only'. This would be also recorded on the MAR request form so the community pharmacy or dispensing doctor can supply a MAR chart for those items only.

4.5.5. If the CP supplies a chart for medications which the SU is self-administering, this should be annotated to indicate 'self-administering', but does not need to be completed with admin data.

4.5.6. The CHW will record the administration of these medications only on the MAR chart.

4.5.7. CHP should ensure that medicines administration records (paper-based or electronic) include:

- the full name, date of birth and preferably weight (if under 16 years or where appropriate, for example, frail patients) of the service user
- details of any medicines the service user is taking, including the name of the medicine and its strength, form, dose, time it is given and where it is given (route of administration)
- known allergies and reactions to medicines or their ingredients
- any special instructions about how the medicine should be taken (such as before, with or after food).

4.5.8. CHP should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home.

The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.

4.5.9. CHP should ensure that all information included on the medicine's administration record is up-to-date and accurate. They may need support from the HCP supplying the medicines and the supplying pharmacy to do this.

4.5.10. Where there is a change in provider, the new provider should take the MAR for their own file and send a copy to the previous provider. This may be in the form of a secure photograph or a photocopy. This is to ensure that both providers have a copy of their own mediation administration record for CQC inspection. Where there are 2 or more providers throughout the length of the MAR, the lead provider will retain the MAR and send a copy to the other providers.

4.5.11. CHP must ensure there is a robust system in place and carry out a periodic check of MAR to ensure they are completed correctly. This is especially important for any handwritten charts.

4.6. ADMINISTRATION PROCEDURE

4.6.1. CHW must record medicines administration, including the date and time, on the relevant medicine's administration record, as soon as possible and ensure that they:

- make the record only when the service user has taken their prescribed medicine
- complete the administration before moving on to the next SU
- recognise that mistakes are less likely if 1 member of staff records administration on the medicine's administration record rather than 2 staff recording
- record 'when required' medicines only when they have been given, noting the dose given and the amount left (where possible), to make sure that there is enough in stock and to reduce waste
- record when and why medicines have not been given
- correct written mistakes with a single line through the mistake followed by the correction and a signature, date and time (correction fluid should not be used).

4.6.2. CHP should keep a record of medicines administered by visiting health professionals on the service user's medicines administration record.

4.6.3. CHWs responsible for administering medicines should add a cross-reference (for example, 'see warfarin administration record') to the service user's medicines administration record when a medicine has a separate MAR.

4.6.4. CHWs should make appropriate records of controlled drugs that have been administered to service users. The CHWs responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. The staff member administering the controlled drug should also sign the MAR.

4.6.5. The administration of medication should be done in accordance with the prescriber’s instructions and following the directions on the MAR.

4.6.6. The CHW must confirm that a dose has been administered by entering their initials in the appropriate box on the MAR; this must be recorded at the time of administration.

4.6.7. CHWs should be aware when administering medication that there can be adverse effects – and these should be monitored, recorded and reported to the responsible HCP as relevant.

4.6.8. CHPs should ensure that the following information is given to the service user and/or their family members or carers when the resident is temporarily away from the care home:

- the medicines taken with the SU
- clear directions and advice on how, when and how much of the medicines the SU should take
- time of the last and next dose of each medicine
- a contact for queries about the resident's medicines, such as the CH, supplying pharmacy or GP.

4.6.9. When required medication (PRN)

4.6.9.1. ‘When required medications’ (PRN) are those that HCP has prescribed to be taken only when certain conditions or criteria are met, e.g., tablets for pain relief or inhalers for asthma.

4.6.9.2. CHP should ensure that a process for administering 'when required' medicines is included in the care home medicines policy. The following information should be included:

- the reasons for giving the 'when required' medicine
- how much to give if a variable dose has been prescribed
- what the medicine is expected to do
- the minimum time between doses if the first dose has not worked
- offering the medicine when needed and not just during 'medication rounds'
- when to check with the prescriber any confusion about which medicines or doses are to be given
- recording 'when required' medicines in the service user's care plan.

4.6.9.3. The use of PRN as a direction should be limited to when there is no other alternative.

4.6.9.4. The prescriber should indicate the following to support the CHW to administer the medication safely:

- When to give the medication including the indication e.g., for pain/constipation with specific details ((for example, 'when low back pain is troublesome take 1 tablet')
- Quantity to be administered e.g., 5ml or 1 tablet
- The dose e.g., up to four times a day
- The repeat dose interval e.g., not more than every 4 hours
- The maximum dose permitted within a 24-hour period.

