ADULT SOCIAL CARE AND HEALTH
OP/PD

Policy and Procedures for the Management of Medication in Adult Services Care Homes, Planned and Emergency Short Stays

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Working Title:	Policy and Procedures for the Management of Medication in Adult Service Care Homes, Planned and Emergency Short Stays
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Replaces:	Policy and Procedures for the Management of Medication in Adult Residential Homes, Short Breaks and Respite Services
Amendments: December 2017	This policy is now only for OPPD . Added section on ordering page 21. Added section on checking on prescriptions received from the GP practice page 21. Added section on checking on prescriptions received from the pharmacy page 21. Added appendices detailing the medication ordering and delivery protocols of each in-house KCC provision Added appendix 26 : " Expiry dates for prescribed items in care homes" as requested by the Head of Medicine Management , Canterbury and Coastal CCG
Version 4 update: issued 7 June 2018	Kent adult social care has commissioned training for managers and supervisors in the requirements of medicines support within in-house provider services. Nominated managers will be assessed as competent to ensure their staff act in ways which are within the law and consistent with KCC medication policies. Training now available. When a prescribed thickening powder is used, the number of scoops used to be recorded on a fluid chart (not MAR).

NOTE

This policy and associated procedures are intended for use by KCC OPPD in-house provision services. Other organisations may view this document but will have responsibility for developing their own policy to meet their own specific needs.

This document has been formatted in a manner which enables it to be printed and kept in premises as a physical document, but it can equally be used in electronic format. It is important that all staff have access to this medication policy and managers must ensure that staff who do not have regular internet access are able to obtain physical copies of this document.

Related legislation policies/procedures/protocols

Guide to Good Practice in the Management of controlled Drugs in Primary Care (England) (Dec 2009)	NHS
Guidelines for the Use of the Incident Reporting System and related forms (2009)	NHS Eastern & Coastal Kent
Health & Safety at Work Act (1974)	HSE
Health & Social Care Act 2008 (Regulated Activities) (Amendment) Regs 2015	Legislation.gov.uk
Homely Remedies for Adults in Care Homes Feb 2005 (revised April 2016)	Kent Local Medical Committee
Management of Health & Safety Regulations (1999)	HSE
Medicines Act (1968)	Dept of Health
Mental Capacity Act 2005	Kent.gov.uk
Mental Capacity Assessment forms for decisions	KCC / KNet
Misuse of Drugs (Safe Custody) (Amendments) Regulations 2007	Gov.uk
Misuse of Drugs Act 1971	Legislation.gov.uk
Misuse of Drugs Regulations 2001	Legislation.gov.uk
Multi-agency Safeguarding Adults Protection Policy, Protocols and Guidance for Kent and Medway	Kent.gov.uk
The Controlled Drugs (Supervision of Management and Use) Regulations 2006	Legislation.gov.uk
The Handling of Medicines in Social Care (Oct 2007)	Royal Pharmaceutical Society
The Safe Custody & Supervision of Medicines (Oct 2008)	NASHICS

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2	Controlled Drugs requirements
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4	Glossary of Terms
5	5.1) Homely Remedies / Stock Medication Approved List and Procedure 5.2) Homely Remedies: Protocol for the Administration of Paracetamol 5.3) Homely Remedies: Protocol for the Administration of Peptac/Gaviscon 5.4) Homely Remedies: Protocol for the Administration of Dioralyte/Oral Rehydration **NB:** For Homely Remedy/Stock Medication Monitoring Form (MED4) see appendix 8.4.
6	6.1) Local protocols for ordering & receiving medication – Blackburn Lodge 6.2) Local protocols for ordering & receiving medication - Broadmeadow 6.3) Local protocols for ordering & receiving medication - Gravesham place 6.4) Local protocols for ordering & receiving medication – Wayfarers 6.5) Local protocols for ordering & receiving medication - Westbrook 6.6) Local protocols for ordering & receiving medication - West View
7	MAR Sheets: 7.1) Guidance on Completion of MAR Form 7.2) Medication Record Sheet **NB:** For Prescribed drugs, PRN and OTC (MED15), see appendix 8.13. **NB:** For Topical, i.e. Applied (MED6) see appendix 8.6.
8	MED Forms: 8.1) Specimen Signatures Form (MED1) 8.2) Control of Medication Form (MED2) 8.3) Homely Remedies Doctor Consent Form (MED3) 8.4) Homely Remedy/Stock Medication Monitoring Form (MED4) 8.5) Risk Assessment for Self-Administration and consent form (MED5) 8.6) Topical, i.e. Applied (MED6) 8.7) Medication Amendment Form (MED7) 8.8) Compliance Aid Form (MED8) 8.9) Administration of Emergency Medication (MED9) 8.10) Training and Assessment Checklist (MED12) 8.11) Medication Error Report (MED13) 8.12) Weekly Audit of MAR Charts Form (MED14) 8.13) Prescribed drugs, PRN and OTC (MED15)
9	9.1) Medication Trolley Checklist 9.2) Medication Trolley Sign
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PART A: OVERVIEW

1.1 Introduction & scope

This document covers the policy and guidance for the management and handling of medicines for older people and people with cognitive impairment, living (permanently or temporarily) in Kent County Council (KCC) care homes, registered with the Care Quality Commission and is underpinned by the NICE quality standard [QS85] (March 2015). This quality standard, in conjunction with the guidance on which it is based, contributes to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult Social Care and Health Outcomes Framework 2015–16
- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Important:

Alternative Policy Use e.g. Integrated Care Centres

Where there is interagency or multiagency collaboration to employ Registered General Nurses (RGN) and/or Registered Mental Health Nurses (RMN) from a single registered unit, the Registered Manager, in agreement with their line manager and/or Heads of Service may choose to adopt the KCC partner agency's medication policy (e.g. Kent Community Health Foundation Trust) in order to support the management of the more complex needs of the service users.

Below are key points which are not listed in order of importance but merely in alphabetical order to make it easier to go back to a specific item.

1.2 Accountability

The primary responsibility for the prescription and therapeutic management of medication rests with the prescriber in consultation with other members of the clinical team, his/her service user and relevant representative members. However, Registered Managers are responsible for ensuring that service users' medication is managed appropriately by staff in their employ (including agency staff) and that service users who self-administrate are robustly risk assessed and monitored.

The Registered Manager for the Service has overall responsibility to ensure that this Medication Policy is implemented, including ensuring that any training, audit, equipment and local protocols necessary are in place.

Support workers are primarily accountable for their own practice and must only perform tasks in which they are trained, competent and confident.

NB "Registered Manager" in this context is the accountable manager for the service, however, it is recognised that not all Services have a registered manager on site therefore duties and responsibilities described herein may be delegated at the discretion of the Registered Manager, as long as that delegation is clearly defined and recorded.

1.3 Agency Staff

Staff employed by Kent County Council (K.C.C.) who are expected, as part of their role, to carry out any of the tasks or duties described herein must adhere to this policy and associated procedure and guidance; the only exception being where an agreed alternative policy (see 1.2 above) is in place.

1.4 Allergies

Any known and newly identified allergies must be written in bold red ink on the top front and the inside page of the MAR chart. Allergies must also be recorded prominent places in the care and support plan.

1.5 Audit

There must be a clear audit trail and a record of actions taken to address any areas identified as in need of development.

1.6 British National Formulary

Managers must ensure a current British National Formulary (BNF) is accessible for reference. https://www.evidence.nhs.uk/formulary/bnf/current)

1.7 Capacity

A Service User shall be deemed to have capacity, unless assessed otherwise.

1.8 Care Quality Commission

http://www.cqc.org.uk/content/fundamental-standards

It is essential that all staff involved in the management and administration of medication have a working knowledge of the Fundamental Standards of Care as described by the Care Quality Commission and as they apply to the handling of medications including receipt, management, recording, storage, administration and disposal.

1.9 Caution

All medication is potentially harmful if not used correctly, and care must be taken with storage, use and disposal. Safe use of medication means it is given in such a way as to maximise benefit and avoid causing harm. GPs and pharmacists are able to advise on ways of managing medication to meet needs, e.g. to prescribe liquid medication for a service user who has difficulty swallowing.

1.10 Choice and Person Centred Approaches

KCC will at all times ensure a consistent person centred approach when assisting with or administering medication, therefore all staff must have an understanding of Person Centred Approaches which respect the choices, lifestyle, dignity, privacy, cultural and religious beliefs of the service user who may have certain preferences relating to equality and diversity. These should be recognised at the assessment stage with arrangements made by the service to accommodate them. All relevant details must be recorded in the care and support plan, with the consent of the service user.

The Royal Pharmaceutical Society document "The handling of medicines in Social Care" states that the following have been established and should be carefully considered by care services:

- Vegetarians and people from some religious groups do not want gelatine capsules (made from animal products)
- Some people may prefer to have medication given to them by people of the same gender
- Some religious festivals include fasting so some people prefer not to have medication given at certain times

1.11 Covert administration of Medication

The covert administration of medicines must only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005.

NB Medication may be crushed or divided to ease administration only if approved by the prescriber and supplying pharmacist and documented in the Support Plan. Specialist equipment will be used for this purpose. Changing the formulation of the medicine in such a way means that the product is being used off-licence which could affect the medico-legal responsibility of both the prescriber and the supplying pharmacist

1.12 Definitions of Drugs and Medication

A drug is something which when taken into the body may change or affect one or more of the body's functions. Medication is a preparation that contains a drug that is used to:

- Treat a condition - e.g. An antibiotic to treat certain infections
- Control a condition - e.g. A medication to lower your blood pressure
- Treat the symptoms of a condition - e.g. A painkiller for toothache
- Prevent someone from becoming unwell - e.g. A vaccination against disease.

1.13 Duty of candour

As a provider of care you must be open and transparent with your Service Users about their care and treatment. Should something go wrong, you must tell them what has happened, provide support, and apologise.

1.14 Enabling Independence

The Registered Manager must implement and maintain a person centred approach to medicines administration and management in KCC care homes, ensuring Service Users are supported to take an active role in decisions about their treatment and, wherever possible, to self-administer their medicines. Care workers should promote the independence of the service user and sensitively work with their views and wishes in accordance with the support plan.

1.15 Information Sharing & Confidentiality

The Service must seek written consent from the Service User to establish as soon as possible who (e.g. representative members and/or carers) they wish to be involved in the decision making process about investigations, treatment and care, including medication. This includes any formal arrangements made for Lasting Power of Attorney. It must also be explained that personal information may be shared with other professionals involved in the Service User's care, but this will only be done in the best interests of the Service User, in line with the directorate's Privacy Notice.

1.16 Key Principles

1.17 Medication Administration Recording Charts

Medication Administration Record (MAR) charts must be of a consistent template throughout the service. The codes differ between various templates therefore to be inconsistent in this area is dangerous practice. The Registered Manager will decide which template is most appropriate for their service. If variety is unavoidable (e.g. if it is part of hospital transfer records) then the Support worker must ensure that the correct codes are used, as dictated by the MAR chart.

Support workers must also be extra vigilant for any variation in date and time positioning in the MAR charts they are expected to follow.

(*Appendix 9* is an example of a MAR chart.)

1.18 Medication Refusal

A Service User may choose to refuse to take their prescribed medication. Any refusal to take medication must be recorded on the MAR chart and signed and dated. The record must include the reason given by the Service User and include any change in their demeanour i.e. they may have become unwell or confused. This must be reported to the member of staff in charge who will liaise as appropriate with the prescriber and/or clinical staff and the appropriate advice sought.

1.19 Medication Reviews

Medication reviews for Service Users must be at a minimum of once every six months and must involve the Service User and/or their representative and the appropriate clinical (including a pharmacist[1]) and social care practitioners (multidisciplinary team) involved in their care. A Support worker must liaise with the prescriber if they have reason to suspect medication is having an adverse effect.

1.20 Medication Transcribing by Registered Nurses

Registered Nurses may transcribe onto MAR charts only in exceptional circumstances and must not be routine practice. The exceptional circumstance is to be decided by the Registered Manager or their deputy.

1.21 Meeting Needs Safely

The Service Provision must not accept any service user whose health needs, they believe, cannot be safely met, or arranged to be met (e.g. with agreed input from, for example community nursing services) in their registered environment.

1.22 Monitored Dosage Systems

UNDER NO CIRCUMSTANCES should Support workers assist with/administer medication from a manually loaded Monitored Dosage System, for example one filled by the representative or friends of a Service User. Only pharmacy dispensed pre-sealed containers are permitted.

[1] This could be the supplying pharmacist.

1.23 Ownership

Medication prescribed by a doctor or non-medical independent prescribers[2] and dispensed by a pharmacist becomes the property of the person for whom they have been prescribed. Under no circumstances should medication belonging to one service user be given to another or be used for self-treatment by staff.

NB With the agreement of the Service User and the prescriber, certain approved Over the Counter (OTC) medication (homely remedies) may be stocked for minor ailments for the duration of 48 hours; subject to further review by the Registered Manager.

1.24 Personal Assistants

Personal Assistants should not administer medication to the service user they assist, whilst that service user is in residential or respite care. The exception to this is if the service user is accessing external activities with the PA then normal procedure must be applied. i.e.: the medication is booked out by the service to the PA and booked in on their return.

1.25 Protective Clothing

Disposable gloves and aprons must be worn when applying external preparations e.g. ointments, creams, lotions.

1.26 Referral

The person responsible for the Service Users' referral must, as far as possible, ensure that the referral and assessment information includes a list of currently prescribed medication.

[2] There are many health professionals who can prescribe now as well as doctors including nurses, pharmacists, Physios, optometrists, paramedics etc.

1.27 Role of the Support worker

Appropriately trained support workers may assist a Service User to take the groups of medication listed below as prescribed by an authorised prescriber (e.g., the GP. the hospital doctor or non-medical independent prescriber) if:

a. The support worker's training is current (up to date) and they are assessed as competent **and**
b. Written consent is on file **or**,
c. If the service user lacks capacity to consent, a capacity assessment and best interest decision has been recorded.

Green (G) all support workers, deemed competent, who have undertaken the appropriate training on the management of medicines may provide assistance

Amber (A) must only be given by support workers who have received instructions on the use of that particular device and have written authorisation from their line manager. Local training may be provided by, for example, the Community Nurses for the administration of medications or preparations to meet specific needs of the service user with the exception of Red (R) products

Red (R) support workers are not permitted to provide assistance with this medication

Medication Roles and Responsibilities	
Medication taken by mouth (oral preparations) e.g. tablets, capsules and oral liquids	**G**
Medication applied externally to intact skin e.g., creams, ointments and lotions	**G**
Administration of drops or other preparations (e.g. ointment) for instillation into the eye, ear or nose	**G**
Medication in patches to be applied to the skin (transdermal patches)**.**	**G**
Using an Epi-pen	G
Assistance with nebulisers and inhaler devices	**A**
Injections	**R**
Suppositories	**R**
Pessaries	**R**
Enemas	**R**
Internal rectal creams	**R**
Internal vaginal creams	**R**
The application of dressings involving wound care	**R**
The application of medication to broken skin	**R**
Emergency administration of suppositories (by appropriately nominated and trained staff). See appendix 20	**A**

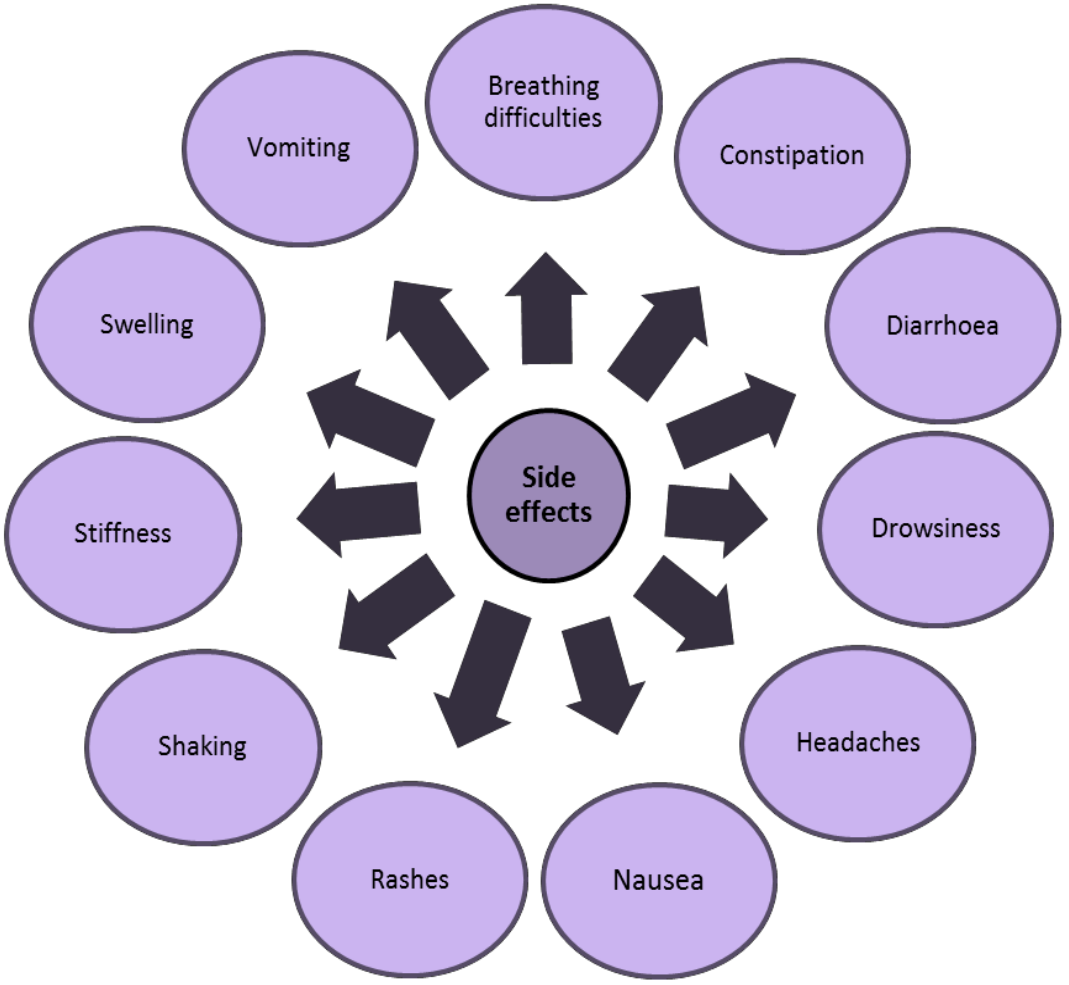
1.28 Service Self-Monitoring

Methodologies and timetables to support the implementation of regular audits of all aspects of Medication Management within the Service must be in place, including medication error reporting and pathways to apply “lessons learned”.

1.29 Side Effects

Unfortunately no medication is without potential side effects and some are worse than others and vary from person to person. They are prescribed where the benefit of the treatment outweighs the risks of the side effects.

Some of the most common side effects are outlined in the diagram below:



Please note this is not an exhaustive list. Staff must be aware of the side effects of medication in common usage in their service and also aware of side effects of any medication prescribed for a service user they are designated to support.

