SERVICE SPECIFICATION
SCHEDULE FIVE (5)

Bournemouth and Poole Joint Adult Services Medicines Guidance

CARE AND SUPPORT AT HOME BOURNEMOUTH CHRISTCHURCH AND POOLE

Medicines Guidance

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Guidance lead:			
Author:	Kevin Moore, Policy Officer, ASC-S		
Produced by:	Kevin Moore, Policy Officer, ASC-S		
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Compliance:

Who must comply with this guidance?	*All staff involved in all aspects of medicine management.*
When does this policy apply?	*The purpose of this guidance document is to give clear direction to all staff involved in all aspects of medicine management. This good practice guidance can also be used by all staff providing care services across the area who are not directly employed by the respective Councils. However, Bournemouth Borough Council and Borough of Poole will not accept liability and therefore advise external agencies to ensure that they have their own adequate legal cover.* *Alongside the associated policy this guidance aims to help practitioners understand unified procedures with regard to medication, which are undertaken in all Adult Social Care services, and also that procedures, policies and training are in place to reduce the risk of medicine related errors and the associated risks to clients / persons and employees.* *It is recognised that application of this guidance in some settings might require different approaches. If so this guidance should be used as a basis to develop local procedures or staff guidance in order to ensure best practice.*
Who needs to be aware of this policy?	*All ASC and C&I staff.*
Enforcement	*If it is found from the investigation that employees have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in line with Bournemouth Borough Council and Borough of Poole's disciplinary Procedures.* *In certain circumstances medication errors may present a safeguarding risk in which case managers should refer to the Multi-Agency Safeguarding Policy and Procedures.*
Roles and responsibilities	*This good practice guidance can also be used by all staff providing care services across the area who are not directly employed by the respective Councils.* *Specific training and qualification requirements are detailed in the guidance.*

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Introduction and policy references

The purpose of this guidance document is to give clear direction to all staff involved in all aspects of medicine management. This good practice guidance can also be used by all staff providing care services across the area who are not directly employed by the respective Councils. However, Bournemouth Borough Council and Borough of Poole will not accept liability and therefore advise external agencies to ensure that they have their own adequate legal cover.

Alongside the associated policy this guidance aims to help practitioners understand unified procedures with regard to medication, which are undertaken in all Adult Social Care services, and also that procedures, policies and training are in place to reduce the risk of medicine related errors and the associated risks to clients / persons and employees.

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Assessment

Role of the Competent Assessor

As part of the initial assessment, when a person is referred to the service, the level of support with respect to medication should be identified or adjusted if necessary and appropriate. This includes the need to define the level when any services that include medication are purchased from independent providers. This should be in accordance with the definitions listed below and the capacity and consent sections detailed in the accompanying policy document.

Capacity and Consent

It is the responsibility of the GP or prescribing practitioner to assess the person's capacity to accept a prescription for medication. If the person lacks the capacity to make this decision, the medication may still be prescribed if the prescriber believes it to be in the person's best interests.

If a person requires support to administer medication their capacity to consent to this support must also be assessed following the guidelines and principles of the Mental Capacity Act 2005. As part of this assessment the assessor should consult with relevant people e.g. family members and carers, to establish whether the person has the capacity to consent to the necessary support.

If the person lacks the capacity to consent to support with administration of medication, it is still possible to administer the medication if it is considered to be in their best interests. Making a decision about best interests should take into account all relevant factors such as the person's own past and present wishes and feelings, the benefits of taking the medication and the views of others who are involved in the care of the person. [See Mental Capacity Act Code of Practice]

If a person has appointed a 'personal welfare attorney' under Lasting Power of Attorney, the attorney may be able to make decisions relating to administration of medication. The attorney can only make these decisions if the person lacks the capacity to do so and must always act in the person's best interests.

Decisions about the administration of medication in the best interests of a person who lacks capacity should involve the prescribing practitioner and relevant people such as other professionals, family and carers. Where the prescribing practitioner refuses or is unable to be involved in making the decision and there is an appropriate range of family, carers and

professionals available to contribute in making the decision, then it can be made without the prescribing practitioner. The details of who was consulted in making the decision, how the decision was reached and what attempts were made to assist the person to make his or her own decision must be documented on the person's file. The final responsibility for determining whether it is in the person's best interest lies with the assessor.