4.6.9.5. Prescribers should not use variable doses e.g., 1 or 2 tablets, unless the prescriber is confident that the SU can direct the CHW to the dose they need.

4.6.9.6. The CHW must be informed as to the specific symptoms that the PRN is prescribed to treat, and these ideally should be recorded on the medication label.

4.6.9.7. The CHW should document each time the PRN medication is offered, taken, not required or refused on the MAR chart.

4.6.9.8. CHWs should ensure that 'when required' medicines are kept in their original packaging.

4.6.10. Controlled drugs (CD)

4.6.10.1. For medicines that are controlled drugs, and subject to CD recording requirements, the CHP must also keep a separate CD register, in addition to the record on the MAR chart. The CD register must be a bound book with numbered pages. There must be a separate page for each form and strength of each controlled drug for each person. A running balance must be included in the register for each medicine.

4.6.10.2. The CD register must be used to record the receipt, administration, transfer or disposal of CDs.

4.6.10.3. The balances in the CD register should be checked at least weekly by two members of appropriately trained staff and reconciled with the actual medication in the CD cabinet. An entry should be made in the register on the appropriate page to indicate that a check has taken place.

4.6.10.4. Any discrepancies found between the recorded balance in the CD register and the actual medication in the CD cabinet should be reported to the registered manager and investigated immediately.

4.6.11. Splitting/crushing of solid dosage forms

4.6.11.1. The unlicensed splitting, cutting or crushing of a solid dosage form or opening a capsule must be the exception and not the rule. It is only acceptable when there is no other alternative and should be fully documented, approval has been secured from the GP or other HCP and should be fully documented to include name of authorising person and date.

4.6.11.2. Some medications CANNOT be safely split or crushed and may cause serious harm to an individual if modified. Prior authorisation from a GP or other HCP MUST always be sought before altering a medication in any way.

4.6.11.3. Any medications that require splitting or crushing must be referred back to the prescriber/dispenser to consider if an alternative formulation is available. If the medication is available in an alternative licensed formulation, for example in liquid form, then the alternative must be prescribed. If there is no alternative licensed formulation, then the prescriber may wish to consider switching to a similar medication that is available in an alternative licensed formulation.

4.6.11.4. Occasions when medication may need to be split or crushed:

- To make it easier for the SU to swallow when there is no other alternative licensed formulation
- To administer a medication covertly (see section 2 - 1.4)
- To administer a medication by a feeding tube

- To administer the correct dose of medication e.g., half a tablet.

4.6.11.5. If there is no licensed alternative, and provided prior approval has been agreed, the dispenser will split tablets during the dispensing process and supply in a suitably labelled container.

4.6.11.6. The prescriber must agree that the medication may be crushed, and this must be clearly indicated on the prescription and dispensing label.

4.6.11.7. Crushing medication must be done individually and immediately prior to administration, using a tablet crusher.

4.6.11.8. CHWs administering medications in this way must have appropriate training.

4.6.12. Refusal

4.6.12.1. Guidance for CHWs should be included in the support plans of service user who regularly refuse medication. This should detail the actions required of the CHW in the event of poor compliance and instructions on when the prescriber should be contacted.

4.6.12.2. It is a service user right to refuse medicine. Medications can be refused or not taken for different reasons. The SU:

- May not be ready for them
- Does not like the taste of their medication
- Finds solid oral dosage forms difficult to swallow
- Does not understand what the medication is for and why you are administering them.

4.6.12.3. If the service user refuses a dose of medication, then the CHW must record the refusal on the MAR chart and also record details of the circumstances of the refusal in the support plan. The manager must be informed, and advice sought from the prescriber when medications are refused for more than 24 hours.

4.6.12.4. When a service user refuses their medication, it is important to try and understand why. There may be simple solutions to help.

4.6.12.5. If a service user is self-administering their medication and the CHW becomes aware that the SU is not taking the prescribed medication, this should warrant the need for further assessment.

4.6.13. Multiproviders

4.6.13.1. If there is more than one provider involved in dealing with medication their respective roles and responsibilities should be clarified and clearly documented in the support plan.