1.30 Signatures and Initials

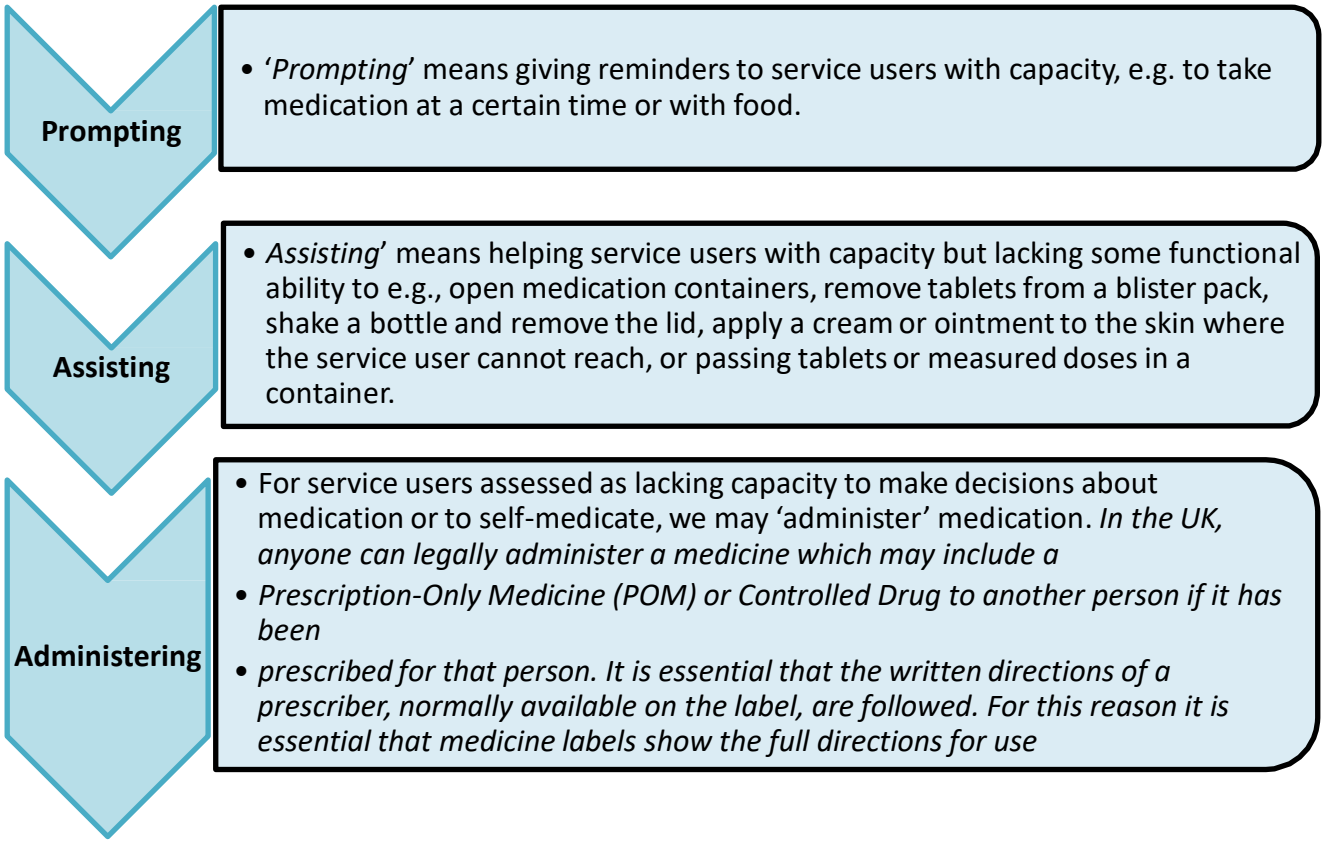
An up-to-date contemporaneous record of initials and signatures of all Staff (including any agency staff) deemed currently competent to endorse their actions on MAR charts must be maintained. The record must clearly identify the full name and job title of the owner of the initials and signature. (Appendix 7).

1.31 Storage of Medication

All forms of medication are potentially harmful. Medication, whether self-administered or given with assistance, must be stored appropriately and securely at all times.

1.32 Support Plan

The specific support the service user requires with medication or related tasks must be detailed in writing in the support plan. There are three general levels:



Administering medicines means that the staff member decides what medicine the service user needs to take, what dose and at what time. This is usually because the service user does not have the mental capacity or ability to take their medicines safely. In this case, the staff member will interpret the MAR chart to decide what should be given. The staff member will prepare the medication and give it to the service user to take. The administration is then recorded on the MAR chart.

Support workers can administer medication according to the instructions on the label attached to the medicine AND/OR as described on any accompanying Medication Administration Record (MAR) chart. The support worker should be assessed and signed off by their line manager as to being competent to understand and carry out the instructions and relevant training to be given to ensure all safety aspects are addressed. If there are NO written instructions then the Support worker should not administer and seek further advice from the prescriber or dispensing pharmacist. (see 1.34)

Administering medication might also include instilling eye, ear or nose drops, applying creams or lotions or preparing nebulisers.

As well as making sure the service user has medication as prescribed, you, as an individual support worker or as a Service are likely to also have responsibility for ordering, storage and disposal of medication. This must also be included in the support plan.

1.33 Terminology

a) The employed persons responsible for direct service user support, general administration, management and/or oversight will be referred to variously as the "Support worker" (including "Senior Support worker") or "Registered Manager" throughout this document. Collectively they will be referred to as "Staff".
b) The individual using the service where this policy is applied will be referred to as the "Service User".
c) The establishment or model of provision where this policy is applied will be referred to as the "Service", this term applies equally where the service is provided in the person's own home
d) Service users' representative and (formal) advocates will be referred to as "representative".
e) The documents detailing the support identified and agreed with the Service User will be referred to collectively as "the care and support plan".

1.34 Training and Competence

The Registered Manager of the Service must ensure all staff involved in the management and support of administration of medicines, including risk assessment and review for self-medication, can evidence appropriate training and competence to provide or deliver their anticipated actions and interventions and record appropriately. Training will also include Control of Substances Hazardous to Health and Infection Control.

All staff are accountable for their own actions and must not engage in any activity for which they are not trained and competent.

1.35 Withholding Medication

Never withhold prescribed medication without first consulting with your line manager and with the prescriber.

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PART B: PROCEDURES AND PROTOCOLS

1. ADMISSION

1.1 Pre-admission

A letter (Appendix 5) must be sent to the Service User and/or their representative explaining the following requirements with regard to medication brought in from home:

Prescribed medication (including creams and eye drops) **AND** any over the counter medication (OTC) brought into the service must:

a) Be in the original packaging as supplied by the pharmacist and contain the guidance leaflet.
b) Have a printed pharmacy label containing the service user's name, date of dispensing, name and strength of medicine, dose and frequency of medicine. (prescribed medication only)
c) If the expiry date is identified as during the period of stay, the Service User should arrange for a new issue where possible.
d) Service users should not be prevented from taking their OTC medications unless the medication is conflicting with prescribed medication[3], use of OTC medications should be reviewed by the GP on admission and confirmed in writing. If out of hours the on call GP should be consulted.
e) When eye drops are required to be administered and the eye drops have already been started, the date of opening must be clearly recorded on the box and the bottle (and signed) as some but not all eye drops must be discarded four weeks after first opening.

NB instructions on any medication stating "as directed/as prescribed" are insufficient and cannot be administered.

Local protocols may agree that the referrer (usually the case manager) sends the pre admission medication letter out with the booking confirmation.

1.2 On admission

- Service users must be given an explanation of the medication procedures on admission.
- Service Users must have their medicines listed by the Service, including any OTC or Homely Remedies.
- If the Service User is admitted from hospital, (the above applies) a copy of the discharge letter should be provided to the service which lists the medication to be taken

[3] If the service is in any doubt about whether an OTC is contra- indicated consult the supplying pharmacist and/ or GP

- For short stay service users the Support worker should ensure there are sufficient quantities of medication (and ideally a further week). If there is found to be an insufficient quantity, immediate action should be taken to obtain a further supply.
- A Service User identification sheet including photograph must be completed
- A capacity and capability risk assessment for self-administration of medicines must be completed by an appropriately trained member of staff,(as per Appendix 4) with the full involvement and signed consent of the service user (or their representative, where applicable).
- The risk assessment may indicate the need for consultation with local Pharmacists and/or the prescriber about adjustments needed at the point of dispensing to facilitate self-administration.
- The assessment and outcomes must inform the Service User's care/support plan and be retained accordingly and reviewed by the Service monthly or as circumstances change.
- The Homely Remedies Consent form (Appendix 6) must be completed.

1.3 On Admission Medication Inventory

1. **Admitted from Hospital**: The Service User must bring their discharge summary listing all current medication. Medication brought in must be checked against the list and any discrepancies immediately raised with the discharging hospital.

2. **Admitted From Home or another Service** anywhere other than hospital, their Surgery should be contacted for an up to date list of prescribed medication.

    - All prescribed medication items and Over the Counter (Homely Remedies) medication approved by the prescriber must be recorded on the form 1:\SS\MED2-CONTROL OF MEDICATION in black ink. (See Appendix 8) by two members of staff trained in the administration of medication. One staff member must be a senior support worker e.g. a team leader.

The following checks must be undertaken:

a) All items of medication must have a printed pharmacy label – check the instructions are clear and unambiguous.	
b) The service users name is on each pharmacy label.	
c) Eye drops must specify left, right or both (not "affected eye"), state the number of drops to be instilled on each administration and the number of times each day they are to be administered.	
d) Labels on liquid medication can be covered with sellotape or sticky backed plastic to allow the wiping of bottles without interference of the instructions on the label.	
e) When medication is foil packed check that the name and strength of the medication on the foil pack corresponds with the printed pharmacy label	
f) Ensure there are no hand-written alterations to the pharmacy label. If there is an alteration then this should be checked with the prescriber.	
g) Ensure the expiry date has not passed. If the foil pack does not have a readable expiry date and the batch number does not match the one on the outside box then it must be discarded.	
h) The date of dispensing (this must be within the last 8 weeks – any medications dispensed over 8 weeks ago must be immediately queried with the doctor)	
i) If 2 or more boxes/packages of the same medication are open use the box with the earliest expiry date first.	
j) When medication is received in a monitored dosage system it must be possible to distinguish the individual tablet from the description provided. If this is not possible the dispensing pharmacist / doctor should be contacted for advice.	

1.4 On Admission Medication Administration Record Chart

The MAR (Medication Administration Record) chart must be completed in black ink for **all** service users (see appendix 9). Allergies must be completed in red ink. Allergies must also be recorded in red ink at points indicated throughout the care and support plan. Two members of staff trained in the administration of medication should undertake this task (one must be a senior).

NB: For those service users who self-medicate, daily recording of administration is not required, however, local operational procedures may decide that a form of record is made to monitor any therapeutic effect and to support systems of audit, storage and reordering.

If medication is temporarily unable to be dispensed due to inadequate labelling instructions the Prescriber or Pharmacist must be contacted for advice.

Photocopying of the MAR is only permitted for sharing information with appropriate professionals, ensuring data protection and confidentiality. If the service user's stay exceeds the last date on the MAR sheet, a new MAR sheet is often provided from the dispensing pharmacist, if this is not the case they should be written from the current prescribed medication packages.

The MAR sheet (and service user identification sheet) must then be placed in the MAR sheet file to assist in identifying the service user to whom the medication is prescribed.

1.5 On Admission Over the Counter Medication (OTC) or Homely Remedies

OTC medication brought in to the centre by the service user must be administered as stated on the label/packaging. Authorisation to administer must be sought from the GP and confirmed in writing at the point of booking in.

NB Ensure that the service user is not already taking the same medication amongst their prescribed medications. I.e. Co-dydramol and Co-codamol also contain Paracetamol. If in doubt seek advice from the prescriber or a pharmacist.

Homely Remedy is medication stocked at the registered managers discretion and is used for minor ailments and can only be used for a maximum period of 48 hours when a GP must be consulted. (See appendix 3).

1.6 On Admission Controlled Drugs

Controlled Drugs (medication which appears on Schedules 2 to 5 of the Misuse of Drugs Regulations 2001) can be identified by referring to the BNF. "CD" next to the name of the drug denotes Controlled Drug.

In very rare circumstances a Schedule 1 drug may be prescribed for medicinal purposes. In this case clarification must be sought from the GP.

Controlled Drugs must also be recorded in the Controlled Drugs Register. The Controlled Drugs Register must be an approved hardback book specifically designed for this purpose. A spare Controlled Drugs Register must always be available in the centre. Each Controlled Drug for each service user must be recorded on a separate page.

The following information must be recorded in the Register (see appendix 16):

- Name of service user at the top of the page
- Name of the Controlled Drug
- Date the Controlled Drug was received.
- Names of the two members of Support Worker receiving the Controlled Drug.
- Amount of controlled drug received.
- Form in which it was received e.g. tablets, liquids in millilitres and injections in ampules.
- The entry must be signed by two members of Staff. The first signature by the support worker recording the entry and the second signature by a staff member witnessing the entry

1.7 Handling of Non-Prescribed Controlled Drugs and their Disposal

A licence is required to possess a Schedule 1 Controlled Drug and they have no recognised medicinal use.

Care home staff can only take possession of them for the purposes of handing them over to the police for disposal.

If it is suspected that a Schedule 1 Controlled Drug has been brought into the centre the following actions must be immediately taken:

1. The pharmacist must be contacted to check whether the drug is on Schedule 1.
2. If the drug is on Schedule 1 the Registered Manager should be informed immediately.
3. The senior on duty must contact the police to inform them that a Schedule 1 Controlled Drug is on the premises.
4. The police will give instruction as to the procedure to be followed to take possession, label and store the drug until the police can collect it.
5. The incident must be fully recorded on an HS157 Accident/Incident form. Details **must** include:
    - the time the telephone call was made to the police
    - the police reference incident number
    - instructions received from the police
6. Inform regulatory bodies (CQC)

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2. ORDERING AND RECEIVING MEDICATION

All Adult residential homes, planned and emergency short stays services across Kent must develop their own in-house protocols in line with their local practice. See appendix 27 for further details.

The registered manager is the member of staff responsible and accountable for ensuring that:

a) There is a written protocol, easily accessible
b) The protocols follow all the good practice principles highlighted below
c) All staff understands and abides by the protocol

Key principles for ordering medication:

- MAR sheets must be reviewed as part of the monthly request
- Ensure any items started mid-month are ordered if required
- Take account of current medication stock levels to avoid waste in all locations
- Check stock levels of “when required” (PRN) medication and order appropriately
- Staff must have protected time to order medicine
- Managers must ensure that at least 2 members of the care home staff have the training and skills to order medicine, although ordering can be done by one member of staff
- Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

Key principles for receiving medication:

2.1 checking of prescriptions received from the GP practice

- Check full name of resident, address and date of birth against the prescription and the MAR sheet
- Check that the item, directions and quantity on the prescription are correct and have been requested on the MAR sheet. Report any discrepancies to the GP practice straight away.
- Prescriptions to be taken/ collected by the pharmacy for dispensing when task completed

2.2 checking of prescriptions received from the pharmacy

- Ensure staff have protected time, the skills and training to check medicine delivery
- Check full name of resident, item , directions and quantity against the MAR sheet

Report any discrepancies to the pharmacy straight away.

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3. MEDICATION, STORAGE AND SECURITY

3.1 Key principles

1) All medication must be stored securely in a lockable storage facility only used for the storage of medication. The lockable storage may be individual (in service user's rooms) or central (in the designated medication room) available to appropriately trained care staff.

2) Refrigerators and cupboards designated for the generic storage of medicines and pharmaceutical supplies must be kept locked and the keys kept within a designated safe place, ideally held personally by the senior Support worker (person in charge). The person in charge is responsible at all times for the safekeeping of all medicines in their department.

3) The keys for the medicines cupboard must be kept on one key ring solely for this purpose and must not be identifiable.

4) Individual keys for lockable storage in the service users' own rooms are held by the service user.

5) The support worker in charge must immediately report any breaches of security to the Local Security Management Specialist. An incident form must be completed.

6) The recommended temperature for storing medicines will be indicated on the container issued by the manufacturer

7) Medicines that do not require storage in a refrigerator are usually stored at temperatures up to 25^{o}C. Cupboards used to store medicines must therefore not be located near radiators or hot water pipes or in areas of high humidity. Any room used to store medicines must be monitored with a room thermometer. When temperatures exceed 25^{o}C advice must be requested from your local pharmacy adviser and any recommendations given recorded.

8) Medication must be stored with the shortest expiry date at the front of the supply to ensure medication with the "**shortest in date shelf life**" is used first.(see appendix 26)

9) When using a trolley for the administration round, only one container of each medication must be in use. The remainder must be kept separately as per local policy.

10) If not in a lockable secure room, trolleys must be secured to the wall for security.

11) The room/medication cabinet must only be accessible by designated staff.

12) Medication for external use must be stored separately away from all other prescribed medications.

13) Medication for each service user should be grouped together.

NB Monitored dosage systems and blister packs must be kept separate from individually boxed/bottled medication with the name of the service user clearly visible.

14) Medication to be stored in the fridge:

- Medicines requiring refrigeration will be marked on the packaging or a label applied by the dispensing pharmacist/doctor. These must be stored in a lockable medicine fridge (**not a domestic fridge**) with a maximum and minimum thermometer which can be read without opening the door of the fridge.
- The normal temperature range should be a minimum of 2°C and a maximum of 8°C. This temperature range should be checked on a **daily** basis and recorded on a Medication fridge thermometer recording chart. Any readings outside these temperatures must be reported to the registered manager or person in charge immediately and the contents quarantined whilst advice is sought from the supplying pharmacist.
- Medicines are best stored away from the sides of the refrigerator.
- Medicines should not be stored in the door of the fridge as the temperature fluctuates when the door is opened.
- The fridge must not be overfilled as the cold air needs to circulate.
- Only medicines should be stored in this fridge

15) All medication must be stored off the floor.

16) COSHH sheets must be available in the medication room/medication cabinet for reference for any medication or liquid which carries a hazard symbol.

17) The security of prescription forms (FP10) is the responsibility of the prescriber. Under no circumstances should blank prescription forms be pre signed before use. The prescription form must only be produced when needed and never left unattended.

3.2 Storage of specific medication

a) Controlled Drugs

Controlled drugs must be stored in a locked metal cabinet, which complies with the Misuse of Drugs (Safe Custody) Regulations 1973 (and subsequent amendments). The metal cabinet should be bolted to an internal wall in the medication room.

Stock should be kept to a minimum and nothing displayed outside to indicate that Controlled Drugs are kept within the room.

A locked receptacle is necessary for drugs in transit.

b) Medication belonging to staff

Staff bringing in their own supply of medication, of either homely remedies or prescribed medication, for self-administration during their work hours have a duty to ensure that the medication is kept securely and inaccessible to others. This may be in a locker provided by the manager. Staff must NOT use to self-treat, any medication which is the property of the service users. It is not recommended that staff access Homely remedies stored in the service to self-treat.

c) Oxygen

Go to section 14 Page 56-59

d) Self-medication

Medication for service users who are self-medicating should be stored in a lockable cupboard. The self-administration risk assessment should include methods of safe storage.

e) Stock Homely remedies medication

All stock Homely remedies will be stored in a separate locked cupboard within the medication room.

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4: MEDICATION & STORAGE AREA MAINTENANCE

4.1 Medication Room/Cabinet

DAILY:

a) The temperature of the Medication Room/cabinet must be taken and recorded on the Medication Room/cabinet Temperature Chart. (Ambient room temperature is defined in the British and European Pharmacopoeias 2005 as between 15°C and 25°C). The temperature must not be allowed to be at 25^{o}C for 3 consecutive days and a risk assessment incorporating appropriate safe working practices must be completed.

b) If the temperature exceeds 25°C, action must be taken to reduce it and said action recorded on the Temperature Chart

c) No medication should be administered until advice has been received from the pharmacist

4.2 Medication Trolley

- A thermometer must be attached to any drug trolley/cabinet, where medication is stored outside of the medication room.
- If the temperature exceeds 25°C, action must be taken to reduce the room/cabinet temperature. The action taken must be recorded on the Temperature Chart
- No medication should be administered until advice has been received from the pharmacist

4.3 Medication Fridge

The temperature of the Medication Fridge must be taken using a minimum/maximum fridge thermometer and recorded on the Medication Fridge Temperature Chart.

- If the temperature is outside the safe range of 2°C - 8°C, action must be taken to rectify the fridge temperature. The action taken must be recorded on the Temperature Chart. If this cannot be achieved the pharmacist should be contacted and advice sought. The advice must be documented on the Temperature Chart.
- No medication should be administered until advice has been received from the pharmacist.

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5: MEDICATION & STORAGE AREA CLEANING

After each medication round:	a) All empty medication packages must be replaced from the stock cupboard with medication that has the shortest expiry date. A note must be made in the diary for disposal and replacement if the expiry date is shorter than 28 days. b) All graduated medicine pots must be disposed of appropriately according to manufacturer's guidelines along with oral syringes where liquid doses are to be measured. (Disposable pots and equipment may be used.)
As required:	The sink and surface areas must be cleaned.
Three times a week (minimum):	a) The floor must be vacuumed. b) The room will be cleaned, including cupboard tops, and the floor washed.
As Necessary	The Medication Fridge must be defrosted. This must be recorded.
Four weekly:	**NB.** If the centre uses a monitored dosage system the medication change-over day is an ideal time to undertake the following maintenance: a) The medication trolley must be emptied and cleaned. b) All medication must be checked to ensure the expiry date does not expire within the next 28 days. Should any of the medications expire during this period a clear instruction must be recorded in the centre diary to remove the medication for disposal and replacement on the relevant date. c) Medication store cupboards must be emptied and cleaned.