Methods of administering the medication should be agreed including the use of covert options as necessary. The decision to administer medication covertly must not be considered routine. Any decision to do so must be reached after careful assessment of the person's needs. There should be open discussion and agreements within the multidisciplinary team and the person's relatives or advocate. The less restrictive option should be chosen, following the principles of the Mental Capacity Act. The decision, the action taken and the names of all parties concerned should be documented in the person's care plan and reviewed at regular intervals.

If there are fluctuations in the person's capacity, the consequences of this should be considered and a strategy put in place. Similarly, if there is a decision to administer the medication in the best interests of a person who lacks capacity, it should be noted whether the person is likely to be compliant with taking the medication and, if not, a strategy should be put in place.

Care and Support plans should include the assessment of a person's capacity to consent (Appendix 3 and Appendix 4) to either assistance with medication or the administration of medication and confirm that any actions taken on behalf of a person who lacks capacity are agreed to be in their best interests. It is good practice to inform the GP of the service input (see Appendix 5).

Guidelines for care providers

The care provider administering the medication can assume that any actions taken under the care plan are agreed to be in the person's best interests. However, they have a key role in assessing capacity and best interests **at the time of administering the medication**. If there are variations in the circumstances covered by the care plan e.g.:

- if a person who lacks capacity but has previously complied with taking medication now refuses to take that medication; or
- if a person who previously had capacity now appears to lack the capacity to agree to assistance with administration of medication.

Then the care provider should not proceed with administering the medication but should refer to their line manager for further advice.

An assessment should consider:

- **Equality and Diversity**
  A person may have certain preferences relating to equality and diversity. These should be recognised at the assessment stage and arrangements made to accommodate them. Examples may include that the person:
  - is vegetarian and the medicine is provided in a gelatin capsule;
  - prefers to have medicines given to them by a member of the same sex;
  - observes religious festivals by fasting and prefers not to have medicine given at certain times;
  - does not wish to take their medicines in front of other people.
- **Covert administration**
  There may be certain circumstances in which covert administration may need to be considered to prevent a person missing out on essential treatment. A multi-professional team plus carers and relatives of the person must assess and then approve the decision, including the pharmacist to ensure that there is no adverse effect on the medication

when mixed with specific foods/liquids. The decision taken should respect any previous instructions given by the person and be recorded in the care plan with a date for review.

- **Storage**
  The assessor **must note** if there is a need to store medication in a specific way e.g. secure or refrigerated. This information should be recorded on the care plan. (Further detail regarding storage can be found at 'Storage')
- **Other parties involved**
  If there is more than one provider, or a provider and a family carer, involved in dealing with medication their respective roles and responsibilities should be clear and documented in the care plan and statement of need.
- **Pharmacy**
  In most cases a person receiving regular medication will use a single pharmacy for all their prescription medication. Where this is not the case the assessor should agree with the person or their representative which pharmacy should be approached to dispense prescriptions.
- **Ordering and collection**
  The usual arrangements for the ordering and collection of prescriptions should be recorded on the care plan. Emergency prescriptions may need to be dispensed by an 'out of hours' pharmacy.

Assisting and Administering

In all cases care workers should only use original containers dispensed and labelled by a pharmacist. This includes monitored dosage systems and multi-compartment compliance aids, which must be filled and labelled by the community pharmacist. Staff must not fill multi-compartment compliance aids themselves. If a carer has any concerns they should always contact their line manager.

The person may qualify for a free service from a community pharmacist if they have been assessed by the community pharmacist as meeting the criteria defined in the Equality Act 2010. Support may involve the provision of other compliance aids e.g. easy open tops, reminder charts, large print labels, etc.

Nationally with the evidence available it is recognised that multi-compartment compliance aids are overused and may not be appropriate or beneficial for the majority of individuals. They should be reserved for a small number of patients usually as a last resort. If the person does not meet the criteria there may be a charge to the person for filling the multi-compartment compliance aid payable to the pharmacist.

The following section is designed to inform about the difference between assisting, administering and administering using specialist techniques.

Level 1: General Support also called Assisting with Medicine

Assisting with medicine generally occurs when the person takes responsibility for their own medication, particularly when they contract support through Direct Payments. In these circumstances the care worker will always be working under the direction of the person receiving the care.