4.6.13.2. Where it has been identified that a service user requires some of their prescribed medication to be administered by a CHW, with the remaining medicines to be administered by SU this needs to be clearly identified in the SU support plan. The support plan should state: “CH to administer the following prescribed medications (Name of Med1) (Name of Med2) (Name of Med3) as instructed via the MAR Chart. The SU will administer all other prescribed medication stated on the MAR chart.”

4.6.13.3. Any changes to medication should be updated by the CHW on the support plan as directed by the HCP.

5. DISPOSAL OF MEDICATION

Guiding Principle - Medications are the property of the SU.

All care settings should have a written policy for the disposal of excess, unwanted or expired medication.

5.1. Before disposing of a medicine that is still being prescribed for a service user, CHW should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.

5.2. When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:

- unwanted medicines (including medicines of any resident who has died)
- expired medicines (including controlled drugs).

5.3. CHP should keep records of medicines (including controlled drugs) that have been disposed of or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a medication room until they are collected or taken to the pharmacy.

5.4. A record of stock to be returned to the pharmacy should be completed as soon as the medication is removed from the medication cabinet and placed in the clinical waste.

5.5. Dropped tablets/spilled liquids can be avoided with good administration techniques e.g., preparing doses over a work surface. If a tablet is dropped /liquid spilled spat out or refused the CHW should assess the situation and prepare another dose where appropriate. If medication is disposed of a note should be made in the MAR of what medications have been disposed of.

5.6. If doses of medication are dropped/disposed of and need replacing a new prescription may be needed to replace these doses e.g., there would be insufficient medication to last to the end of the 28-day period. This should be explained to the GP surgery when the extra medication is ordered by the person identified on the MAR request form. It is not acceptable to just begin a new cycle of medication as this leads to waste.

5.7. Individual tablets should be placed in a small container or envelope and clearly labelled ‘medications for return and destruction’. This container should then be kept separate from the medication to be administered and arrangements made to return to the pharmacy at the end of the month. If the medication is kept in safe storage, then this container or envelope should be placed in the locked box or tamper proof container.

Care homes with Nursing MUST have a waste contract in place and cannot return medication to a pharmacy for disposal.

HOSPITAL APPOINMENTS, ADMISSION AND DISCHARGE

6.1. OUTPATIENT APPOINTMENT

6.1.1. If a service user attends an outpatient appointment, they should take a copy of the repeat prescription or copy of current MAR with them.

6.1.2. Where a routine medication is recommended at an outpatient appointment the hospital will write to the SU GP outlining the reasons for this. The GP will consider the recommendation and prescribe any necessary medication if appropriate. The GP will then inform the CH that there is a new medication and supply a prescription. The normal procedure can then be followed.

6.1.3. The exception to this is where a SU is prescribed a hospital only medicine or requires an urgent supply. In these circumstances a handwritten MAR may be required.

6.1.4. If family or an informal carer takes the SU for a hospital appointment, and the CH is aware of this, they should be asked to follow the same guidelines

6.2. HOSPITAL ADMISSION

6.2.1. If a service user is admitted to hospital all medication should be sent with them. The original MAR should remain in the CH.

6.2.2. If this MAR is superseded by another MAR then the newest version of should be used.

6.3. HOSPITAL DISCHARGE

6.3.1. A copy of the discharge letter must be sent the CHP. In addition, CHP should then inform the CP of any medication changes following a discharge from hospital ideally providing a copy of the discharge letter to the pharmacy.

Also, the CP should be notified if a change to the CHR GP occurs.

6.3.2. Service user discharged from hospital may have medication that differs from that which they had before admission. Sufficient current medication must be provided to allow the SU to take their required medication whilst the CH establishes a new supply. For short stay/respite the medication provided should be sufficient to cover the whole stay wherever possible.

6.3.3. CHP must ensure that arrangements are made with the SU GP to ensure the continuity of supply of the medication, where this is necessary. Where the SU is changing doctors, CHP should ensure that the registration with the new GP is completed as soon as possible. CHP should also check with the new surgery if they have any registration processes, for example “new patient health checks”, and if so, these should be followed to ensure that care can be transferred smoothly.

6.3.4. Prescribed medication must be supplied in the container as originally dispensed by the pharmacy/dispensing GP or hospital pharmacy and have the dispensing label attached.