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6. KEYS

6.1 Management and Storage of Medication Keys

- The keys to access any of the medication storage areas must be properly controlled.
- Staff authorised to administer medication by the Registered Manager must be the only people to hold the keys. (This will usually be the senior on duty on the unit).).
- Only one set of keys must be in use unless risk assessment/safe system of work states otherwise.
- The medication room keys must not be part of a master key system.
- There must not be a method of identifying the key to the lock (e.g. keys labelled "medication room" or colour coding of the lock and key). Keys must be labelled with a number only, which can be checked against a key index. The key index must be only accessible by the key holder.
- When not in use, the keys must be kept in a locked key press.
- Procedures for the custody and handing over of keys should be understood by all staff authorised to hold them.
- A District Nurse will only have access to the medication which she/he is administering.

6.2 Medication Key Management for people who self-administer

- The senior support worker must provide the service user with a key to a personal lockable drawer or cabinet in which to store all their medication. (This includes Controlled Drugs.)
- The service user must be invited to give their consent to the senior support worker to hold a spare key to access medication in the event of an emergency.

6.3 Loss of Keys

Loss of keys must be reported immediately to the Registered Manager, to include:

a) Time of loss identified
b) Time of the report to the manager
c) Who was known to hold the keys last, when and where.

If keys remain lost, despite reasonable search and/or if there is reason to believe they have been stolen, this must be reported to the police and to C.Q.C.

If the keys are not recovered within 24 hours the locks must be changed.

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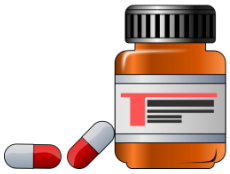
7: MEDICATION ADMINISTRATION PROCEDURES

Key Principle: the 5 Rs

The five 'R's must always be followed for each medication due to be administered (see appendix 13) and the following checks must always be done.

	**Right Person**	• Check and confirm the identity of the service user with the MAR chart assisted by the photograph • Check with the service user that they are happy to take their medication.
	**Right Medicine**	• Check that the name of the service user and name and strength on the medication container correspond with the name and strength of the medication on the MAR chart.*
	**Right Dose**	• Check that the dose on the medication container corresponds with the dose recorded on the MAR sheet. • Check that the name and strength printed on foil packaged medication correspond with the printed pharmacy label.
	**Right Time**	• Check that the time recorded on the medication container corresponds with the time on the MAR sheet.
	**Right Route**	• Check the route on the medication container corresponds with the route recorded on the MAR sheet.

*(Should the printed label become illegible or detached from the container the medication must not be given and advice must be sought from the pharmacist.)

7.1 Arrangements for medication administration for service users who self-medicate

1. Assessing competence to self-medicate

The service user must be assessed as competent to administer their own medication. (Appendix 4)

In order to manage their medication, a service user must be able to:

- Understand how and when to take their medication.
- Understand in broad terms the nature of the medication and why it is being prescribed.
- Be aware of any probable side effects.
- Understand the consequences of either not taking the medication or not following the doctor's orders.
- Make choices and communicate them.
- Understand the necessity to store their medication securely.

Where the service user is self-medicating but may need physical assistance, the Support worker, with the informed consent of the service user, may be asked to assist, guide or support them as specified in their support plan and informed by the Medication Risk Assessment.
The service user retains responsibility for the administration of their medication.

2. Use of compartmentalised daily dispensers

Concordance aids such as compartmentalised daily dispensers (monitored dosage systems) are available to help in self-administration but only in consultation with GP and dispensed by the pharmacist. The only exception to this is when the Service User is temporarily leaving the centre for a short time (see section 7.10).

The recommendation of the Royal Pharmaceutical Society is that the use of original packs of medicines, supported by appropriate pharmaceutical care, should be the preferred intervention for the supply of medicines.
The Service User must be invited to retain the service user information leaflet.

3. Medication refusal

If the Service User declines to take a particular medication then the Support worker should explore the reasons for this. It should be recorded on the support plan. The refusal must be reported to the Senior Support worker and the health professional/GP informed.

In cases where you suspect that a self-medicating service user is persistently failing to comply with their prescription, then explore this with the Service User in the first instance. A risk reassessment must be carried out and recorded and the Service User's prescriber consulted.

7.2 Arrangements for medication administration for service users who do not self-medicate

1. Support worker's responsibilities

When a service user has been assessed as unable to administer their own medication the service will ensure support workers administer the medication in a way which respects the Service User's choices, lifestyle, dignity, privacy, cultural and religious beliefs.

When administering medication to a Service User the Support worker must be familiar with the Service User's support plan which must include the above information.

Support workers must encourage and support the Service User in ensuring that an adequate supply of prescribed medication is available by re-ordering in a timely manner and documenting accordingly. Any problems with supply must be reported to their line manager.

2. MAR sheet contents

A Medication Administration Record (MAR) chart for the Service User is required to identify:

- The name of the Service User,
- The name and the dose of the medication,
- The route, date and time of administration.
- Any known allergies

3. Administering from the medication trolley

If administering from the medication trolley, it must be first checked to ensure it contains all the necessary items for the task. (See Appendix 12.a) this list can be photocopied and placed on the trolley to be used as a checklist).

Medication in blister packs to be dispensed from a trolley must be clipped onto the relevant blister pack file and any reminder cards (for medications not dispensed into a blister pack) behind the divider.

When removing medication from its packaging avoid touching it to minimise the risk of cross infection or absorption through your skin.

Before administration,

- The expiry date of each drug must be checked to ensure the medication is still within date.
- The pharmacy label must be checked against the information recorded on the MAR for accuracy
- If any discrepancy is found between the MAR sheet and the printed pharmacy label, advice must be sought immediately from the dispensing pharmacist before administering the medication.

After administration

- At the time the medication has been taken by the individual Service User, the record and initial must be made on the MAR chart by the Support worker.

Administration of Medication:

When measuring out small amounts of liquid medication use an oral syringe to ensure accuracy. Put the medication into a spoon or graduated medicine pot. Should any liquid drip down the bottle, clean immediately wearing gloves to prevent the medication being absorbed through the skin.	
When using a medication trolley and the last dose of a medication is administered, place the empty container in a 'for replacement' box on the trolley. At the end on the medication round replace the medication from the stock cupboard before disposing of the empty container.	
Medication must be given to the Service User from the original dispensing packaging directly into the Service User's hand or into a clean container for immediate administration.	
As each medication is removed from its container into the vessel to be given to the service user, an ink dot can be made in the relevant MAR sheet square. This will provide a visual check of dispensed medication. Prior to administration the dots can then be counted and the number checked against the number of medications to be given to the service user.	
Once the medication has been given to the service user, with a full glass of water if it is in solid form, the service user should be discreetly observed to ensure they have swallowed the administered medication.	
At no time must a container be left with a service user to be taken at a later time.	
The MAR sheet must only be initialled when the support worker administering the medication is confident (as far as practically possible) that the medication has been taken. Only one initial set is required unless the medication is a Controlled Drug: two signatures are then required.	

7.3 Administering from monitored dosage systems

When administering from monitored dosage systems (MDS) ensure the medication is taken from the correct week, day and time. If medication is spoilt from a MDS then replace with the last dose in pack and order a replacement immediately.

7.4 Administration of PRN (as required) medication

Management of PRN (as/when required) medication must be documented in the care Support Plan stating the signs/symptoms present to identify when it is needed and only administered for the reason it was prescribed and should always be offered to the service user at the time.

7.5 Procedure for prn medication

a) Write on front of MAR chart when to give or offer PRN medication e.g. 'Give cream when rash appears on face' or' Give painkillers when right arm is painful'
b) The front of the MAR sheet should be signed in the relevant box.
c) On the reverse of the MAR sheet the date, time, medication, dose (including number of tablets if a variable dose is prescribed) and the initials of the person administering the medication.
d) If the service user declines the medication the appropriate key letter for refused must be recorded on the front of the MAR sheet to record that the medication has been offered.

7.6 Administration of Over the Counter (OTC) / homely remedy medication:

1. Administration of OTC medication belonging to the Service User

OTC medication brought into the centre by the service user must be administered as above, except that it will not be possible to check information against the pharmacy label. (See appendix 17)

The OTC medication must not be administered beyond a continuous 48-hour period without the prescriber's written consent.

2. Administration of Stocked Homely Remedy Medication

At the discretion of the Registered Manager, certain approved over the counter Homely Remedies may be stocked for general use by service users for those ad hoc occasions when needed for minor ailments and for the duration of 48 hours maximum. For continued use, the GP must be consulted. (See appendix 17)

Within the Integrated Care Centres, the qualified nurses will always be consulted for unplanned use of Homely Remedy medication. In other establishments the GP will be consulted.

For the list of approved Homely Remedy drugs to be kept as stock medication and protocol (see Appendix 3).

7. 7 Service user asleep at time of administration

1. If a service user is asleep at the prescribed medication time, they must be woken and offered the medication.
2. A service user should not be woken for PRN ('as necessary/when necessary') medication unless they have previously requested this. (The request must be documented on the service users support plan).
3. If the Service User is frequently asleep at the prescribed time, the Service User's doctor must be contacted to see if the medication can be prescribed at an alternative time. If, however, the medication is prescribed is to assist sleep, the doctor should be asked to review.

7.8 Night staff access to medication

Steps must be taken to minimise wherever possible the need for administration of medication at night. Locally agreed and documented procedures must be in place. Only staff trained in the administration of medication will be authorised to do so and appropriate recording procedures will be followed.

7.9 Emergency arising during a medication round

The must be no interruptions during the medication round. (See appendix 12b) for Medication Trolley Sign suggested template). Registered Managers should ensure as far as possible that the Support worker doing the medication round has protected time. The wearing of a designated apron or bib indicating **DO NOT DISTURB** Medication round in progress is useful. However should an emergency situation occur and there is no other staff member to deal with the emergency, the medication must be made secure by either locking the medication cupboard or, if the medication is in a trolley the trolley must be locked and secured to a wall using a purpose built device

7.10 Medication to be administered while away from the centre

IMPORTANT: Under no circumstances must secondary dispensing of medication take place.

1. When a service user is away from the service for longer than one day (a holiday, for example,) the medication must be given to the service user/relative in the dispensed containers. If the service user is not self-medicating, clear instructions must be given to the individual identified as accountable for supporting the service user with the medication and the identified individual must sign the Support plan as having taken accountability for the medication.

2. When a service user goes out of the centre regularly (e.g. every lunchtime) and is prescribed medication at a time they are away, the Team Leader should first liaise with the doctor to establish if there is a suitable alternative, or whether the dose can be given at another time.

3. If the medication must be taken while the service user is away from the service the team leader should request a separate, formally labelled container of medication from the pharmacist/doctor.

7.11 Administration of emergency PRN medication

An emergency in this context is defined as a potentially life threatening situation in need of immediate attention.

Medication most commonly coming into this emergency use category are Rectal Diazepam or Buccal Midazolam

1. Only support workers specifically trained and approved as competent to assess the service user and make the judgement (informed by the risk assessment) as to whether the emergency PRN medication is needed are permitted to carry out the procedure.	
2. A risk assessment informed by the GP and/or relevant health professional must be completed for each individual likely to require emergency treatment.	
3. Clear written instructions must be made available from the prescribing GP setting out which medication should be given and to whom; under what circumstances, the dosage, the route and any precautions necessary.	
4. This must be recorded in the Support Plan as well as on the MAR chart.	
5. The administration of Emergency Medication form must be used (Appendix 18).	
6. If emergency circumstances arise and there is no approved member of staff available, the emergency services must be called.	

7.12 Lack of availability of prescribed medication

An oversight in management or an event where medication has been spoiled may result in a medication being unavailable to administer at the prescribed time. When this occurs, the following procedure must be followed:

1. The doctor must be contacted, the situation explained and an emergency prescription obtained.

2. The prescription must then be taken to the pharmacist to obtain the emergency supply.

3. If it is not possible to obtain a replacement within the necessary timeframe to administer the medication, advice must be obtained from the doctor regarding the missed dose and guidance on further administration.

4. The doctor's verbal instructions must be confirmed in writing by fax. (It may be necessary for the centre to record the instruction and fax it to the surgery for the doctor's signature. The surgery must then return the signed instruction by fax).

5. Should this issue occur after the surgery has closed the 'Out of Hours' doctor must be contacted for an emergency prescription and advice.

6. Local contacts and arrangements for out of hour's pharmacy must be held with contact details for out of hours GP.

7. Should it not be possible to release a member of staff from the centre to collect the medication, a taxi should be sent, unless it is for a controlled drug, in which case the senior on duty must make arrangements to get it collected.

IMPORTANT: Service users should not be without medication at any time. It is a service responsibility to ensure sufficient stock is available.

8: ADMINISTRATION OF CONTROLLED DRUGS

Two members of staff (one must be a senior) must follow the procedure below when administering controlled drugs. The designated member of staff carries out the activity and the second member of staff witnesses the process and must be present throughout the whole procedure:

1. The designated member of staff takes the Controlled Drug from the Controlled Drug cabinet and checks it against the MAR sheet.
2. The stock amount of the Controlled Drug must be checked with the Controlled Drug register.
3. The Controlled Drug and its dosage must then be checked.
4. The Controlled Drug must be put in a clean graduated medicine vessel.
5. The remaining stock of the Controlled Drug must then be returned to the Controlled Drug cabinet and locked securely.
6. The Controlled Drug register and the MAR sheet is then taken to the service user
7. The Controlled Drug is then administered to the service user.
8. The Controlled Drug Register is then completed and the remaining stock balance documented. Both members of staff must sign the Register to confirm that the Controlled Drug has been administered and the remaining stock balance is correct.
9. The person administering and witnessing the controlled drug must also both sign the MAR sheet.
10. Liquid paper must never be used to correct a mistake. The mistake must be crossed through in black ink and initialled by both members of staff. The correct information must then be recorded.

NB – See separate guidance for the administration of rectal diazepam and buccal midazolam. (See appendix 19)

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9: MEDICATION REFUSALS

Best practice

When a Service User refuses to take a particular medication, the Support worker should try to encourage the Service User to take the medication by explaining why it is necessary. If the Service User still refuses this should be respected by the Support Worker. An entry should be made on the Medication Administration Record Sheet and the refusal reported to the senior on duty as soon as possible.

If a Service User spits out medication. This should be disposed of and recorded as a refusal on the Medication Administration Record.

The refusal should be referred back to the Service User's GP

Recording medication refusals

1. The key letter for 'refused'' must be recorded in the relevant box on the MAR chart.

   NB always check the bottom of the MAR chart for the appropriate code as these vary.

2. The reason for the refusal must be recorded on the back of the MAR chart. The entry must be signed and dated

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10: MEDICATION MONITORING AND REVIEW

10.1 Monitoring and Review of Service Users

Staff involved in medication administration or direct provision with the service users must maintain their knowledge of common side effects of medications.

The home should maintain a folder of patient information leaflets for staff to consult.

Where a staff member has concerns about possible side effects for any resident they should consult the pharmacist, GP, dial 111 or 999 as appropriate to the condition of the resident.

10.2 Audit of Self-Managed medication

Service Users who self-manage their medication must be audited weekly. The audit should involve the service user and be recorded on the MAR and in the CD record book where appropriate

10.3 Medication Reviews

All long stay service users taking medication must have a full medication review by their GP at every 6 months, or sooner if there is a change in their condition, or if there is reason to believe it may benefit the Service User.

10.4 Monitoring for Side Effects

All service users taking medication should be closely monitored. If a service user develops an adverse reaction to any medication, or if contra-indications (medical conditions which may be worsened by certain medications) are discovered, then a doctor should be contacted without delay. Advice should also be sought whenever it is suspected that a service user no longer needs prescribed medication.

11: DEATH OF SERVICE USER AND RETENTION OF MEDICATION

Medications must be retained for a minimum period of 7 days following the death of a service user in case the Coroner's Office or Courts require them.

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12: DISPOSAL AND RETURNS OF MEDICATION

12.1 Surplus or unwanted medication must be returned to the Community Pharmacist for Disposal.

IMPORTANT: Surplus or unwanted medication must never be administered to another person.

12.2 Controlled Drugs

The disposal/return of Controlled Drugs must also be recorded as described in the Controlled Drugs Register. Local procedure MUST be followed.

12.3 Spoiled medication

If medication is 'spoilt' during the administration process it must be disposed of by the following procedure:

1. If the service user is able to make the decision their consent must first be obtained to dispose of the medication.
2. The following must be recorded on the front of the MAR sheet under the relevant medication (Appendix 9):
   - **Destroyed** must be entered in the 'returned: destroyed' box for spoilt medication.
   - **Returned** must be entered in the "returned: destroyed" box for returned medication.
   - The amount/quantity of medication must be entered in the 'quant.' box.
   - The member of staff's initials must be entered in the 'by' box.
   - If a Controlled Drug is "spoilt", then need to follow CD policy for the destruction of Controlled Drugs

It must also be recorded on the MED2-CONTROL OF MEDICATION form (Appendix 8) under DISCHARGE by recording:

- Date
- Quantity out
- Counted by: (2 signatures required)
- 'See pharmacy returns book' across 'Handed over by Team Leader' box.

12.4 Medication returns

Residential including Short Planned or Emergency stays

1.	The medication must be put in designated receptacle	
2.	The receptacle must be labelled with its contents if known or the returns book completed with; the name and strength of the medication and initials if using a returns book.	
3.	The receptacle must then be placed in the 'Medication Returned to the Pharmacy' box or returned to the pharmacy immediately.	
4.	The box must be kept in a locked cupboard in the medication room until collected or returned to pharmacy.	
5.	The staff member supporting the process must ensure that local procedures and protocols are followed and the collection of medication returned to the pharmacy is appropriately recorded and receipted. Under no circumstances must the service dispose of the medication on site. All medication must be returned to the pharmacist for safe disposal. This will include medication mixed with water, which must be put in a container sufficient to hold the whole amount of fluid	
6.	If liquid medication is spilt the amount lost must be recorded in the Discharge section of the MED2-CONTROL OF MEDICATION form (see appendix 8) with an explanation to provide a full audit trail.	

12.5 Medication disposal and returns

Integrated Care Centres

1.	Record name and quantity of drug as well as service user's initials into the drug disposal book. (Ensure carbon paper is in situ for duplicate copy).	
2.	Place unwanted medication into the returns receptacle in the foil packaging.	
3.	For Controlled drugs, use small 'Controlled drug destruction kit'. Follow instructions for use on the side of the container and then place the container into the returns receptacle, again recording the drugs into the drug disposal book.	
4.	Sign the bottom of the drug list.	
5.	Also record disposal of controlled drugs in the Unit Controlled Drug Book kept in the clinical room.	
6.	For service users going home, who have given you permission to dispose of their unwanted drugs, ensure the drug admission/discharge sheet shows the drugs disposed of.	
7.	Keep the returns receptacle locked away until the disposal company arrive to collect bucket.	
8.	Shred original pharmacy labels as per information governance or place in the confidentiality bin.	
9.	The Disposal Collection Agent must sign disposal sheet.	
10.	Tear off first copy for agent to take away with drugs and retain bottom copy in the book.	

12.6 Disposal of syringes, needles and other sharps

Management and practice must comply with The Health & Safety (Sharp Instruments in Healthcare) Regulations 2013.

1. Appropriate Sharps boxes must be provided for the disposal of all sharps (including syringes) used by staff and by service users. This may be for service users self-administering injections or for disposing of a lancet for blood-sugar tests.

2. Service users handling sharps must be appropriately trained and risk assessed in self administration and disposal of sharps. This must be recorded in their support plan and noted on their MAR chart.

3. The procedure for sharps disposal, and which container to use, must be clearly displayed.

4. Sharps boxes must be dated and collected on a monthly basis by the approved waste contractor for disposal.

13: WARFARIN

NB Support workers must not be involved in the administration and management of Service Users on Warfarin until specifically trained and deemed competent.

a) The MAR chart, medication record and support plan must record that Warfarin is being prescribed and administered together with any known interactions from foods or other drugs.

b) The Warfarin Dose is often variable and adjusted following the results of an INR test taken by the designated professional (Doctor, Anticoagulant Clinic or Pharmacist)

c) A document (usually the 'Yellow Book', but local protocol may vary) is provided to the Service User to record date of monitoring, blood level, medication dosage requirement and date of next test. The service user must be supported to maintain this.

d) Always double check with another Support worker the most recent INR report when giving a dose - it is essential that dosages are not given from old INR reports

e) If there is a discrepancy, between the 'yellow book' prescribed dosage and the MAR chart, the designated healthcare professional and/or GP must be consulted urgently.

f) It is important support workers administering medicines are familiar with the different colours of the various strengths of warfarin tablets as different colours (strengths) of tablets may be required to make up a dose.

g) Warfarin tablets should be taken at the same time each day with a full glass of water

h) If a dose is missed for any reason, the GP should be contacted for advice and a note made in the Medication Administration record (MAR) chart, in the daily record/support plan and a med error form completed.

i) Support workers must enable Service Users to attend regular medication reviews with their designated health care professional as per their support plan and informed by their “Yellow Book”, at not more than 12 week intervals.

j) There should be a process in place to follow up results if they have not been received within 3 days. If you have not received the record within 3 days, contact the anticoagulation service or GP.

k) It is good practice to attach the written oral anticoagulant dosage supplied by the lab to the MAR chart.

Procedure for adjustment to warfarin dose

The new dose must be confirmed by either:

a) A faxed instruction by the Doctor

Or

b) An entry made by the designated professional in the Anticoagulant Therapy Record (Yellow Book)

Once confirmed, the procedures are as follows:

- The faxed instruction/Anticoagulant Therapy Record must be kept with the MAR sheet.
- The new dose must be recorded as a new entry, at the correct date and time, on the MAR chart. This must be checked and signed by two Support workers
- The signing boxes on the entry of the originally prescribed dose must be clearly crossed through from the date of the alteration.
- All empty signing boxes on the MAR sheet prior to the date of the new entry must be lined through.
- A note must be made in the diary to check new instruction on the date of the next INR test.

14: OXYGEN

14.1 Key points

1. Oxygen is a prescribed medicinal product and must be treated as such. Oxygen is prescribed on a Home Oxygen Order Form (HOOF) written by either the GP or hospital consultant. The HOOF contains details of how the oxygen should be used. The HOOF is sent directly to the oxygen supplier who will then arrange for the delivery of the oxygen.

2. If more oxygen cylinders are required or there is a problem with the concentrator the supplier should be contacted directly – there is no need to order a repeat prescription from the surgery. The supplier of the oxygen should provide information on the use of the oxygen when the delivery is made.

3. Changes in the service user's clinical condition must be referred to the doctor who can organise a new HOOF if required. The supplier can only deliver oxygen in accordance with the direction on the HOOF.

4. When used correctly oxygen is safe and effective. However safety precautions need to be in place as oxygen allows fires to start more easily, burn more fiercely and be harder to put out.

14.2 Maintenance and storage of oxygen

1. Maintenance

- Oxygen cylinders have an expiry date and this must be checked on a regular basis to ensure that out of date oxygen is not administered.
- Any remaining oxygen cylinders and equipment which are no longer required or have passed the expiry date should be returned to the supplier.
- Oxygen equipment should be kept clean and dry using the method recommended by the supplier.
- Care should be taken to ensure that tubes and masks are kept clean and in good condition and that the tube is not crushed or kinked. Tubing and masks/nasal cannula should be replaced on a regular basis as advised by the supplier.
- In the event of a suspected leak or any other damage, the Support worker should **immediately** inform the oxygen supplier and where possible move the cylinder outside to allow the oxygen to escape into the air. If this action creates more danger it should be left where it is, people in the area evacuated and ventilation increased in the area.
- Contact suppliers for more specialist advice where necessary.

2. The do's and don'ts of **OXYGEN STORAGE**	
Do 	**Don't** 
Clearly display appropriate hazard warning signs as soon oxygen is brought on to the premises including ''no smoking''.	Do not smoke or allow anyone else to smoke around the oxygen equipment.
Oxygen cylinders and concentrators must be stored and used in well ventilated areas to prevent the development of an oxygen enriched atmosphere.	Oxygen must not be stored in areas which would block any exits or fire escape routes.
Oxygen cylinders should be stored securely to prevent unauthorised removal.	Oxygen must not be stored or used near sources of heat e.g. fires, radiators. It should be at least 3 metres from an open fire and 1.5 metres from a closed fire/radiator.
Store the oxygen at room temperature.	Oxygen must not be stored with other combustible material e.g. paraffin, flammable liquids.
Oxygen cylinders must be tethered (e.g. to a wall) to prevent unauthorised removal and to prevent the cylinder from falling which can cause damage to the cylinder and/or injury to staff or service users.	
Hazard notices should be in place for areas where oxygen is stored or used including the service users bedroom. This should include a notice that oxygen is in the room and a notice to say that no smoking or naked flames are allowed.	
Oxygen cylinders should only be moved using the appropriate cylinder trolley as advised by the supplier unless they are designed to be portable.	
When not in use the oxygen equipment must be turned off to prevent the build-up of oxygen in the atmosphere.	

3. In the event of a fire

- When the call “999” call is made it must be stated that oxygen is in the building. On arrival the fire brigade must be informed of the exact location of the oxygen.

- Under no circumstances should support workers use oxygen cylinders, which have been involved in a fire unless they have been thoroughly checked and authorised for re-use by the oxygen supplier and the fire officer.

- Notify the emergency services of the location and contents of the medical gas cylinder store.

(See appendix 15)

14.3 Oxygen documentation and administration

1) A policy and documentation must be in place covering the ordering, receipt, storage, administration and removal of the oxygen.

2) A procedure must be in place for informing the emergency services of the location of oxygen if they are required to attend in the event of a fire or fire alarm.

3) Documentation must be in place covering the administration details for the oxygen including the flow rate and length of time the oxygen should be used for and the prescriber’s details. The flow rate and duration of the therapy must not be altered unless advised by the prescriber. All changes must be documented.

4) A documented robust risk assessment must be in place for both the use and storage of the oxygen. Safety advice provided by the supplier must be available to all staff administering oxygen and the advice must be followed.

5) If the service user is self-administering the oxygen then a documented robust risk assessment must be in place and regularly reviewed to assess their ability to do so correctly and safely.

6) Oxygen and associated equipment (e.g. masks/nasal cannula and tubing) must only be used for the person for whom it was supplied. The oxygen cylinder/concentrator should be labelled to ensure that the person for whom it is intended is identifiable.

7) The administration of oxygen and changing of oxygen cylinders are specialized techniques and only staff who have been appropriately trained can administer oxygen. Training must be documented.

8) Oil based products should not be allowed to come into contact with the oxygen and the oxygen equipment should never be lubricated with oil based products.

Only products which are provided or advised by the supplier should be used on the oxygen equipment. Hands should be washed before handling the equipment to ensure no grease is present on the hands.

9) If the service user has dry skin, especially around the nose and face areas where the mask or nasal cannula sits, a water based moisturiser should be used. Seek the advice of a pharmacist for suitable water based products.

If oxygen is prescribed the assessor must ensure that the current oxygen supplier is able to deliver to the centre to ensure a continued supply.
An oxygen supplier can only supply oxygen to a service user if a written contract to supply the “flow meter” has been signed by both the supplier and the service user.

14.4 If the centre is outside the oxygen supplier’s area the following action must be taken:

- If oxygen is to be used on a regular basis then consideration of an oxygen concentrator should be made rather than using oxygen cylinders.
- The supplier who currently holds the contract must be informed that the service user will be moving out of their area.
- The temporary doctor who will be providing medical cover during the service user’s stay must be contacted to request a prescription for a flow meter/headset, mask, tubing and an oxygen cylinder.
- The local oxygen supplier must be contacted to ascertain if they are able to supply the oxygen. Should they be unable to provide the service they should be able to advise who can.
- The prescription must be collected from the doctor and passed to the new oxygen supplier and arrangements made for the oxygen and equipment to be delivered to the service user on the day of admission.
- In the event of an emergency admission the service user must be asked to bring their oxygen and equipment to the centre and the above procedure for future supplies must be carried out immediately.
- The senior on duty must ensure that two pictorial Oxygen Signs are available for display in reception and on the service users’ bedroom door. The sign must contain the following information:
- "Caution - Compressed Gas. Oxygen in Use"
- No Smoking. No Naked Flames
- Only Support workers trained in the administration of medication who have received instruction from the oxygen supplier and are deemed competent are permitted to.

15: MANAGEMENT OF MEDICATION ERRORS

15.1 Key points

Everyone is accountable for their own practice and must not take on any task, including administration of medication, if they do not feel and are deemed competent so to do.

Safe medication management is the acceptable standard. If, in exceptional circumstances, an error occurs, each employee is accountable and has a duty to immediately report any errors or suspected malpractice to his/her line manager whether the error is their own, or someone else's.

As soon as a medication error has been identified the line manager will support the following action to be taken:

15.2 Internal Error (In-house member of staff)

The Service User's wellbeing is paramount and their doctor must be immediately contacted and advice sought. If the medication has been given, it may constitute a medical emergency.	
The Service User must be informed. If they do not have capacity in this respect, the line manager must make a judgement when to contact and inform the Relevant Person's Representative.	
Any doctor's verbal instructions or advice given must be witnessed by two members of staff and recorded on a 'Medication Amendment Record' and signed by the two witnesses (see appendix 10), then confirmed and signed by the doctor at the earliest opportunity.	
The error must be recorded on a Medication Error Report. Once completed this must be passed to the senior on duty and/or line manager/on call manager as appropriate who will decide if an Adult at Risk Notification needs to be raised, (which would include C.Q.C notification.)	
If the discrepancy is found to be an error of subtraction or addition in the calculation of stock balance for Controlled Drugs, do not change the balance column or use correction fluid. Under the last entry, details of the following should be recorded: 1. The date 2. The error in subtraction/addition (indicated with an asterisk) 3. The correct balance 4. The signature of the nurse/member of staff and the witnessing nurse/member of staff	
The Service User and case manager must be informed of the doctor's instructions. If the service user does not have capacity in this respect, the line manager must make a judgement when to contact and inform the Relevant Person's Representative.	

The Service User's Support Plan will be revised to include any instructions from the GP, for example, monitoring and reporting any side effects and change in condition.	
An investigation must take place as soon as possible after the event. If the event constitutes Safeguarding then investigation must take place under the direction of the nominated Designated Senior Officer for Safeguarding.	
Any action or recommendations made in light of the findings of the investigation must involve the appropriate personnel e.g. Human Resources, Policy, Safeguarding and/or senior line management.	

15.3 External Errors (i.e. Pharmacy or Prescriber Errors)

IMPORTANT - Follow procedure as for 15.2, with the addition of:

Check with the supplying pharmacist and the GP to ensure there has not been a change in the prescription and a communication breakdown.	
Unless the Designated Senior Officer for Safeguarding advises otherwise, the manager responsible for the person making the error should be consulted with and a copy of the form, (with the service users identifiable details removed), shared with them and/or the relevant Health Lead, Also copied, to the registered manager, case manager and relevant Head of Service.	

15.4 Medication error reporting

a) Collation

Medication must be rigorously audited. All Error Reporting forms are to be collated to inform a report to a nominated person by local arrangement (see appendix 22). This information can then be overseen to identify themes and trends, therefore informing recommendations for policy and practice development. Medicines management group to meet regularly to review practices and policy as required in conjunction with pharmacy support.

b) Reporting to CQC

Medication errors are not required to be reported to CQC unless it constitutes an Adult at Risk Alert, has caused harm to a service user or when it is likely there is a serious breach e.g. theft of medication involving a criminal investigation.

16: MANAGING GP CHANGES IN PRESCRIPTIONS DURING VISIT TO SERVICE

16.1 GP Prescribes New Medication

- The prescription must be obtained as soon as operationally possible.
- The MAR sheet must be updated to include the new medication.

16.2 GP Alters dose of prescribed medication

a) A new prescription must be written out.
b) The Doctor must then be asked to clearly record, date and sign the change on the MAR sheet.
c) The current record of the medication must be 'stopped'.
d) The medication must be re-written in a new box with the new instruction.
e) A line must then be drawn horizontally through the MAR sheet signing boxes after the change on the old instruction but before the change in the new instruction.
f) If the medication is imminently due it may be necessary for the doctor to make a hand written amendment to the printed pharmacy label. The amendment must be signed and dated **by the doctor only**.
NB This is the only instance when an alteration can be made to the printed pharmacy label.
g) A record must be made within the care and support plan/daily report.

16.3 GP Stops Medication

a) The doctor must be asked to clearly record that the medication has been stopped on the MAR sheet.
b) The entry must be signed and dated.
c) Medication must be disposed of as 17 Medication Returns.

16.4 GP gives Verbal instructions over the phone to alter or stop medication

a) Verbal instructions from a doctor must be witnessed by two people, recorded on the professional contact sheet and MAR and followed up by writing or a fax from the G.P. (or prescribing nurse).
b) **Any instructions to change a service user's medication must be given in writing.** It may be necessary for the service to record the instruction and fax it to the surgery for the doctor's signature. The signed instruction must then be returned by the surgery to the centre by fax.
c) On no account must an emergency instruction be accepted from a doctor, (even if confirmed in writing) to administer medication to a service user which is prescribed for another service user.

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17: DEATH OR DISCHARGE OF A SERVICE USER

17.1 Death of a service user

When a service user dies the following procedure must be followed:

- The first three columns of the DISCHARGE section of the MEDS2-CONTROL OF MEDICATION form should be completed. 'Discharge Date' should be crossed through and Date of Death recorded.
- The medication must be clearly labelled and stored in a locked cupboard.
- The medication must be retained for at least seven days before disposal in case the Coroner's Office requires it.
- **Medication should be disposed of in accordance with Section 12 of this policy.**

17.2 Discharge of a service user

NB: Two Support Workers trained in the administration of medication must carry out the following procedure:

1. After the service user has received their last planned administration of medication at the service the MEDS2-CONTROL OF MEDICATION form (Appendix 8) and all of the medication belonging to the service user must be assembled.
2. Under the Discharge section
   - The discharge date must be entered next to each medication to be discharged with the service user.
   - The balance of remaining medication must be recorded.
   - The two staff members counting the medication must sign the 'Counted by' boxes (the medication must be counted twice, once by each member of staff to check the balance is accurate).
3. If the medication is a Controlled Drug it must also be signed out in the Controlled Drugs Register.
4. The medication and form must then be locked away until the point of discharge.
5. At the point of discharge (and not before)
   - The member of staff handing over the medication must sign the 'Handed over by' box.
   - The name of the person receiving the medication (service user/relative/care manager) must be recorded in the 'Medication handed to' box.
   - The person receiving the medication must sign to confirm receipt in the 'signature of' box.
   - A record of medication taken that day prior to discharge should be made.
6. The medication can then be handed over to the service user/representative. MAR sheets must be kept for 8 years from the date of the last entry.

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18: AUDITING OF MEDICATION AND MEDICATION PROCEDURES

The Registered Manager/ Senior Support worker should ensure the following audits are completed and outcomes (including any action taken) submitted alongside the Medication Error Records to the Medication Management group.

(At Least) Weekly	**MAR charts to be audited.** As the sizes of the services vary, the number of MAR charts to be audited is left to the manager's discretion. The manager may choose to introduce a rolling programme of MAR chart audit. (See appendix 23). Whatever the manager decides to implement as the local requirement must be made explicit.
	Homely remedies to be audited against stock purchase records and MAR charts
	The balance of Controlled Drugs stock must be **checked** against the balance recorded in the Controlled Drugs Register. This check must be undertaken by two members of staff and signed off accordingly in the Controlled Drugs Register. Whatever the manager decides to implement as the local requirement must be made explicit.
(At Least) Monthly	**Check prescribed stock** held against balance as indicated by MAR charts.
(At Least) Annually	The Registered Manager must facilitate completion of the '**Pharmaceutical Audit Tool'**, (see Appendix 24).

18.1 Training

- KCC approved and certified training must be provided to all Managers and Support workers involved in the overseeing, managing, administration and control of medication at the level to which they are expected to operate/be involved. This may include Supervisors and Care/Case Managers from induction through to specialist areas of practice.
- No Support worker is allowed to manage or administer medication unsupervised until they are trained and assessed as competent to do so.
- Training Records must be kept up to date.

Medication training must include:

1.	Induction training in the principles of the policies and procedures.	
2.	Familiarisation with their own responsibilities with regard to the policy, procedures and record keeping.	
3.	An overview of the legislation related to medication, including controlled drugs data protection and information governance.	
4.	An overview of how medicines in common use, and how to recognise common interactions and side effects	
5.	Interpreting and implementing dosage instructions,	
6.	Methods and process of administration; including oral, inhalers, topical, ear nose and eye preparations.	
7.	Safe storage; safe systems of ordering and receipt.	
8.	Disposal and destruction.	
9.	Prevention of infection and good hygiene.	
10.	An understanding of the principles behind all aspects of the relevant policies and procedures on medicines.	
11.	The practical use of recording systems.	
12.	The side effects of medications in common usage, their use and how to observe and report these observations. a) Information on specific drugs used within the Service. b) Where to get information and support. c) Specific Training will be provided where invasive procedures are involved e.g. rectal diazepam, PEG feed. Consent will be obtained from the Service User, parent or carer and specific training provided on an individual basis by a health professional.	

Delivery of training

The training will comprise session(s) delivered by a professional with medication knowledge such as a pharmacist or nurse and certificated stating what has been covered.

Assessment of training

1. The support worker must be appropriately assessed to establish whether he/she is competent to undertake the responsibility of medicine administration in respect of following KCC procedures and will be reassessed on a 2 yearly basis (using Appendix 22) or more frequently if a medication error has occurred.
2. Managers expected to assess competence as part of their role will have completed, be up to date and competent in all their medication training and additionally be trained and assessed as competent to assess support Workers.

Refresher training

1. Refresher/retraining must be taken on a 2 yearly basis and provided by Health Care Professionals.
2. Managers should also ensure refresher training on the policy takes place annually.

19. POLICY REVIEW

Review of the policy and guidance should be carried out if for any reason it is considered insufficient or at a minimum of 2 yearly intervals.

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Appendices

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ADMINISTRATION OF RECTAL DIAZEPAM

Administration

The administration of emergency medication such as rectal diazepam may only be undertaken by trained and approved staff, and as detailed in the individual's support plan. The prescriber or overseeing consultant is responsible for defining the circumstances under which such medications can be given.

Consent

Written consent must be sought from the Service User likely to require rectal diazepam to control convulsions setting out their agreement for KCC staff to undertake the procedure as necessary. See the form at Appendix 18 Emergency Medication Form.

Emergency situations

Rectal diazepam must only be administered in emergency situations when it is evident that the emergency services will not reach the individual within the specified period of intervention as determined by the Health Professionals.

Staff training

Only those employees who are willing and have undergone relevant training should undertake the administration of rectal diazepam. The staff supervision process should be used to discuss and record the employee's preference in respect of this task. It is unlikely to be possible to definitely determine competence, as staff will be unable to practice in "safe surroundings".

2 members of staff

It would normally be preferable for two staff to be present when emergency administration is being carried out. The absence of a second member of staff however, should not delay administration.

Gender preference

Whenever feasible, the individual's preference concerning the gender of administration staff should be respected. For those not able to express a preference, male should administer to male and female to female.

In an emergency, the absence of the appropriate staff gender should not delay administration.

Dignity

If the administration of rectal diazepam is required the staff should calmly request others present to move to another area or different part of the room so as to maintain the dignity and privacy of the individual.

Emergency Services

In a public place, the emergency services (ambulance) should be called out. If due to unforeseen circumstances, the situation becomes potentially life threatening, administration of rectal diazepam may be conducted within the criteria set by the GP while providing the maximum privacy possible.

CONTROLLED DRUGS REQUIREMENTS (CD)

Admission

Controlled Drugs (medication which appears on Schedules 2 to 4 of the Misuse of Drugs Regulations 2001) can be identified by referring to the BNF. CD next to the name of the drug denotes Controlled Drug.

In very rare circumstances a Schedule 1 drug may be prescribed for medicinal purposes. In this case clarification must be sought from the GP.

Controlled Drugs must also be recorded in the Controlled Drugs Register. The Controlled Drugs Register must be an approved hardback book specifically designed for this purpose. A spare Controlled Drugs Register must always be available in the centre. Each Controlled Drug for each service user must be recorded on a separate page.

The following information must be recorded in the Register:

- Date the Controlled Drug was received.
- Names of the two members of Support Worker receiving the Controlled Drug.
- Amount of controlled drug received.
- Form in which it was received e.g. tablets, liquids in millilitres and injections in ampules.
- The entry must be signed by two members of Staff – the first signature by the Support Worker recording the entry, the second signature by a member of staff witnessing the entry.

Handling of Non-Prescribed Controlled Drugs and their Disposal

- A licence is required to possess a Schedule 1 Controlled Drug, drug not authorised for medical use.
- **Care home staff can only take possession of them for the purposes of handing them over to the police for disposal**.