6.3.5. If MAR is not supplied and medication has been sent home with the SU, the CH should clarify with the hospital ward which medicines should be administered. This should be cross checked against the discharge note.

6.3.6. All new medication should be recorded on a handwritten MAR chart if necessary, following the guidance in Appendix 1. It must be written in ink with the name of the medicine written in block capitals.

7. TRAINING CHW TO SAFELY ADMINISTER MEDICATION

7.1. In residential care services, any CHW who is involved with medication including ordering and collecting medication needs to have training in line with this policy and be signed off as competent.

7.2. All medication (except those for self-administration), including the application of external medication such as creams, should be administered by designated and appropriately trained staff.

7.3. Medication training must be carried out by trainers that are knowledgeable in the subject area and have relevant current experience in handling medication so that CHWs who are responsible for managing and administering medicines can be assessed by an external assessor.

Training undertaken must reflect the requirements of the Residential Care Home Medication Policy.

7.4. The CHP must establish a formal means to assess whether the CHW is sufficiently competent in medication administration before being allowed to handle medicines and this process must be recorded in the CHW's training file.

7.5. Training for care staff must include:

- The principles behind all aspects of the policy
- Basic knowledge of how medicines are used and how to recognise and deal with problems in use.

7.6. Basic training should be received by all CHWs involved in any aspect of medication support including

- Ordering, collecting medication or applying creams
- Safe handling of medication.

7.7. Specialist training will apply in specific situations and is specific to individuals. This training should be provided by suitably trained HCPs experienced in the required technique.

7.8. CHP should ensure that all CHW have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. CHP should identify any other training needed by CHW responsible for managing and administering medicines.

7.9. CHPs must ensure that competency assessors have the relevant practical knowledge to assess CHW.

8. ERRORS AND UNTOWARD INCIDENTS

8.1. Medication error as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice. Examples of administration errors could include a service user receiving the wrong dose or incorrect medication or could be a missed dose.

8.2. Most medication errors do not harm the individual although some can have serious consequences. Errors may result in an accident or an adverse event, or where averted, they can be classified as a “near miss”.

8.3. Commissioners and providers of health or social care services have to ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving service users. This is important to inform improved practice, including any relevant updates to policy.

8.4. CHWs must report errors in the administration of medication and related tasks to relevant HCP as well as the manager. This may result in appropriate further training and competence testing. It is important that all errors are recorded, and the cause investigated to learn from the incidents and prevent a similar error happening in future.

8.5. CHWs should be trained in recognising medication errors, incidents and near misses and be clear as to the definition of a medication error, incident and “near miss”.

8.6. If a CHW is aware of having made an error in administering medication or notices that an error has been made e.g., by another CHW, the pharmacy or the prescriber, the following action should be taken:

- Notify the manager. If unable to contact the manager, the CHW should not delay seeking medical advice.
- Seek advice from, the SU's GP or an appropriate HCP e.g., pharmacist or 111. Some errors may appear trivial e.g., omitting a dose of paracetamol or antibiotics however since it is not appropriate for the CHW to gauge the seriousness of an error advice from a professional MUST be sought. Medication errors must not be treated as trivial, and ALL must be reported Enter details of the error on the MAR chart.

8.7. THE STATUTORY REQUIREMENTS FOR REPORTING MEDICATION ERRORS

8.7.1. From 1 October 2010, all adult social care services including CHPs must notify the Care Quality Commission (CQC) under the Health and Social Care Act 2008 about specific incidents and errors, as per CQC procedure. The law requires these notifications to be submitted within certain timescales.

8.7.2. Further guidance is available via the CQC guidance on Statutory Notifications: Regulation 20 – ‘Duty of Candour’. This covers any event which adversely affects the well-being or safety of any service user. It also sets out some specific requirements that CHP must follow when things go wrong with care and treatment. The notification must be made in writing and the CQC provide template forms to simplify the notification process, which should be emailed to CQC notifications.

8.7.3. A notifiable incident is an error in the administration of a prescribed medication that leads to harm or a medical consultation.

8.7.4. Once the manager is aware of a notifiable incident they must:

- Notify the Care Quality Commission of the error in writing. The timescale for reporting is within 24 hours of becoming aware.
- Follow the requirements of the safeguarding tool, inform the SU's GP if not already done so or, if out of hours, call NHS111.
- Investigate the cause of the incident.