If it is suspected that a Schedule 1 Controlled Drug has been brought into the centre the following actions must be immediately taken:

1. The pharmacist must be contacted to check whether the drug is on Schedule

2. If the drug is on Schedule 1 the Registered Manager should be informed immediately.
3. The Registered Manager must contact the police to inform them that a Schedule 1 Controlled Drug is on the premises.

4. The police will give instruction as to the procedure to be followed to take possession, label and store the drug until the police can collect it.

5. The incident must be fully recorded on an HS157 Accident/Incident form. Details **must** include:
   - the time the telephone call was made to the police
   - the police reference incident number
   - instructions received from the police

6. Inform regulatory bodies (CQC)

Storage
Controlled drugs must be stored in a locked metal cabinet, which complies with the Misuse of Drugs (Safe Custody) Regulations 1973. The metal cabinet should be bolted to an internal wall in the medication room.

Stock should be kept to a minimum and nothing should be displayed outside to indicate that Controlled Drugs are kept within the receptacle.

A locked receptacle is necessary for drugs in transit.

Administration Procedures
Two members of staff (one must be a team leader) must follow the procedure below when administering controlled drugs. The designated member of staff carries out the activity; **the second member of staff witnesses the process and must be present throughout the whole procedure:**

1. The designated member of staff takes the Controlled Drug from the Controlled Drug cabinet and checks it against the MAR sheet.

2. The stock amount of the Controlled Drug must be checked with the Controlled Drug register.

3. The Controlled Drug and its dosage must then be checked.

4. The Controlled Drug must be put in a clean graduated medicine pot.

5. The remaining stock of the Controlled Drug must then be returned to the Controlled Drug cabinet and locked securely

6. The Controlled Drug is then administered to the service user.

7. The Controlled Drug Register is then completed and the remaining stock balance documented. Both members of staff must sign the Register to confirm that the Controlled Drug has been administered and the remaining stock balance is correct.

8. The person administering the controlled drug must also sign the MAR sheet.

9. Liquid paper must never be used to correct a mistake. The mistake must be crossed through in black ink and initialled by both members of staff. The correct information must then be recorded.

NB – See separate guidance for the administration of rectal diazepam and buccal midazolam.

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EXPIRY DATES FOR PRESCRIBED ITEMS IN CARE HOMES

Provided the medicine or preparation is:

- still currently prescribed,
- within its expiry date
  and
- the manufacturer's literature does **not** specify a short shelf-life when the product is opened

There is no requirement for the medicine to be disposed of early and it should be carried forward to the next 28-day supply cycle.

When care home staff are uncertain of the shelf life of a particular medicine once opened, they should check the information supplied with the medicine or contact a pharmacist for advice.

BACKGROUND

The Department of Health's (2012) report and action plan on 'Improving the use of medicines (for better outcomes and reduced waste)' recognises the specific needs and circumstances required for the care of older people, and that the care home providers and health professionals may have adopted a number of system approaches to managing medicines that may in themselves create waste. For example, care home staff returning tubs of topical preparations such as creams and ointments back to the supplying pharmacy every month and ordering new ones.

The Guideline Development Group (GDG) for the NICE Guidelines on Managing medicines in care homes concluded that:

- provided the medicine is still currently prescribed,
- is within its expiry date and
- the manufacturer's literature does not specify a short shelf-life (the recommended maximum time that the medicine can be stored for as stated in the manufacturer's literature during which the defined quality of the medicine remains acceptable under expected (or specified) conditions of storage) when the product is opened then, there is no requirement for the medicine to be disposed of early and it should be carried forward to the next 28-day supply cycle.

Approved by: East Kent Prescribing Group *(Representing Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG)*
Date: May 2014
Address: c/o *Canterbury and Coastal CCG, Brook House, John Wilson Business Park, Whitstable, CT5 3DD*
Contact: T: 01227 791267 | E: accg.eastkent.prescribing@nhs.net

When care home staff are uncertain of the shelf life of a particular medicine once opened, they should check the information supplied with the medicine or contact a pharmacist for advice.

NICE Guidelines on Managing medicines in care homes makes the following recommendations:

RECOMMENDATION 1.12.4
Before disposing of a medicine that is still being prescribed for a resident, care home staff (registered nurses and social care practitioners working in care homes) 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.

RECOMMENDATION 1.12.5
When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:

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

RECOMMENDATION 1.12.6
Care home providers 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 cupboard until they are collected or taken to the pharmacy.

REFERENCE

Managing medicines in care homes
http://www.nice.org.uk/guidance/sc/SC1.jsp
Published: 14 March 2014

GLOSSARY OF TERMS

Administration of medication vs. Assistance with medication
The following descriptions define what assisting with medicines means and what administering medicines means: (Ref CQC Professional Advice)

- When a care worker assists someone with their medicine, the person must indicate to the care worker what actions they are to take on each occasion.
- If the person is not able to do this or if the care worker gives any medicines without being requested (by the person) to do so, this activity must be interpreted as administering medicine.

Within KCC both 'Administration' and 'Assisting' are carried out in accordance with the Support Worker Tasks provided in Appendix 21.

Approved training
This is a structured programme of training that has been agreed between Health and Families and Social Care. Staff involved in managing Service User's medication will be assessed regarding their competency to undertake specific tasks and then judged whether competent to do so.

As required medication
Medicine to be given when required for defined problems, e.g. pain relief. Can also be referred to as PRN (Pro Re Nata).

Capability to self-medicate
This refers to the Service User's physical capability to self-administer the medication provided for them.

Care/case management
Is the process of tailoring services to meet individual needs following a holistic assessment and care planning by Care/Case Manager.

Care/case manager
Is a professional representative of Families and Social Care who assesses the needs of a Service User, plans and arranges delivery of services required to meet those needs.

Care plan / support plan
For the purposes of this policy, the Care Plan is devised by the Care / Case Managers and the Support Plan by the Registered Care Centre.

Care programme monitoring/contact book
This is any record of the Support provided to an individual and can also be referred to as Contact Notes.

This may be referred to as Support Plan/Care Plan and Contact Book, Professional Notes etc.

Controlled drugs (CD)
CDs are medicines that may be used to treat severe pain or drug dependence. There are legal requirements for storage and record keeping that apply in service user settings.

GP/doctor
This is normally the healthcare professional who has overall responsibility for the service users health. Some responsibilities may be delegated to another health care professional e.g. prescribing may be carried out by a non-medical prescriber.

GP surgery
This is the provider who has overall responsibility for providing General Medical Services (GMS) to the service user. The GP/Doctor is usually based here.

Health professional
These are people who are medically trained and assessed as competent in their field of work. They may all prescribe medication. These can include:- Doctors, Pharmacists, Nurse Practitioners, Ophthalmic Opticians, Physiotherapists.

Line manager
Can include:- line manager, team leader, senior support worker, supervisor etc. who manage the Direct Services provided by Support Workers.

Mental capacity
This relates to the Mental Capacity Act (MCA) 2005. Guidance is provided at Appendix 25.

Monitored dosage systems
They can also be referred to as: dossett boxes, blister packs, nomads. These are systems for packing medicines to make use easier, e.g. by putting medicine for each time of day in separate blisters or compartments.

Multi-agency team
This consists of all KCC and Healthcare professionals involved in an individual's care.

Non-medical prescriber
Is a healthcare professional who has undertaken additional training in order to enable him/her to prescribe medication.

Over the counter (OTC)
These are non-prescribed medications which can be purchased from pharmacists, supermarkets, etc., and can also be referred to as Homely Remedies. OTC medication may include: tablets, liquids, creams, herbal remedies.

PEG (Percutaneous Endoscopic Gastrostomy) tube
A flexible tube that goes through the abdominal wall directly into the stomach. Used for giving liquid food.

Prescriber
This is the health care professional who has responsibility for prescribing medications for the service user. This person may not necessarily be the GP or doctor but will work in close liaison – see Non-medical prescriber

Provider
A resource providing a service at an agreed cost.

Secondary dispensing
Re-packaging a medicine that has already been dispensed by a pharmacist or dispensing doctor.

Senior care professional
This refers to a senior member of the care team and can include:
Team Leader, Registered Manager, Senior Team Leader, Nurse, Senior Home Support Worker.

Service delivery order
An order for providing a support package, from the service purchaser to the service provider which is produced by translating an individual service plan via the Care Management Information System.

Service user

This term also means client, customer or service user and describes anyone who makes use of the services provided by Families and Social Care or its contractors.

Support planning

Means negotiating the most appropriate ways of achieving objectives identified via an assessment of need and incorporating them into an individual support plan.

Support worker

For the purposes of this policy document, the Support worker refers to anyone employed by KCC to assist with or administer medication.

HOMELY REMEDIES / STOCK MEDICATION APPROVED LIST AND PROCEDURE

This is a KCC agreed list of homely or household remedies that a service may purchase to alleviate minor ailments. A homely or household remedy is another name for a non-prescription medicines available over the counter in community pharmacies, used in a care home for the short term management of minor, self-limiting conditions, e.g. toothache, mild diarrhoea, cold symptoms, cough, headache, occasional pain, or mild indigestion.

In the case of service users who are considered not to have the capacity to make decisions about their care (in line with the Mental Capacity Act 2005) the recommended items should still be available for care home staff to make an appropriate response to symptoms of a minor nature.

Product	Purpose	Dose	Frequency	Maximum Administration
Paracetamol	Mild pain relief Low grade pyrexia (i.e. raised temperature)	500mgs-1gram	4-6 hourly. (not to be given on an empty stomach	2 tablets every 4 hours. Maximum 8 tablets in 24 hours.
Dioralyte	Rehydration	One or two sachets	Take after each loose motion	
Gaviscon	Antacid for indigestion	10mls-20mls	After meals and at bedtime	

- At the discretion of the Registered Manager the approved medication (see above) may be obtained and stored within the centre for generic use.

- Written consent must be sought from the GP and the Service User on admission stating whether stock medication of the approved Homely Remedies may be given. Available information relating to the individual's past medical history must be shared with the medical professional including any details of allergies or specific treatments.

- The senior on duty with the required medication training will decide (with the service user where possible) if the Homely Remedy is appropriate for the presenting symptom.

- If there is ANY doubt as to whether a homely remedy is suitable for a service user a pharmacist, or GP should always be consulted.

- NB If temperature is above 38'C then the GP must be consulted.

- Homely Remedies may only be given from Stock medication for a maximum of 48 hours.

- If the symptoms continue or worsen then the G.P. must be contacted.

- KCC Medication Policy and Procedures apply.

- The administration of any homely remedy/stock medication must be clearly recorded on the individual's MAR. This must include full details of the medication, the exact time it was given and by whom.

- The stock medication monitoring form must be completed.

- The individual must have a support plan in place to include assessment, monitoring and review of the symptoms for which the homely remedy is being administered.

- If there is any cause for concern advice must be sought immediately.

- If symptoms persist the individual's GP must be contacted and a longer term treatment plan obtained.

Storage and Monitoring of Stock

Stock medication must be stored in a secure centralised area, for example, a medication room.

Stock monitoring forms must be completed at the time of administration.

HOMELY REMEDIES: PROTOCOL FOR THE ADMINISTRATION OF PARACETAMOL 500MG TABLETS/SOLUBLE TABLETS

Indication

Paracetamol must ONLY be used for:

- Relief of mild to moderate pain
- Relief of pyrexia (raised temperature). NB If temperature is above 38'C then the GP must be consulted.

Dose

500mg to 1g (One or Two tablets) every 4-6 hours to a maximum of 4g daily (8 tablets) **FOR MAXIMUM 48hrs**

Inclusion Criteria

- Service users >18 yrs of age in: Adult services care homes, planned and emergency short stays

Exclusion Criteria

Paracetamol must NOT be used in service users with the following medical conditions. Please seek medical advice.

- Known hepatic and renal impairment
- Alcohol dependence/Chronic Alcoholism (if they routinely have more than 3 alcoholic drinks a day, seek advice from the GP).
- Chronic Malnutrition
- Dehydration

Interactions

Staff must ALWAYS check the pharmacy advice note and check with the GP in the event of possible interactions with other medication.

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HOMELY REMEDIES: PROTOCOL FOR THE ADMINISTRATION OF PEPTAC OR GAVISCON ADVANCE SUSPENSION

Indication

- Relief of symptoms of acid reflux
- Relief of symptoms of dyspepsia

Dose

Peptac® suspension

- 10-20ml After meals and at Bedtime

Gaviscon® Advance suspension

- 5-10ml after meals and at Bedtime

Inclusion Criteria

- Service users >18 yrs of age in: Adult services care homes, planned and emergency short stays

Exclusion Criteria

- Service users on a salt restricted diet e.g. in some cases of congestive cardiac failure and renal impairment or when taking drugs which can increase plasma potassium levels.

Interactions

- Antacids should preferably not be taken at the same time as other drugs since they may impair absorption, particularly antibacterial and cytotoxic medication.
- Antacids may also damage enteric coatings designed to prevent dissolution in the stomach.

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HOMELY REMEDIES: PROTOCOL FOR THE ADMINISTRATION OF DIORALYTE® ORAL REHYDRATION POWDER

Indication

- Oral correction of fluid and electrolyte loss as a result of watery diarrhoea of various aetiologies including gastro-enteritis.

Dose

Reconstitute ONE sachet in 200ml of water and administer after each loose bowel movement. After reconstitution any unused solution should be discarded no later than 1 hour after preparation.

Inclusion Criteria

- Service users >18 yrs of age in: Adult care homes, Planned and emergency short stays

Exclusion Criteria

Service users with the following:

- Renal Disease
- Electrolyte restriction for any other reason
- Intestinal obstruction requiring surgical intervention

Interactions

There are no known interactions with Dioralyte.

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BLACKBURN LODGE CARE HOME

LOCAL PROCEDURE FOR ORDERING AND RECEIVING MEDICATION

Blackburn Lodge Care Home protocol for ordering monthly medication:

- MAR charts are sent to BBL on delivery of previous month's medication.
- Allocated person at BBL checks charts against current medication.
- Check all medications on MAR charts are still required.
- Check all doses and strengths are correct.
- Inform chemist of any changes.
- Checked MAR charts are used to order medication for following month in week 2.
- Ticking ALL regular medication.
- Current stock levels, creams, ointments are checked before ordering.

The MAR copies are sent to the pharmacy and a copy is kept at the home. The pharmacy sends copy to the surgeries.

The pharmacy collects the scripts and issues the medication at the beginning of week 4.

On receipt of the medication the team leader checks the medication in with another member of staff and signs the mar sheets. Any errors are noted and the pharmacy informed.

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BROADMEADOW REGISTERED CARE CENTRE
LOCAL PROCEDURE FOR ORDERING AND RECEIVING MEDICATION

On admission into Broadmeadow Registered Care Centre the Team Leader/Senior Night Carer receiving the service users medication, must do the following prior to booking it in;

Ordering Medication

- If the service user is admitted into Broadmeadow Registered Care Centre from a hospital setting all medication must be checked against the discharge notification. The Team Leader/Senior Night Carer must ensure the pharmacy labels and medication contents match what is recorded on the hospital discharge notification and all service user details are accurate.

- If the service user is admitted into Broadmeadow Registered Care Centre from the community, the Team Leader/Senior Night Carer must obtain a medical summary from the named G.P. Surgery. The Team Leader/Senior Night Carer must ensure the pharmacy labels and medication contents match what is recorded on the medical summary and all service user details are accurate.

- The amounts of each medication will then be counted with another (competent assessed) member of staff and recorded on the admission and discharge form. Both members of staff must sign to agree that the balances are correct; this is to be done for each medication that differs in form, dose and strength. At this point the packet contents are to be checked against the packet label and pharmacy label, to ensure all three match up, the expiry date needs to be checked and batch numbers must match the batch number from the packaging.

- If there are discrepancies such as the service user is no longer on this type/dose, or its expired, it must be signed out on this same form as returns and placed In the medication returns cupboard. Medication is then put in to two areas; in use where it is put in to a labelled container in the designated medication trolley/ Cd cupboard or fridge, or as spare supplies in to the wall cupboards assigned for each unit.

- The service user must be consulted with regards to wishes and abilities to self-medicate completely, with supervision or full support and a risk assessment completed to reflect this. If the service user has been assessed as competent to self-medicate, suitable lockable storage and key to be offered and quantities of medication given to be recorded on a self-medication chart and an agreed check date to review the self-medication agreement.

- The Team Leader/Senior Night Carer will list down each medicine and the directions as per the label onto a typed medication ordering form. Once complete this must be printed off and faxed to the temporarily registered G. P. Surgery. The transmission report is then stapled to the medication order form as evidence that a medication request has been requested.

- The Team Leader/Senior Night Carer will then record the date that they have requested the medication and place on the front of the medication cupboards using a magnet. This ensures that all staff whom are involved with medication ordering process are aware that the medication has been ordered. For medicines such as pain relief that comes up with 2 week supply as opposed to 4, will need to have another date put on this form to remind staff to request more sooner than the normal monthly order.

- If the service user comes in with items listed on their EDN but have not arrived with these items, the senior member of staff must contact the hospital ward to explain this and seek retrieval of these items.

- If the service user came from home and has medication items missing that they should be in, every effort should be made to retrieve the items from their home via friends/family/case manager. If this cannot happen an urgent prescription must be requested from their own G.P, Temp G.P or out of hours G.P.

- If the service user has come in with medication that is not listed on their EDN or Medical Summary, this must be still booked in on the admissions form but not added to the MAR, and written clarification from a G.P must be sought before any medication can be administered.

- Homely remedies procedure must be followed for the administration of homely remedies.

- If the service user comes in with medication that cannot be identified, such as in unlabelled bottles, or mixed packaging/blister packs etc. It would be safer practice to disregard the administration of these medicines and request full prescription of all medication required from G.P, Temp G.P, Out of hours so safe administration of medications can take place.

Repeat Medication Ordering

- The Team Leader/Senior Night Carer must check the medication ordering dates listed on the front of the medication cupboards on a daily basis to ensure sufficient stock of medication is held for each service user
- This is ordered in the same way as above; a medication request form is completed and faxed to the relevant temporary registered service with a list of what is required.

- If the service user is with their own G.P surgery, this can be ordered in the same way but ensure they are aware of the persons temporary address and that we usually use Taylors pharmacy to deliver or Guildhall street pharmacy also deliver.

Receiving Medication

- The pharmacies will deliver medication to the reception area at Broadmeadow Registered Care Centre. The two main pharmacies involved in this process are Taylors, Cheriton and Guildhall Pharmacy, Folkestone.

- The reception staff will accept medication from the delivery driver checking that names match the service users that are currently residing at Broadmeadow Registered Care Centre. The staff member will then sign to acknowledge receipt of the medication.

- If part of the medication delivery contains controlled drugs, a Team Leader or competent person, will count the medication and check that we have received the correct amount and dose prior to signing the pharmacies controlled drugs book.

- The medication will then be taken to the Team Leader on duty so that the medication can be booked in.

- The Team Leader/Senior Night Carer must check the received medication against the medication order form. This ensures that the all medication requested has been received and the dosage / Instruction/format are correct.

- The Team Leader/Senior Night Carer will also check the received medication against the MAR chart this will highlight any new medication.

- The medication is booked in on the admissions form by two competent assessed staff, and the quantities are added to the MAR to reflect total stock quantity, and put either on the trolley for immediate use (new medicines prescribed by the G.P.) or placed in the wall cupboard for supplies, with exception of CD Items or fridge items.

- On booking in medication the same applies as above with checking the packet, label and contents and expiry dates.

- CD Medication is as above but with the added record of the CD Register, which is located with the CD Cupboard, two competent assessed staff will check and sign the items in and clarify the total balance.

GRAVESHAM PLACE INTEGRATED CARE CENTRE

MEDICATION ORDERING AND DELIVERY PROTOCOLS

- Photo copy MAR.
- Indicate on MAR what is needed using a tick to needed items.
- Fax through to relevant GP surgery using prescription's fax.
- Place ordered meds in medication ordering tracking folder.
- Pharmacy made aware of order/start date.
- This is generally done on the third week of in house medication.

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WAYFARERS CARE HOME

MEDICATION ORDERING AND DELIVERY PROTOCOLS

- We use Boots at deal for all our medication and use their MAR system.
- We register clients with three surgeries.
- The way we request medication depends on the surgery:

Market Place surgery:

Market place surgery use the medication administration record :

- When you have started the beginning of week 2 of your Monitored Dosage System you will need to order medication required for the following month.
- You need to gather the white and yellow carbon copies of the current MAR Sheets and the current MAR sheet.
- Check what stock there is in the cupboard before requesting any further supplies (please note only order the amount you need to take you to the end of the following ordering cycle.)
- Check the current MAR for any changes in dosage or stopped/new medicines
- Now complete the carbon copies of the MAR sheets as this is the ordering sheet.
- If there are any new medications add this to the bottom of the sheet.
- Once complete the carbon copies are to be sent to Market Place Surgery as soon as possible for processing.
- When the prescriptions are ready Market Place surgery will make contact with Wayfarers so that we can collect these.
- The prescriptions are then checked against the carbon copies of the MAR sheets to ensure that what we have ordered has been prescribed.
- Once checked and correct contact Boots Pharmacy at Deal for collection.
- Carbon copies are kept in the medication room until delivery.
- Boots once dispensed will deliver.
- When delivery is received the medication must be checked against new MAR sheets and the carbon copies.

- The new MAR sheets must have a record of any balance carried over, new balance, allergies and if any new medication have recently been prescribed/changed/stopped this must also be reflected on the new MAR sheet.
- **Two staff must carry out the booking in process as above.**

The Butchery surgery:

The butchery surgery uses electronic prescription service and we order medication this way:

- Email sent to surgery requesting medication by checking with current MAR
- Butchery medication team checks over the request
- Butchery medication team issues white script and sends direct to Boots at Deal

Medication delivery:
Boot delivers the medication together with monthlies from Market Place and Butchery surgery with a MAR sheet

The Ash surgery :

The surgery Ash also uses electronic prescription service and we order medication this way:

- Email sent to surgery requesting medication by checking with current MAR
- Ash prescription team checks over the request
- Ash prescription team issues white script and sends script direct to Boots at Deal

Medication delivery:
Boots sends us copy of white script to check medication dispensed for the Ash surgery.

Receiving medication

- All the medication from the three surgeries are delivered by Boots in sealed blue bags in time for following monthly start
- All scripts go to Boots at Deal and are delivered every 28 days for our permanent clients.
- Other mid-term scripts are sent and delivered by Boots as and when requested.

- When a new service users has medication prescribed we fill out a Boots service user update form and care service fax sheet

- We use the paperwork from the current medication policy for booking in, dispensing .

- A team leader and another staff member book the medication in when it arrives using the M A R sheet and meds booking in form

- Short term /assessment and interim medication are booked in on the MAR and meds booking in form appendix 8 of the policy

- When medication is delivered a team leader and a member of care staff check the instructions, count the medication, check for any contra indications with other medications then book in the medication on MAR and booking in form.

Out of Hours scripts:

On occasion for out of hour scripts we use an independent pharmacy i.e. Tesco, ASDA or Paydens depending on time of opening

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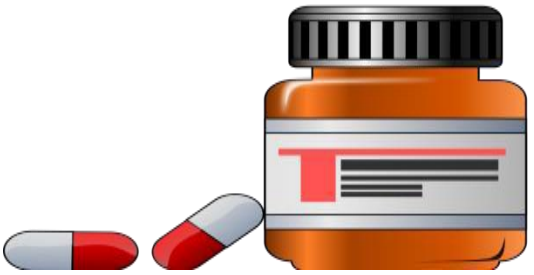
WESTBROOK HOUSE INTEGRATED CARE CENTRE MEDICATION ORDERING AND DELIVERY PROTOCOLS FOR THE APPLETON UNIT



Protocols for service users who are accessing assessment beds on Appleton/Ogden units

Ordering medication for service users who are temporary registered at Garlinge/The Limes surgeries:-

- All Medication for the Appleton unit is only to be ordered/requested by team leaders, senior team leader or registered manager.
- When ordering medication please check that the service user has been temporarily registered with the Garlindge/Limes surgeries
- Complete the “prescription request for service users at Westbrook House Integrated Care Centre” form.
- The original form to be hand delivered to the surgery and a copy retained for the individual service user’s file.
- In the event that a service user is assessed by senior staff as requiring a medication which is not prescribed (e.g. paracetamol, laxative), a request to the Garlinge/Limes surgery can be made over the telephone. It is at the discretion of the GP whether they will then prescribe the medication. In this case the prescription will be sent to the pharmacy, who will deliver it.

Booking in medication when received:-

- All medication when entering the unit must be handed to the team leader, senior team leader or registered manager.
- The senior on duty alongside an identified member of staff (this could be a care worker if no other senior on site) is responsible for booking in medication received from pharmacists, following Kent County Council’s Policies and Procedures for the Management of Medication in Adult Residential Homes, Short Breaks and Respite Services.
- Medication to be logged in on the Kent County Councils MED 2 form with a double signature.
- Medications then to be transferred into Appleton Units secure medication trolley or lockable cupboard in the clinical room if it is to be used at a later date.
- The copy of the “prescription request for service users at Westbrook House Integrated Care Centre” form to be completed with date medication received.

Protocols for service users who are accessing respite beds

Ordering medication for service users who are remaining with their own G.P practice:-

- A welcome letter is sent to the service users and their representatives prior to planned stay. The letter informs of the procedures in regards to medication in line with Kent County Council's Policies and Procedures for the Management of Medication in Adult Residential Homes, Short Breaks and Respite Services.
- and local protocols for the Appleton Unit:

"All medication must be provided in the **original pharmacy dispensed boxes or bottles**.

All medication must have its original pharmacy labels intact and clear, and must have been dispensed with your name on it, not that of a relative or friend. This includes eye drops/ointments and creams.

All medication must have been dispensed within the last six months.
Where you have been prescribed ointments or eye drops which will expire within a set period of time after opening, please bring new, unopened bottles or tubes with you.

All medication must have clear dosages and instructions on the pharmacy labels: **Instructions such as 'when necessary', or 'as directed'**, **are not acceptable.**

If any medication brought in that does not meet the requirements set out above we will not be able to keep these in the building or administer them.

The unit is unable to obtain repeat prescriptions and this is, unfortunately due to changes to G.P. cover arrangements at Westbrook from March 31st 2016. These are; that all service users accessing the Appleton unit will remain registered with their own G.P.

Service users staying with us on the Appleton unit for a period of assessment will be required to provide at least one month's supply of their prescribed medication.

Due to the new G.P. arrangements if additional medication is required during your stay with us your relatives/carers will be required to request any repeat prescription's from the your own G.P. and obtain the medication from the pharmacy and deliver to the unit.

Please speak to the Team Leader on duty if you have any concerns or questions about the above arrangements.

If you wish to administer your own medication, this is possible, but is subject to the establishment's agreement. You will need to keep all medication in the lockable draw provided in your bedroom."

- In the event that a service user does not have sufficient medication for the length of their stay, this could be because the stay has been extended, the service user's family should be contacted and asked to provide further medication. If this is not appropriate the service user's own GP should be contacted to request a repeat prescription.

Booking in respite medication when received:-

- All medication when entering the unit to be handed to the team leader, senior team leader or registered manager.
- The senior on duty alongside identified member of staff (this could be a care worker if no other senior on site) is responsible for booking in medication received, following Kent County Council' s Policies and Procedures for the Management of Medication in Adult Residential Homes, Short Breaks and Respite Services.
- Medication to be logged in on the Kent County Councils MED 2 form with a double signature.
- Medications then to be transferred into Appleton Units secure medication trolley or lockable cupboard in the clinical room if it is to be used at a later date.

These protocols should be carried out with regard given to Kent County Council's Policies and Procedures for the Management of Medication in Adult Residential Homes, Short Breaks and Respite Services at every stage.

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WEST VIEW INTEGRATED CARE CENTRE
MEDICATION ORDERING AND DELIVERY PROTOCOLS

Permanent Service Users

- When you have started the beginning of week 2 of your Monitored Dosage System you will need to order medication required for the following month.
- You need to gather the white and yellow carbon copies of the current MAR Sheets and the current MAR sheet.
- Check what stock there is in the cupboard before requesting any further supplies (please note only order the amount you need to take you to the end of the following ordering cycle.)
- Check the current MAR for any changes in dosage or stopped/new medicines
- Now complete the carbon copies of the MAR sheets as this is the ordering sheet.
- If there are any new medications add this to the bottom of the sheet.
- Once complete the carbon copies are to be sent to Ivy Court Surgery as soon as possible for processing.
- When the prescriptions are ready Ivy Court will make contact with West View so that we can collect these.
- The prescriptions are then checked against the carbon copies of the MAR sheets to ensure that what we have ordered has been prescribed.
- Once checked and correct contact Boots Pharmacy at Sevington for collection.
- Carbon copies are kept in the medication room until delivery.
- Boots once dispensed will deliver.
- When delivery is received the medication must be checked against new MAR sheets and the carbon copies.
- The new MAR sheets must have a record of any balance carried over, new balance, allergies and if any new medication have recently been prescribed/changed/stopped this must also be reflected on the new MAR sheet.
- Two staff must carry out the booking in process as above.

Respite – Lindens/Wittersham

- If a service user has not arrived for their stay with enough medication you must make contact with the next of kin/friend/case manager for further supplies to be obtained.
- If further supplies are not able to be obtained then you need to order a new supply of medication.
- The Team Leader will need to email one of the administration staff a list of medications required for the individual so that a secure email can be sent to Ivy Court surgery (In the event that there are no administration staff this task can be carried out by the Registered Manager, Senior Team Leader or Registered Nurses.)
- Once Ivy Court has completed the prescription this will automatically be sent to Boots Pharmacy Sevington for dispensing and delivery.
- On arrival to the unit the medication must be booked in using the MAR2 form and balance added to the current MAR sheet.

Benenden East and West

- All service users should arrive with a small amount of medication to last at least 2 weeks.
- On a Wednesday Night the Registered Nurses on duty will count all medication and complete a list of medications required for each individual.
- The Registered Nurse will complete the prescriptions on EMIS(GP online system) and print ready for the GP to check and sign the following morning. (If EMIS is not working then the list is to be left for the GP to take to the surgery for printing.)
- Prescriptions are photocopied and faxed to Boots Pharmacy Sevington with an indication on the urgency of each medication required to be dispensed.

1. – URGENT Same Day
2. – 2 days delivery
3. – with the week

- If prescriptions are at Ivy Court Surgery they will be collected by Boots Pharmacy Sevington. The Registered Nurse will need to inform Boots by telephone the urgency of each medication prescribed.
- On arrival to the unit the medication must be booked in using the MAR2 form and balance added to the current MAR sheet.

GUIDANCE ON COMPLETION OF MEDICATION ADMINISTRATION RECORD (MAR) FORM

1. The MAR has been designed to enable administration of different types of medication to be recorded for a period of up to 31 days (1 month).

2. As and when required, medication must state the signs/symptoms present to identify when to administer the medication.

3. On commencing use of the form, enter the following information across the top of the form :
   - Name of service user
   - Date of birth
   - GP – name
   - Allergies – enter details of any known allergies in Capital letters with RED pen.
   - Month & Year – a new sheet will be required at start of each new calendar month.

4. Enter following information down the left-hand side of the form for each medication prescribed for the client.

   - Name of medication/drug, strength and any cautions included on label.
   - Dose (e.g. 1 x 20 mg tablet, 10 ml)
   - Expiry Date – enter expiry date of medication if included on container.
   - Signature – of support staff entering information on the sheet.
   - Signature of second support staff as witness that information recorded is accurate
   - Route – enter route by which medication is taken (e.g. Oral)
   - Time – enter the time/s that the medication is taken.

5. The small boxes should be initialled by the administrator to indicate that the medication has been administered on the day and times indicated. If dose is variable, e.g. PRN paracetamol prescribed as “one or two” tabs, insert actual amount administered.

6. Where medication is not administered on a specific day or time, one of the letters at the bottom of the sheet is entered in the box and, if necessary, comments are made on the Medication Record Sheet.

7. The horizontal line beneath each drug type must also be completed as follows:

- ‘Recd’ (Received) – enter date new supplies of medication are received.
- ‘Quan’ (Quantity) – enter quantity received.
- ‘By – enter initials
- Returned/Destroyed – enter date medication returned to pharmacist.

NB – spoilt medication should be wrapped in tissue, placed in a clearly marked envelope and taken to the pharmacist.

NB In some cases a service user may have a number of concurrent MAR charts. The service manager must be satisfied that every precaution is taken to maximise safe and effective practice and that all MAR charts in use are checked

MEDICATION RECORD SHEET

Please use this sheet for recording any untoward occurrence involving medication.

Date	Time	Details	Initials

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(MED1) – SPECIMEN SIGNATURES FORM

NAME:	INITIALS:	SIGNATURE:

DATE:_____

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SHEET…….**OF**….. .
NAME OF CLIENT…….
UNIT……

RECORD OF ALL MEDICATION RECEIVED ON ADMISSION (ALSO RECORDED ON ADMINISTRATION RECORD – MAR – SHEET) AND PROVIDED ON DISCHARGE/RETURN TO PHARMACY

Record of medication returned to client on discharge*/short term leave from the centre*/returned to pharmacy for safe disposal:

*delete as appropriate

ADMISSIONS			
Date:	Medication provided on Receipt/discharge/STC leave	Quantity	Received by: Signature (1) 2 Signatures

DISCHARGE					
Discharge Date:	Quantity Out:	Counted by (2 signatures required)	Handed over by Team Leader (initials)	Medication handed to e.g. relative/care manager/client /Pharmacist	Signature of (e.g. relative/care manager/client Pharmacist)

Records on reverse: yes/no

SHEET…….**OF**….. .
NAME OF CLIENT…….
UNIT……

RECORD OF ALL MEDICATION RECEIVED ON ADMISSION (ALSO RECORDED ON ADMINISTRATION RECORD – MAR – SHEET) AND PROVIDED ON DISCHARGE/RETURN TO PHARMACY

Record of medication returned to client on discharge*/short term leave from the centre*/returned to pharmacy for safe disposal:

*delete as appropriate

ADMISSIONS			
Date:	Medication provided on Receipt/discharge/STC leave	Quantity	Received by: Signature (1) 2 Signatures

DISCHARGE					
Discharge Date:	Quantity Out:	Counted by (2 signatures required)	Handed over by Team Leader (initials)	Medication handed to e.g. relative/care manager/client /Pharmacist	Signature of (e.g. relative/care manager/client Pharmacist)

Records on reverse: yes/no

(MED3) – HOMELY REMEDIES DOCTORS CONSENT FORM

(Please complete in BLOCK CAPITALS)

I, Dr_____ of_____Surgery

give my consent to ********** Care Centre staff to administer the following homely remedies in accordance with the manufacturer's written instructions and KCC stocked medication protocols where applicable to:

Name of service user:_____

D.O.B: _____

Address:_____

while she/he is staying at ********** Care Centre.

NAME OF HOMELY REMEDY:
NAME OF STOCKED MEDICATION (see below)

I understand that only staff formally trained in the administration of medication will administer the medication.

Signed:_____

Date:_____

Note: Stocked medication includes:- Paracetemol, Dioralyte, Gaviscon Advance or Peptac. Such medication will only be given for a maximum of 48 hours. If required after this time, advice will be sought from a health professional.

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(MED 4) - HOMELY REMEDY / STOCK MEDICATION MONITORING

Name of Medicine	
Preparation type (liquid/tablet etc)	
Strength (e.g. 500mg)	
Quantity	
Date Obtained	
Expiry Date	
Disposal Date	

ADMINISTRATION RECORD

Date	Service User (given to)	Time	Authorised by	Dose given	Quantity remaining	Signed

Note: Details must also be recorded on the Service User's MAR or on the day sheet.

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Kent County Council
Planned Short stays and emergency short stays
(MED5) - RISK ASSESSMENT FOR THE SELF ADMINISTRATION OF MEDICATION

Unit:	**Name:**
D.O.B:	
Have you assessed the service user as currently lacking Mental Capacity and/or Physical Capacity to self-medicate?	**If NO, continue Part 2**
If YES, Give details of your assessments (attach Capacity/ Best Interests assessments as necessary): **And insert a date for reassessment of capacity to self-medicate**	**Reassessment date …./…./……**

For those considering self-medication:

1	**Would you like to self-medicate and manage your own medication? Do you need assistance?**
	If the answer is no and they are able but reluctant, establish what the reason for this is and record what could be done to support self-medication:
2	**Can you tell me, broadly, why you are prescribed each of your medications?**
	Comments:
3	**Can you tell me when and how you take each medication? Do you need assistance?**
	Comments:
4	**Can you identify each of your medications?**
	Comments:
5	**Can you open your medication packets/bottles? Do you need assistance?**
	Comments:

6	**Can you access and lock the lockable storage space? Do you need assistance?**
	Comments:
7	**Can you explain to me why your medication has to be kept secure?**
	Comments:
8	**Have you signed and understood our self-medication management guidance for Service Users?**
	Comments:
9	**Have you read your medication information leaflets? Do you need assistance?** Comments:

Notes

You may need to support the Service User to understand the questions overleaf.

Wherever possible we should support individuals to self-administer medication. From the questions asked and any other relevant information, ensure you are satisfied that the individual is competent and used to self-medicating. It is always wise to double check any details you are not confident about with another professional/carer involved in working with the individual.

If there is a history of self-harm, drug or alcohol abuse, self-administration of medication may only proceed if current risk is assessed as very low.

If it is decided that the individual is not able to self-administer medication, you must clearly state the reasons for this decision in the comments box.

	What level of supervision does the service user need initially? (See 4 levels below)	**Tick box below**
Level 1	Service User assessed as or feels unable to self-medicate at this time.	
Level 2	A Support Worker will take the medicines to the Service User and instruct them as to which medicine they should take at each round and how much. The Support Worker will then ensure that the Service User takes the appropriate medicine.	
Level 3	Medicines are kept in the Service User's own cupboard but the Support Worker holds the key. At the appropriate time the Support Worker will give the Service User the key. The Service User will then self-administer medication with supervision from the Support Worker.	
Level 4	When assessed as able, the service user administers their own medication without supervision. The Support Worker continues to check compliance by checking the number of drugs left weekly or supervising at regular intervals as agreed on the service user's support plan.	

Medication Consent and Review

1. No Assistance

I agree that I do not need any support with the administration of my medication.

Signed (Service User) or their representative	**Signed (KCC representative)**
……	…… **Name (in block capitals)**
Date……	**Date**……

2. Some Assistance Required

I require some assistance from formally trained staff for the management of my medication

Signed (Service User) or their representative	**Signed (KCC representative)**
……	…… **Name (in block capitals)**
Date……	**Date**……

3. **Administration of Medication** I understand that formally trained staff only will administer medication and that the medication must be supplied in a suitably labelled bottle as dispensed by the pharmacist.

I understand the content of this form and give consent for medication to be administered to me as outlined in my support programme.

Signed (Service User) or their representative	**Signed (KCC representative)**
……	…… **Name (in block capitals)**
Date……	**Date**……

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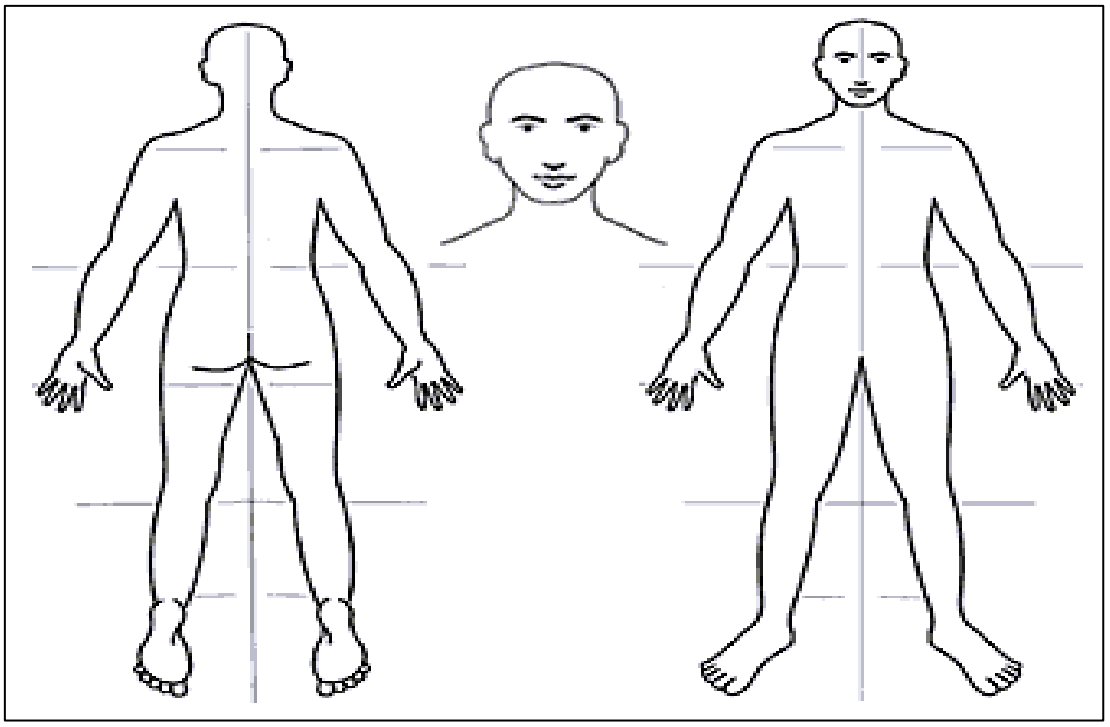
MED6 - TOPICAL MEDICINES APPLICATION RECORD

Service Users Name		
D.O.B.		**Room No.**
Type of Topical Application e.g. lotion, cream, ointment		**Allergies**
Name of Product as written on prescription		
DIRECTIONS As written on prescription		
Name of Transcriber		**countersigned by**

Date	**Time**	**Applied by Print Name**	**Signature**
Date	**Time**	**Applied by Print Name**	**Signature**

Topical Medicines Application Record

Service Users Name:



- Hands should be washed and gloves worn for the application of topical medicines.
- Apply the medication according to the directions to the areas outlined on the diagram.
- Record on the Pharmacy MAR sheet.