8.7.4. As part of the CQC inspection and regulation, CHPs are required to have written procedures for the reporting of adverse events, adverse drug reactions, incidents, errors and near misses. These should encourage reporting, learning and promoting an open and fair culture of safety.

8.7.5. Providers must keep a record of the written notification, along with any enquiries and investigations and the outcome or results of the enquiries or investigations.

8.7.6. If a service user is unwell as a result of the medication error or incident, medical assistance should be sought straight away. If serious negligence or an attempt to cover up an error is discovered, this should be treated as a disciplinary offence and the safeguards alert process should be followed, including informing the Police. This may result in legal action against the CHW, their employer or both.

8.7.7. All notifiable incidents should be reported to the CQC. However, CHPs should not ignore other errors, incidents or near misses - no errors should be ignored.

8.7.8. CHPs should encourage a culture that allows their CHWs to report incidents without the fear of an unjustifiable level of recrimination. The more evidence that is reported the more information is available about what could possibly go wrong.

8.7.9. The CHP should have a clear process for error reporting and reviewing, including the requirement for a written report describing:

- What has happened
- What was done to rectify the immediate situation and what has been done to prevent it happening again
- A regular schedule for investigating and reviewing medication errors, incidents and near misses by a designated member of staff
- The results of these regular investigations should be recorded including any actions taken such as offering training to individuals or reviewing existing procedures to prevent a similar error happening in the future. Regular meetings should be held with all CHWs involved with the handling of medications to review the outcomes and investigations of errors/incidents/near misses share learnings and prevent reoccurrence of similar errors, incidents or near misses.

8.7.10. The CHP should also log any incidents that occur as a result of errors made as part of the prescribing or dispensing process, for example, by GPs or community pharmacists. Such errors should be discussed with the GP or community pharmacist.

8.7.11. The CHP should have a robust system for the constant review of the accuracy of medication administration records. This will help to reduce administration errors and is recommended by the 'Care Home Use of Medicines Study' (CHUMS). This system could be in form of a regular audit or review and could focus on, for example, reasons for omitted doses, coding of refusals, and administration of when required medicines. Poor practice can result in harm when risks are not identified, and no action is taken to prevent further incidents occurring or the concern escalating.

8.7.12. The CHP incident logs should always be checked for patterns. If the same or similar incident occurs that relates to the same or another service user, it would suggest that the risk assessment/care plan or other elements of prevention in place are not effective. Recurring incidents may not appear to have any visible impact on the SU or others, however raising a safeguarding alert should be considered, to prevent harm being experienced in the long-term.

8.7.13. Whenever it becomes apparent that a notifiable incident has occurred, the CHP must notify the Care Quality Commission (CQC) (Regulation 20). There is also a positive obligation on the part of all CHWs and CHP to consider whether a safeguarding alert should be triggered. In reaching a decision, reference and guidance should be sought from the Safeguarding team.

8.8. REPORTING ADVERSE DRUG REACTIONS

8.8.1. If a new medication is prescribed for a service user and they become unwell, this could be because of the new medication. NICE guidance recommends that CHWs should report all suspected adverse reactions that a SU has had from the use of prescribed medications to the HCP who prescribed the medication or another HCP as soon as possible.

8.8.2. CHWs should record the details in the service user's care plans and notify the prescriber. Doctors, nurses and pharmacists can report adverse drug reactions to the Medicine and Healthcare products Regulatory Agency (MHRA). There are some occasions when it is appropriate for a SU or CHW to make this report. Further information can be obtained from their website (www.mhra.gov.uk).

9. MEDICATION FOR ADMINISTRATION BY HEALTH CARE PROFESSIONALS (HCP)

9.1. There may be times when a service user receives support services from HCP which include the administration of medication separate to their normal medication (for example Just in Case medication boxes or insulin).

9.2. In these instances, there is a need for clear communication between all involved parties, including the SU, Care Management Team, Healthcare team, CHP and CP, as to what medication CHWs are to administer and what is to be administered by HCP Professionals.

9.3. Medication administered by the HCP should be clearly identified on the MAR chart as administered by the HCP. These would likely be, but not wholly, injections so would be outside the level 2 administration procedure.

9.4. In some circumstances it may not be possible to include the medication to be administered by health care professionals on the MAR. If this is the case it should be clarified in the SU care plan and the medication to be administered by the HCP to be kept separately from medication the CHWs are responsible for administering.