For Information purposes:

- Apply sparingly/thinly – means only a thin layer should be applied.
- Apply liberally – means a more generous layer should be applied.

CARE HOME NAME:		
Date of Birth:	**Room No.**	
Record of Observations		
Signature	**Print Name**	**Date**

(MED7) - MEDICATION AMENDMENT RECORD

NAME OF DOCTOR:	
SURGERY:	
ADDRESS:	
TELEPHONE NUMBER	
FAX NUMBER:	

DATE:_____

TIME:_____

Service user's Name:

_____

Service user's DOB: _____

Name and Address of Care Centre: _____

_____

_____

_____

Fax Number: _____

Confirmation of Verbal Instructions Received _____

_____

_____

_____

_____

(MED7) - MEDICATION AMENDMENT RECORD

Name and Position of Staff Members Receiving Amendment:

1._____

2._____

This form must be faxed to the Doctor for authorisation of the amendment and authorisation obtained by return fax before making the amendment.

Signature of Doctor: _____

To be filed with MAR sheet on completion.

NAME OF REGISTERED CARE CENTRE:_____

(MED8) - INVENTORY OF MEDICATIONS DISPENSED INTO COMPLIANCE AIDS
NB *ONLY TO BE USED IN EXCEPTIONAL CIRCUMSTANCES OVER MAXIMUM 24HRS *

Date:	Name of Service user:	Medication and strength:	Time of dose	Administration instructions given - to include cautions ("YES" to be recorded once given)	Time of next dose to be given by the centre	Signature of member of staff dispensing medication and giving instruction	Signature of member of staff witnessing the process	Signature of service user/relative receiving medication and instruction	Service user/ Relative Print Name

NAME OF REGISTERED CARE CENTRE:_____

(MED8) - INVENTORY OF MEDICATIONS DISPENSED INTO COMPLIANCE AIDS
NB *ONLY TO BE USED IN EXCEPTIONAL CIRCUMSTANCES OVER MAXIMUM 24HRS *

(MED9) - ADMINISTRATION OF EMERGENCY MEDICATION (ONLY FOR ADULT SERVICE USERS, AGE 18 AND ABOVE)

To be completed by the appropriate healthcare professional and then countersigned by the Service User

(In block capitals please)

Service User's Name _____Date of birth _____

Medical Condition requiring emergency medication _____

Drug, strength of dose and identification of when the medication is needed (one drug per form):-
_____
_____

Trigger Points	**Action**	**Guidance where necessary**
♦ Recognition of when medication is needed. ♦ At what point should emergency services be called? ♦ When should the first dose be given? ♦ How should the service user be cared for? ♦ Observations to be made. ♦ When should a repeat dose be given? ♦ Aftercare required?		e.g. recovery position. i.e. pulse taking etc + expectations/side effects.

Can this medication be administered by a member of the community without further training:

YES/NO

If no, what level of additional training is required:

_____

Additional comments:

_____

_____

Signature of Healthcare professional: _____

Date: _____

Name of Healthcare professional:

_____

Address:

_____

_____

Telephone Number:

_____

It is the duty of the Service User to supply Kent Adult Social Service with emergency medication in properly labelled containers. It is also the duty of the Service User to advise KCC if any medication or the instructions change in any way.

I consent to administration of medicine in this defined emergency situation by a member of KCC staff as set out in this protocol.

I express a preference for a male/female* member of staff to undertake this procedure or I have no preference*

*delete as appropriate

I give consent for this information to be shared among KCC staff who are involved in my care.

Signature: _____ Date: _____

Service User name:

_____

Address:

_____

Telephone Number:

_____

2nd Emergency Contact:

_____

Telephone Number:

_____

If the Service User lacks mental capacity it is the responsibility of the Healthcare Professional to make the "best interest" decision to administer the medication following consultation with relevant individuals.

Review of form and medication required at least annually.

Date of Review	Reviewed By (Block Capitals)	Signature

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(MED12) - TRAINING AND ASSESSMENT CHECKLIST FOR THE ADMINISTRATION AND CONTROL OF MEDICATION

Name of Employee: …….. Service/Team: ……...…...

CRITERIA	Training				Training Assessments					
	Induction		Training							
	Given by	Date	Covered by	Date	By	Date	By	Date	By	Date
Ordering of medication										
Receiving medication										
Recording the delivery of medication										
Storage of medication										
Disposal of medication when spoilt										
Disposal of medication when returning to Pharmacist										

When preparing equipment for the administration of medication cleanliness care and safety is demonstrated										
All equipment and documentation is assembled prior to commencing the administration										
Safety is observed and storage consistent throughout										
Correctly identifies the Service User receiving the medication										
Checks the correct time										
Checks the correct route of administration										
Checks the expiry date has not passed										

Administers and records the taking of the medication in line with Medication Policy and Procedures										
Observe/discuss action taken to secure medication if interrupted										
Discuss the importance of medication legislation within job profile										
Discuss the importance of reinforcing with Service Users the positive effects of treatment										
Discuss side effects of current medication being administered										
Explain the policy and procedures on self-administration										
Discuss action to be taken when Service User is non-compliant										

Discuss action to be taken if there is an accidental loss or damage to medication										
Discuss the procedure for reporting medication errors										

* To be reassessed on a yearly basis by the Supervisor.

Employee's comments

……

……

……

Supervisor's comments

……

……

……

Employee Signature ……..…… Supervisor's signature ……..……..

Position …….. Date …… Position ……Date ……..……..

Form
No:…**M**……

(MED13) - ADULT SOCIAL CARE & HEALTH
MEDICATION ERROR REPORT FORM

Name of Service
User…….……Establishment……...
Ref No:…….
Error or incident identified by:……..

Name of person completing this form……
Job Title of person completing this form ……...

Date……& Time……of incident/error

TYPE OF MEDICATION ERROR (please tick)

1. Drug given to wrong person.	
2. Drug given at wrong dose (over or under) to correct person.	
3. Drug given by wrong route.	
4. Drug given at wrong time of day including error in respect of cautions mealtimes.	
5. Missed medication.	
6. Drugs administered out of date.	
7. Missed initials. Incomplete entry on MAR sheet.	
8. Drugs mislaid.	
9. Drug wrongly prescribed. (state name & address of prescriber)	
10. Wrongly dispensed from pharmacy (state name & address of pharmacy)	
10a. Drugs supplied in error.	
10b. Dosage information – not current dose on label.	
11. Stray medication found (not community services)	
12. Other (please state reason)	

***Note: The pharmacy / GP must be referred to immediately if incorrect medication is provided by them. The relevant PCT Medicines Management Team must also be informed.**

For Pharmacy / GP errors

All CD incidents report to CD.Kent@nhs.net

Other medicine incidents report to medicines.kent@nhs.net

Describe error and drugs identified:
.....
.....
.....
.....

Did the Service User become unwell because of this incident? YES/NO
If yes, please give details:
.....
.....
.....
.....

Immediate Action taken (in as much detail as possible):
……
……
……
……

Signature of member of staff completing form……
Date:……..
(use separate sheet as necessary)

If at any time there is doubt about the person's wellbeing the GP must be contacted immediately. If GP unavailable contact A&E, Pharmacist, District Nurse or NHS Direct on 0845 46 47.

Manager's Investigation

Please detail any factors that you found/contributed to this incident:
……
……
……
……
……
……
……
……
……
……
……
……

What measures have been taken to prevent a repeat of this incident in the future?

……
……
……
……
……
……
……
……
……
……
……
……

Signature of Manager……Date…….

Circulate to:- Care/Case
Manager Provision/Operation
Manager H&S Adviser

Senior Manager's Comments & any further action required……
……
……
……
……
……
……
……
……
Manager's signature……..Date…….

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(MED14) - WEEKLY AUDIT OF MAR CHARTS

Reference:	A	B	C	D
Date:				
Service user:				
Room No:				
1. All parts of the MAR sheet completed				
2. Name of medication checked:				
3. Instructions correct as on printed pharmacy label:				
4. Instructions clearly written				
5. All signing boxes initialled				
6. Medication balance correct				
7. Medication has not exceeded the expiry date:				
8. Medication correctly stored:				
9. 1:\SS\MED2 – CONTROL OF MEDICATION checked and correct				
10. Audit completed by:				

(MED14) - WEEKLY AUDIT OF MAR CHARTS

Reference (e.g.A8)	Action Taken:	Signed:	Date:

KENT COUNTY COUNCIL - ADULT SOCIAL CARE & HEALTH MEDICATION ADMINISTRATION RECORD MONTH &YEAR:

ALLERGIES: | GP: | DATE OF BIRTH: | NAME OF CLIENT: | ROOM:

DRUG - Medication Strengths Cautions	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DOSE:																																
EXP:																																
SIGN (x2):																																
START DATE: ROUTE:		RECD.					QUAN.					BY				NEW SUPPLY									QUAN.					BY		
DOSE:																																
EXP:																																
SIGN (x2):																																
START DATE: ROUTE:		RECD.					QUAN.					BY				NEW SUPPLY									QUAN.					BY		
DOSE:																																
EXP:																																
SIGN (x2):																																
START DATE: ROUTE:		RECD.					QUAN.					BY				NEW SUPPLY									QUAN.					BY		
DOSE:																																
EXP:																																
SIGN (x2):																																
START DATE: ROUTE:		RECD.					QUAN.					BY				NEW SUPPLY									QUAN.					BY		

KEY: R = refused B = nausea or vomitting C = hospitalisation D = social leave E = refused & destroyed F = other (define)
G = see note overleaf N = PRN Offered but not required

Service User's Name…………………………

Page No……………

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MEDICATION TROLLEY CHECKLIST

MAR sheets	
Medicines stored in the fridge	
Clean graduated medicine pots	
Medicine spoons	
Water	
Glasses	
Drinking straws	
Tissues/paper towels	
Container for used equipment	
Container for empty medication containers	
Waste disposal container	
Oral syringe for the measurement of small amounts of liquid	

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NO INTERRUPTIONS

MEDICATION ADMINISTRATION IN PROGRESS

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STATUTORY DUTIES UNDER THE MENTAL CAPACITY ACT (MCA) 2005

(Guidance Briefing in respect of Medication Management)

1. The 5 statutory principles of MCA must be followed at all times:

   - 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 help him to do so have been taken without success.
   - A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
   - An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
   - Any such actions or decisions must be achieved, wherever possible, in a way that is least restrictive of the person's rights.

2. If the person is assessed to have mental capacity for the specific decision at the time the decision needs to be made, the person signs consent for this decision. Assessment of capacity must be undertaken under the framework of MCA.
3. If the person is assessed to lack mental capacity for the specific decision at the time the decision needs to be made, then the statutory best interests decision process follows.
   Under MCA, the decision maker needs to be identified and the decision maker consults all relevant individuals (other professionals, representative, an independent advocate if appropriate), taking into account past and present wishes and feelings of the person, and the decision maker then makes the final decision in the best interests of the person.
   No one in this consultation process should sign consent on behalf of the incapacitated person, but the decision maker should show in their recording that consultation has been fully undertaken. Others can sign to say they have been consulted, and the decision maker can sign to state this is the final decision they have reached.

4. Assessment of capacity must be decision specific and time specific. A person could be assessed as having capacity for one medication decision and lacking in capacity for a different medication decision. Where a person's capacity fluctuates over time, the determination of capacity is based on the balance of probability after all practicable steps have been taken to do so.

5. If the person has a registered Personal Welfare Lasting Power of Attorney (LPA) with relevant health decision making authority, then the LPA makes the final decision. Enduring Powers of Attorney (EPA) and Property and Affairs LPA are not the decision makers for healthcare decisions, but they should be consulted under the best interests decision process of MCA.

6. If a person has made a valid and applicable Advance Decision whilst they have capacity, stating specific treatment they would refuse when they lose capacity, the Advance Decision must be followed.

MENTAL CAPACITY ASSESSMENT – FOR LESS COMPLEX DECISIONS

If a person does not have an impairment or disturbance of the mind or brain, they will not lack capacity under the Mental Capacity Act 2005.

NB The Mental Capacity Act's first principle is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity in relation to those matters.
The assessment must be about a particular decision that has to be made at the time the decision needs to be made.

1. **Individua l' s Details**

Name:

Address:

Date of Birth:

Location at Time of Assessment:

2. **Decision Requiring Assessment of Mental Capacity** (provide details)

NB: Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make that decision themselves.

3. **Two-Stage Test of Mental Capacity** (See Code of Practice Chapter Four)

a. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.) Provide evidence.

b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Can the person:
Delete as appropriate:

(a) understand the information relevant to the decision?

(b) retain that information?

(c) use or weigh that information as part of the process of making the decision?

(d) communicate his/her decision (whether by talking or any other means)

Provide evidence in respect of the person's ability in relation to each of these four elements of the test:

NB: If a person cannot do one or more of these four things, they are unable to make the decision.

4. **Outcome of Mental Capacity Assessment**

On the balance of probabilities, there is a reasonable belief that:

The person **has** capacity to make this particular decision at this time.

Or
The person **does not have** capacity to make this particular decision at this time.

Details of Assessor

Assessor: Signature: Designation:

Date: Time:

Using this form: Mental Capacity Assessment – for less complex decisions

The Mental Capacity Act 2005 states that anyone can assess another person's mental capacity especially in relation to day to day decisions and simple decisions.

Practitioners must abide by the following **five statutory principles** which are as follows:

1. A person must be **assumed** to have capacity unless it is established that he/she lacks capacity (by undertaking capacity assessment).

2. A person is not to be treated as unable to make a decision unless all practicable steps to **help** him/her to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he/she makes an **unwise** decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his/her **best interests**.

5. Before the act is done, or decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive** of the person's rights and freedom of action.

This form has been developed to aide practitioners to assess and document a person's mental capacity giving due regard to the Mental Capacity Act 2005. Day to day interventions and decisions can be recorded in the person's care plan/notes e.g. personal hygiene care, feeding a service user etc, and assessments of capacity in respect of such decisions should be reviewed.

If a practitioner proposes health or social care treatment, they must assess the person's capacity to consent. This can involve the multi-disciplinary team, but ultimately it is up to the practitioner responsible for the person's treatment to make sure that the person's mental capacity has been assessed. No one can give consent on behalf of a person who lacks capacity to make the decision for himself/herself.

Using a different form: Mental Capacity Assessment – for complex decisions

When the decision to be made, is more complex or could have serious consequences for the person, careful consideration about the level of assessment, and who should be involved, will be required. More formal assessments might be required in complex cases or cases where mental capacity or the decision to be made is disputed. However, the final decision about a person's mental capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks mental capacity.

In an urgent or emergency situation, a decision may be made in the person's best interests to give urgent treatment or care without delay - except when the healthcare professional giving treatment is satisfied that an Advance Decision to refuse that treatment exists; or an Attorney or Deputy with relevant authority exists.

If it has been established that the person lacks mental capacity for the required decision, the Decision Maker should now consider what would be in the person's best interests

OVER THE COUNTER MEDICINES (OTC)

Pre Admission

The Service User must also be informed that should they be taking “OTC remedies” the centre will require written consent from their doctor to administer the “OTC remedies” beyond a 48 hour period of regular use (see appendix 6). They should also be informed that any OTC remedies brought into the centre must be in the original packaging and contain the guidance leaflet.

A standard letter has been composed to provide the Service User with the above information on the centre’s requirements. (See appendices 5 and 6). Care/Case Managers should be encouraged to send this out with booking confirmation letters. The Registered Manager should place advice and information on OTCs in the centre’s brochure.

It is vital that this information is given to the service user in sufficient time prior to admission to enable them to comply with the centre’s requirements, as it may be necessary for them to obtain a new prescription, should their current supply not meet the requirements.

Admission

OTC coming into the centre should also be recorded on the MAR sheet. The Homely Remedies Doctor consent form (see appendix 5) authorising their use should be filed with the Homely Remedies MAR sheet, should the medication require to be administered beyond a 48 hour period.

When the Doctor’s consent has not been obtained a line should be drawn through the MAR signing boxes after the 48 hour period has elapsed to ensure the 48 hour period is not exceeded.

Administration Procedures

OTC Medication Belonging to the Service user

OTC remedies brought into the centre by the service user should be administered as above. (It will not be possible to check information against the pharmacy label).

The OTC must not be administered beyond a continuous 48-hour period without the Doctor’s written consent.

Stocked OTC Medication (Homely Remedy)

At the discretion of the Registered Manager, certain approved over the counter (OTC) medication may be stocked for general use by service users for those ad hoc occasions when needed for minor ailments and for the duration of 48 hours maximum. For continued use, the GP must be consulted. All stock OTC medication will be stored in a separate locked cupboard within the medication room.

Within the Integrated Care Centres, the qualified nurses will always be consulted for unplanned use of OTC medication. In other establishments the GP will be consulted.

For the list of approved OTC drugs to be kept as stock medication and protocol see Appendix 3.

OXYGEN REQUIREMENTS

Pre Admission

If oxygen is prescribed the assessor must ensure that the current oxygen supplier is able to deliver to the centre to ensure a continued supply.

An oxygen supplier can only supply oxygen to a service user if a written contract to supply the “flow meter” has been signed by both the supplier and the service user.
If the centre is outside the oxygen supplier’s area the following action must be taken:

1. If oxygen is to be used on a regular basis then consideration of an oxygen concentrator should be made rather than using oxygen cylinders.

2. The supplier who currently holds the contract must be informed that the service user will be moving out of their area.

3. The temporary doctor who will be providing medical cover during the service user’s stay must be contacted to request a prescription for a flow meter/headset, mask, tubing and an oxygen cylinder.

4. The local oxygen supplier must be contacted to ascertain if they are able to supply the oxygen. Should they be unable to provide the service they should be able to advise who can.

5. The prescription must be collected from the doctor and passed to the new oxygen supplier and arrangements made for the oxygen and equipment to be delivered to the service user on the day of admission.

6. In the event of an emergency admission the service user must be asked to bring their oxygen and equipment to the centre and the above procedure for future supplies must be carried out immediately.

7. The team leader must ensure that two Oxygen Signs are available for display in reception and on the service users’ bedroom door. The sign must contain the following information:

- CAUTION – Compressed Gas. Oxygen in Use
- No Smoking. No Naked Flames
- The signs must be pictorial to comply with Health and Safety and DDA requirements.

8. Support Workers authorised in the administration of medication **and** who have received instruction from the oxygen supplier are permitted to change oxygen cylinders.

Storage

Oxygen signs must be displayed as soon as Oxygen is brought into the building.

It is preferable for each service user to have only one oxygen cylinder in use in the centre in the service user's bedroom due to the following:

- Oxygen cylinders when not in use must be stored in a well-ventilated storage area or compound away from combustible materials and separated from cylinders of flammable gas.
- The cylinder must be handled carefully and a purpose built trolley must be used to move it.
- Cylinders must be kept chained or clamped to a wall to prevent them from falling over.