9.5. It is essential to allow HCP access to the service user MAR for information purposes. When HCP administers controlled drugs (CDs) for example anticipatory medications in the care home, the record should be made in the CD register as well as in the service user MAR chart.

The CHWs are responsible for recording on service user MAR that the medication is administered by HCP.

Appendix 1 – Guidance for handwriting a Medication Administration Record Chart

In exceptional circumstances a service user with medication administration needs may not have a MAR available for CHPs to record medication administration. These circumstances may include a new mid-cycle medication, a change in dose or following hospital discharge.

There may be no alternative than for a CHP to hand-write a Medication Administration Record (MAR).

1. Confirm the need for a handwritten MAR to be made and document the reasons in the service user's records.
2. The duty manager must authorise the production of a MAR.
3. Only nominated staff, who have completed general medication training and are deemed competent, are allowed to produce a MAR.
4. Using a suitable MAR template fill in the correct service users details into the Name, Address, and Date of Birth and any allergies.
5. Read the full instructions on the dispensing label.
6. The entry on to the MAR is to be made in full by the trained carer and counter signed by another trained carer before it can be used to administer medication.
   The entry on to the MAR **must** be a complete copy of the dispensing label in the medication entry space provided on the MAR including:
   - Quantity on label and quantity received
   - Medication including name, strength and form
   - Dosage instructions including warnings (e.g., store in a fridge)
   - Dosage times (e.g., 8am, 12noon)
   - Signature of staff member making the entry.
7. Handwritten entries on MAR charts must be made in legible handwriting in black indelible ink.
8. If there is more information on the label than can be easily fitted into the space provided, then it is permitted to carry on into the next medication entry space down as long as the dosage boxes for that medication entry space are then crossed through.
9. Whenever a different carer is required to administer from this handwritten chart, they must take extra care to ensure that the instructions on the MAR chart are exactly the same as on the label before they proceed with any administration and if they have any concerns then they must report to the manger.

Appendix 2 – MANAGEMENT OF PATIENTS PRESCRIBED

ANTICOAGULANTS

Despite measures taken to reduce the risks associated with warfarin, incidents continue to occur, mainly due to inadequate communication regarding dose changes. To improve patient safety, the preferred anticoagulant is a direct oral anticoagulant (DOAC) administered once daily. However, this medication is not suitable for all patients and/or all conditions. The decision to prescribe rests with the GP in discussion the patient/family.

The following process must be followed:

- At assessment, any service user prescribed warfarin should be identified
- The service user's GP should be contacted for a medication review and consideration of changing to a DOAC
- In the meantime, the DCW should continue to administer required dose of warfarin, as detailed on the MAR until outcome of review.
- For any service user who can be changed, their GP should prescribe a DOAC with single daily dose (rivaroxaban or edoxaban)
- Full instructions for changing to a DOAC should be written on the prescription and explained to the DCA
- For any service users not suitable for a DOAC, the DCA will continue to continue to administer warfarin
- For this small number of high-risk service users, it is essential that named individuals within the GP Practice, Community pharmacy/dispensary and DCA have the responsibility for communication regarding warfarin dosage and any changes
- GPs should prescribe 1mg only tablets, to simplify the administration of variable doses.

Appendix 3 Example Incident Report Form

The person who administered the medication or discovered the error and their line manager must complete an incident form. Report all incidents within 24 hours. It is good practice to record all near misses as this may prevent someone else making an error. This list is not exhaustive:

Example Incident Report Form

About the Incident:	
When did the incident occur?	
When was the incident discovered?	
Who was involved?	
Has the service user / next of kin been informed?	
What was the error?	
Wrong person	
Wrong medicine	
Wrong amount given	
Wrong strength	
Wrong form	
Medicine not given	
Medicine out of date	
Recording error	
Wrong Time	
Prescription error	
Pharmacy error	
Other, please state	
Brief description of the circumstances/ what do you think went wrong?	
Interruption by another member of staff	
Medicine poorly labelled	
Administration of medicine not recorded	
by previous carer	
interruption by the service user	
interruption by another service user	
phone ringing	
Other, please state.	
Who did you contact?	
Did you contact the GP / Pharmacist /	

NHS Direct /Out of Hours GP Service?	
Did you contact your line manager?	
When did you contact the above for advice?	
What advice was given?	
Did you act on the advice given?	