When bringing oxygen into a service user's bedroom the following must be observed:

- Oxygen must not be stored near naked lights, near gas fires, radiators, cookers or other hazardous substances.
- Where oxygen is being administered **smoking must not be allowed.**
- Never lubricate cylinder valves or associated equipment and keep cylinders free from any oil or grease.
- Oxygen cylinders must not be knocked or allowed to fall over.
- In the event of a suspected leak or any other damage the Support Worker should **immediately** inform the oxygen supplier and where possible move the cylinder outside to allow the oxygen to escape into the air. If this action creates more danger it should be left where it is, people in the area evacuated and ventilation increased in the area.
- In the event of a fire, when the "999" call is made it must be stated that oxygen is in the building. On arrival the fire brigade must be informed of the exact location of the oxygen.
- Under no circumstances should Support Workers use oxygen cylinders, which have been involved in a fire unless they have been thoroughly checked and authorised for re-use by the oxygen supplier and the fire officer.

MEDICINES MANAGEMENT AUDIT TOOL

(Adapted from the Royal Pharmaceutical Society Guidelines)
For Adult Care Homes, Short Breaks and Respite Services

Date
……

Name of Establishment
……

Type of Establishment
……

By Whom
……

Contact Details of Auditor
……

		Y	N	N/A
POLICIES AND PROCEDURES				
1.	A copy of the policy is present and made available to all relevant staff.			
2.	The home has a British National Formulary (BNF) published within the last 12 months.			
3.	A range of books with current data and references particular to the specialities in the home is available.			
Action:				
SUPPLY OF MEDICINES (check 3 samples)				
4.	Medicines are:-			
	a. Labelled with name.			
	b. Verified with pharmacist that no interactions with prescribed medicines, this must be recorded, dated, timed, signed and placed in the client's records.			
	d. Stored in a safe manner.			
5.	Record of all prescriptions ordered.			
6.	Record of all drugs received from any source.			
7.	All medicine containers are labelled.			
8.	All medicines are labelled with full instructions (Not "As Directed")			
	a. Dose and frequency are stated.			
	b. Minimum dose interval is stated on "as required" (PRN) medicines			
Action:				
STORAGE OF MEDICINES				
9.	Only medicines are stored in medicine cupboards.			
10.	COSHH Regulations met.			
11.	Evidence of efficient control of stock:			
	a. Easily seen/counted.			
	b. New stock placed behind (i.e. stock rotation).			
	c. No evidence of over stocking.			
Action:				

		Y	N	N/A
Location				
12.	All medication stored in a locked clinical/medication room of adequate size with:-			
	a. Adequate secure storage.			
	b. Adequate work surfaces.			
	c. Good lighting.			
	d. A sink with drainer.			
	e. A wash hand basin with liquid soap, paper towel dispenser and foot operated pedal bin.			
	f. Good working environment for checking and preparation procedures.			
	g. A British Standard lock on the door.			
	h. No direct exterior access.			
	i. Ground floor windows locked and screened.			
	j. No attention brought to content of cupboards.			
	k. Cupboards positioned away from heat sources and well illuminated.			
	l. Cupboards conforming to BS2881 (1989), metal cupboards are recommended.			
	m. All are clean, well finished, robust and secure.			
	n. Under sink storage is not used for medicines, appliances or dressings.			
	o. Wall cupboards do not have the upper surface more than 1750mm from the floor.			
	p. Medicine trolley, when not in use, is secured to a fixed point.			
	q. The room temperature does not exceed 25 degrees centigrade.			
	r. A daily record of room temperatures is kept.			
13.	Sufficient and separate lockable storage is available for:			
	a. Internal medicines.			
	b. External medicines			
	c. Controlled drugs.			
	d. Self-administration			
	e. Medicines requiring cold storage.			
	f. Disinfectants and antiseptics.			
	g. New supply of medicines.			
	h. Medicines awaiting transfer/disposal.			
14.	Sufficient space for dressings.			
15.	Sufficient space for appliances.			
16.	Sufficient space for food supplements.			
17.	All stored items are lifted clear of the floor.			

		Y	N	N/A
18.	Medicines requiring cold storage are stored in a separate lockable refrigerator between 2-8 degrees centigrade.			
19.	The temperature of the fridge is recorded daily using a maximum/minimum thermometer.			
20.	Defrosting takes place at regular intervals and is recorded.			
Action:				
Controlled Drug Storage				
21.	A separate controlled drug cupboard which is bolted to a solid wall and is of a sufficient size to store liquids, sachets and patches.			
22.	Only controlled drugs stored in CD cupboard.			
23.	All Schedule 2 and Schedule 3 controlled drugs are stored in this cupboard. (e.g. Temazepam).			
Action:				
Medicine Trolley				
24.	Trolley(s) are of adequate size to accommodate all medicines needed for round.			
25.	Internal and external medicines are separated in the trolley and clearly labelled.			
26.	Medication trolley temperature does not exceed 25 degrees centigrade.			
Action:				
Monitored Dose Systems				
27.	Adequate lockable storage for all medicines supplied including the change over period.			
28.	Medicine supplied in this system is not stored for longer than 8 weeks from filling.			
Action:				

		Y	N	N/A
Self Administration				
29.	Service User's have a lockable facility to store their medication.			
30.	The lockable facility is secured to the floor or wall.			
Action:				
Stocked Homely Remedies				
31.	Stocked homely remedies are kept separate from the Service User's medicines.			
32.	A log of amount used and for which Service User is maintained.			
33.	Medicines are not used by staff.			
Action:				
Testing Strips				
34.	Stored in a separate cupboard or sealed contained marked "TESTING STRIPS ONLY"			
Action:				
Dressings/Appliances				
35.	Adequate storage away from heat and moisture, not on the floor.			
36.	Medicated dressings are stored in a locked cupboard.			
Action:				
Disinfectants				
37.	Disinfectants and antiseptics stored in a separate cupboard. COSHH data sheets available at point of storage.			
Action:				

		Y	N	N/A
Sterile Fluids				
38.	When large volume sterile fluids are used they are stored separately and not on the floor.			
Action:				
Emergency Medication				
39.	These medicines are readily available and easily accessible but stored ensuring their safe keeping.			
40.	All medicines used in emergency situations are in accordance with the Service User's Support Plan.			
Action:				
Nutritional Feeds/Supplements				
41.	Feeds and supplements are stored off the floor and all expiry dates checked regularly.			
Action:				
Gases				
42.	All cylinders are stored in areas which are:			
	a. Dry			
	b. Clean			
	c. Well ventilated			
	d. Secured so unable to fall.			
	e. Away from heat and sources of ignition.			
	f. Away from highly flammable or combustible materials.			
43.	A yellow safety warning notice is displayed indicating where medical gases are stored.			
44.	All Oxygen cylinders set up ready for use are tested weekly.			
	a. A weekly record of testing is kept.			
	b. The expiry date of each cylinder is recorded.			
	c. Maintenance schedules of heads and cylinders are recorded.			
45.	Oxygen prescribed for a Service User is only used for that Service User.			
46.	Safety guidelines and any relevant data sheets are followed and are displayed/available at point of storage.			

		Y	N	N/A
47.	Fire Safety Officer aware of storage area and happy with arrangements.			
Action:				
Flammable Liquids				
48.	Are stored in a locked cupboard away from direct heat or sources of ignition.			
Action:				
KEYS				
49.	All areas where medicines are kept are locked at all times, i.e.			
	a. All rooms			
	b. All cupboards			
	c. All trolleys			
50.	Keys are labelled with a number only and checked against a key index.			
51.	Only staff authorised to administer medication hold the keys.			
52.	Medication keys are not part of a master key system.			
Action:				
RECORDING STAFFS' SIGNATURES AND INITIALS				
53.	A list of specimen signatures and initials for identifying the member of staff administering any medicines is maintained.			
54.	The specimen list is dated and updated regularly.			
55.	Staffs' signature or initials do not vary.			
56.	The use of only one letter is not evidenced as this can cause confusion with the codes for non-administration.			
Action:				
ADMINISTRATION OF MEDICINES				
57.	All medicines are administered in accordance with a prescription written by a recognised medical professional or under the Over the Counter Medicines protocol.			

		Y	N	N/A
58.	Service Users are identified by means of a photograph provided they are a good likeness.			
59.	Medicines are administered in accordance with 'Support Worker Tasks'.			
60.	Risk assessments are completed for Service Users for the self-administration of medication.			
61.	Only those signatures recorded on the specimen signature list are found on the MAR.			
Action:				
Transport of Medicines				
62.	A secure system for taking medicines to Service Users in all parts of the home is in place (i.e. medicines, trolley).			
63.	Unlocked medicine trolleys are never left unattended.			
Action:				
64.	All medicine rounds are uninterrupted.			
65.	All medicines are administered at a suitable time taking into account:			
	a. The nature of the medicine.			
	b. The prescribers instructions.			
	c. Any additional labelling.			
66.	Certain medicines may be required to be given at specific times, these must be specified by either:			
	a. The prescriber.			
	b. Recommendations by the manufacturer.			
	c. Pharmaceutical advice/BNF instructions.			
Action:				
Times for administration of medication				
67.	Specified times for administration of medication are adhered to.			
68.	Deviation of greater than one hour from the prescribed time is recorded with the new time noted on the chart and an explanation given in the nursing notes.			
69.	All "As required" medication times are recorded on the MAR chart.			

		Y	N	N/A
70.	All medicines are administered directly from the container in which it has been dispensed.			
71.	Labels on containers are not altered under any circumstances.			
72.	No staff have dispensed from a container with an altered label.			
73.	Any discrepancies in the dose on the label and that on the medication record are reported to the prescriber and recorded.			
74.	Labels are not defaced or medication administered from containers if labels cannot be clearly read.			
75.	Labels on liquid medication have been covered with either sellotape or sticky backed plastic to allow the wiping of bottles without interference of the instructions on the label.			
76.	All medicines brought in by Service Users have been checked at the time of receipt for 'fitness of use' and are only being used if:			
	a. They can be positively identified.			
	b. Are clearly labelled.			
	c. Are within their allocated shelf-life.			
Action:				
Controlled Drugs				
77.	The administration of Controlled drugs is undertaken by an authorised member of staff which is counter signed.			
Action:				
Recording Controlled drugs				
78.	Each receipt, administration, transfer or disposal of a controlled drug must have been recorded on a new line with the remaining balance in stock clearly shown.			
79.	A separate page should have been used for each drug, form and strength for each client.			
80.	Controlled drugs which are no longer required or have reached their expiry date should have been collected by either the community pharmacist or the dispensing doctor, they should have signed the C.D. register and been witnessed by the registered nurse handing them over.			
81.	Spare Controlled Drug Registers should be available in the home.			

		Y	N	N/A
Action:				
VERBAL PRESCRIPTIONS				
82.	No verbal instructions are taken to alter doses of Warfarin.			
83.	No verbal instructions are taken to alter any other medication.			
84.	Faxes or written instruction is received from the GP for short notice changes to dosage.			
Action:				
Records				
85.	All records are written in black ink.			
86.	No correction fluid or form of obliteration has been used.			
87.	All records of medicines **Ordered** either from the surgery or through the pharmacy have been retained for at least **six** months.			
88.	**All** records relating to the receipt, disposal and administration of medicines is kept for **eight** years from the date of the last entry.			
89.	Only medicines required for the next month have been ordered.			
90.	No medicine has been marked out of stock, except in extenuating circumstances.			
91.	All Nomad cassettes have a weekly record of receipt.			
92.	The quantities and strengths of all medicines have been recorded, dated and signed when leaving the home.			
93.	Any medication returned to pharmacy left in Nomad cassettes at the end of seven days has been recorded.			
Action:				
THE MAR CHARTS				
94.	The MAR charts have the following recorded on them:			
	a. The full name and date of birth of the client.			
	b. Any known allergy to food or drugs.			
	c. The name of the medicine and the strength.			
	d. The dose.			
	e. The route of administration			
	f. The frequency and time of administration of each dose.			
	g. The commencement date.			

		Y	N	N/A
	h. Any special requirements e.g., one hour before food.			
	i. The date of discontinuation of the medicine.			
	j. The name of the client's doctor.			
	k. Spaces for recording administration.			
	l. Details of codes used for non-administration			
95.	If the prescription is transcribed by hand, all the above included and signed by an authorised person.			
96.	All hand written entries are checked and signed by a second member of staff as soon as possible.			
97.	Plain English is used and mirror the directions on the medicine label. N.B. NO Latin abbreviations are acceptable.			
Action:				
Dose Changes				
98.	When a dose has been changed, the existing medicine should have been discontinued using a vertical line draw through the next spaces for signatures and signing and dating by the nurse.			
Action:				
DISPOSAL/DESTRUCTION OF MEDICATIONS				
99.	All clients' medication is their own property and is disposed of with the consent of the client or their relatives and the disposal recorded.			
100	Medication is disposed of when:			
	a. Discontinued by the prescriber.			
	b. The expiry date is reached.			
	c. The medicine is unfit for use.			
	d. The client dies.			
101	All medicine belonging to a deceased client is retained for a minimum of seven days as they may be required by the Coroner.			
Action:				

		Y	N	N/A
Expiry Dates				
102	If an expiry date is not specified the guidance provided is followed.			
Action:				
SELF ADMINISTRATION				
103	All clients who are self administering have:			
	a. Regular checks and recording of compliance with regime.			
Action:				
HOMELY REMEDIES				
104	Written agreement between the home and clients GP.			
105	All agreements/authorisations are reviewed 6 monthly.			
106	Homely Remedies list includes:-			
	a. The name of the medicine.			
	b. The indication for use.			
	c. The dose.			
	d. The permitted frequency of administration.			
	e. The maximum daily dose.			
	f. Contra-indications/special precautions.			
107	All purchases of Homely Remedies are recorded.			
Action:				
DRUG ERRORS				
108	All errors are recorded according to policy.			
109	Safeguarding alerts are raised appropriately.			
Action:				

MEDICINES MANAGEMENT AUDIT - ACTIONS

Establishment		**Date of Audit**	
Name of Inspecting Manager		**Managers Signature**	

ISSUES IDENTIFIED / CARRIED OVER FROM PREVIOUS INSPECTION

Inspection Date	Issue Identified	Actions Outstanding	By Whom	By When	Completed

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ROUTES OF ADMINISTRATION

Buccal - the pouch between the cheek and the top gums

Inhalation – breathed in via nose/mouth into the lungs

Intra-aural – into the ears

***Intra-muscular** – injected into a large muscle in the arm leg or buttock

Intra-nasal – into the nose

Intra-ocular – into the eyes

***Intradermal** – very small amounts of injection given just under the skin

***Intra-venous** – injected directly into the vein or via a cannulae, or given over a period of time as an intravenous infusion (drip)

Oral – by mouth

****Percutaneous Endoscopic Gastrostomy (PEG)** – medicines given directly into a PEG tube inserted directly into the service user's stomach

****Rectal** – into the rectum

****Subcutaneous** – injected into the subcutaneous layer (below the skin but above the muscle layer)

Sublingual – under the tongue

Topical – applied to the outer surface of the body e.g. Skin

Transdermal – introduced onto/into the skin, usually in a patch which the service user wears as prescribed

****Vaginal** – into the vagina

ROUTES PREFIXED WITH * CAN ONLY BE ADMINISTERED BY A MEMBER OF STAFF EMPLOYED IN THE CENTRE AS A QUALIFIED NURSE**

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Service User Medication Letter

Tel:
Your ref:
Our ref:
Date

Dear

Re: Planned admission/short term stay for _____ from_____until_____

I am writing to advise you of our requirements regarding the supply of medication to be administered by (Name of RCC) staff during this period. This will enable (Name of Registered Care Centre) staff to carry out medication procedures safely and in compliance with both internal and external policies and procedures.

1. Prescribed Medication (including creams and eye drops)

The printed label must contain the following information:
*Service user's name *Date of dispensing *Name and strength of medicine
*Dose and frequency of medicine

Please ensure medication is in the original packaging as dispensed by the pharmacist and contains all the information on the pharmacy label as listed above. Instructions stating "as directed/as prescribed" are insufficient and cannot be administered. If there is an expiry date/use before on the medication it should not expire during the length of the stay as it can be harmful to give out of date medication.

Eyedrops:
When eye drops are required to be administered and the eye drops have already been started the date of opening must be clearly recorded on the box. This is due to the instruction on all eye drop medication "To be discarded four weeks after first opening".

2. Homely Remedies (Over the Counter Medication)

Should “homely remedies” be required (Name of RCC) is unable to continue to administer them beyond 48 hours, unless the doctor gives written consent to their continued use.

I am therefore enclosing a pro-forma to assist you in obtaining your GP’s consent for the administration of any homely remedy to be administered during the stay. Please also ensure any homely remedies are brought in the original packaging and contain the guidance leaflet.

I hope you have found this information helpful. Should any of the above information be unclear or give you any cause for concern please don’t hesitate to contact either the team leader on duty or myself.

We look forward to making your forthcoming stay as enjoyable as possible.

Yours sincerely

Registered Manager

cc Next of kin (when addressed to a prospective service user)
Service user’s support plan

SOURCES FOR REFERENCE SERVICES

British National Formulary (BNF)
Each centre must be in possession of a BNF, which provides detailed information on medication. The BNF should be current and is available online or from booksellers.

Patient Information Leaflets (PIL)
The Patient Information Leaflets are supplied with medication and provide information on the therapeutic use, its normal dose, side effects, precautions and contra-indications of its use. The leaflets must be available for reference by the service user and centre staff.

Pharmacy Services
Centre staff should refer questions or problems about medication and drugs to the community pharmacist. The community pharmacist can be included in medication review and support self-medication through the use of aids.

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SUPPORT WORKER TASKS
RESIDENTIAL, SHORT BREAK AND RESPITE SERVICES

RED (tasks NOT to be undertaken by Support Workers)

- Change wound dressings
- Filling or altering syringe drivers
- Filling a compliance aid (dosette box or similar)
- Give injections
- Give suppositories (with the exception of administering emergency diazepam, subject to competence)
- Give pessaries and enemas
- Advising on the prescribing of any medication including OTC

AMBER (tasks which MAY BE undertaken by named Support Workers who have received specific accredited training. They must be assessed as competent and monitoring arrangements to be provided by appropriately qualified health professionals. Training and assessment must be documented and included in staff files.

- Assisting with administration of nebulisers
- Administration of PEG feed
- Administration of and assistance with oxygen in liaison with the oxygen supplier.
- Administering of Rectal Diazepam and Buccal Midazolam
- Monitoring of blood glucose levels
-

GREEN (tasks which may be undertaken by all Support Workers who have received accredited training and assessed as competent)

- Remind Service Users to take their prescribed medication
- Give tablets, capsules or liquids to be swallowed
- Give medication to dissolve in the mouth or suck
- Application of creams and ointments to skin
- Changing ordinary support stockings
- Assisting with administration of inhalers and sprays
- Replacement of a simple dressing, e.g. temporary first aid measure
- Assist with putting on post-operative stockings (e.g. TED)
- Application of patches e.g. GTN (Glyceryl Trinitrate), Fentanyl, HRT (Hormone Replacement Therapy)
- Using an EpiPen

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THE FIVE RIGHTS
FOR ADMINISTERING MEDICATION

When assisting with/administering medication KCC staff should always remember the five rights.

1. Is this the **RIGHT PERSON** for whom the medication has been prescribed with their name on the label. Check and confirm the identity of the service user with the MAR sheet. The photograph on the identification/MAR sheet will assist in this process. Also check with the service user that they wish to take all/part of their medication before proceeding.

2. Is this the **RIGHT MEDICINE** and within the use by date. For medication recorded on the MAR sheet to be administered on the current round find the medication container. Check that the name of the resident and name and strength on the medication container corresponds with the name and strength of the medication on the MAR sheet. (Should the printed label become illegible or detached from the container the medication must not be given and advice must be sought from the pharmacist).

3. Am I assisting with/administering the **RIGHT DOSE.** Check that the dose on the medication container corresponds with the dose recorded on the MAR sheet.

4. Am I giving this help at the **RIGHT TIME** of day. Check that the time recorded on the medication container corresponds with the time on the MAR sheet.

5. Am I using the **RIGHT ROUTE** for this medicine. Check that the route on the medication container corresponds with the route recorded on the MAR sheet.

    - Is it to be swallowed?
    - Is it to be inhaled?
    - Is it to be applied to the skin?
    - Is it to be put in the eyes?
    - Is it to be put in the ears?

ALWAYS CAREFULLY CHECK THE LABEL ON MEDICINES –
To get it ALL RIGHT!