Assisting with medicine may include some or all of the following:

- requesting repeat prescriptions from the GP;
- collecting medicines from the community pharmacy;
- disposing of unwanted medicines safely by return to a community pharmacy (when requested by the person). NB Care Homes (Nursing) must make their own arrangements to dispose of waste medicines);

- an occasional reminder from the care worker to an adult to take their medicines. (A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medicines and should prompt a review of the person's care plan);
- manipulation of a container, for example, opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the person and when the care worker has not been required to select the medication.

If care workers carry out a level one task it must be recorded in the communication sheets in the person's documentation.

Using multi-compartment compliance aids can help adults retain their independence and should be considered if packs and bottles are difficult to open or they have difficulty remembering whether they have taken medicines.

Level 2: Administering Medication

If an assessment identifies that a person is unable to take responsibility for their own medicines, perhaps due to impaired cognitive awareness through dementia, a learning disability or a physical disability a care worker may need to administer medication.

If the person has capacity they must agree to have the care worker administer medication and the consent should be documented in the person's care plan. If an adult is unable to communicate informed consent then it must be indicated formally that the treatment is in the best interest of the individual.

Administering refers to the use of tablets, capsules, liquids, ear nose and eye drops, inhalers, patches and topical preparations. It may include some or all of the following:

- the care worker selects and prepares medicines for immediate administration, including selection from a monitored dosage system or multi-compartment compliance aid;
- the care worker selects and measures a dose of liquid medication for the person to take;
- the care worker applies a medicated cream / ointment: inserts drops to ear, nose or eye; and administers inhaled medication (including inhalers and nebulisers);
- when the care worker applies a transdermal patch;
- when the care worker selects and puts out medication for the person to take themselves at a later (prescribed) time to enable their independence. (A Risk Assessment must have been completed before this can take place);
- where the carer selects the medication and places the medication into the person's mouth as the person is physically unable to do this. This must only be carried out if agreed by a multidisciplinary team and if detailed in the care plan;
- in an instance where family would like to be involved with medicine administering there should be a clear communication between the care worker and the family. Full responsibility should be taken by the family if agreed to medicine administering.

The need for medication to be administered should be identified at the needs / care assessment stage by the competent assessor and any subsequent reviews recorded in the person's plan. Ongoing records will also be required in the continuation notes.

Each service must ensure that there is a written system in place to ensure that only competent and confident staff are assigned to a person who requires Level 2 administration. An example of a competency assessment is included in Appendix 2. Staff that have not received training and have not been assessed as competent must not administer medicines. Procedures should enable care workers to administer medication when they have received suitable training and feel competent and confident to do so.

Level 3: Administering Medication by Specialised Techniques

In exceptional circumstances and following an assessment by an appropriate healthcare professional a care worker with appropriate Advanced Level training may be asked to administer medication by a specialist technique, for example:

- rectal administration, e.g. suppositories, diazepam (for epileptic seizure);
- use of an epipen;
- insulin by injection including testing of blood sugars and use of an insulin pen;
- administration through a Percutaneous Endoscopic Gastrostomy (PEG);
- buccal administration e.g. midazolam;
- oxygen.

Please note that this list is not exhaustive. In most instances this additional training is person and person specific. Therefore, if you have been trained to support one person you cannot assume that you can transfer those skills to support another person without checking with the health care professional who is delegating the task. This must be recorded in the care plan. The provider and the healthcare professional must make certain that adequate arrangements are in place to ensure continuity of care.

Specialist administering techniques must be discussed with the person, carer and their line manager before being undertaken. Consent must be obtained from both the person and the carer involved and recorded in the care plan.

Records must show that each individual care worker has been trained by a healthcare professional (usually Community Nurse, Community Psychiatric Nurse, etc) for the administration of a particular medicine in a particular dose to a particular person. The care worker must have agreed to undertake the task and the person must agree to allow the carer to perform the task. In addition, the care provider must have detailed guidelines as to when medication should or shouldn't be given and who to contact if there are any concerns. If the dose is changed the nurse must re-train or perform the task themselves (particularly in the case of insulin). Care staff must also be aware of any other relevant policies in place (e.g. infection control, needle stick injury, epilepsy guidelines etc).

Persons who wish to self medicate

Wherever possible, the person should take responsibility for their own medicine. This preserves independence regardless of the social care environment.

Self administration of medicines is not an ‘all or nothing’ situation. For example, some people might keep and use their own inhalers but not their other medicines. Alternatively, a person might be able to manage their medicines provided that care workers assist them. For example:

- a person who has suffered a stroke and is unable to open containers may want to keep medicines and ask care workers to assist at the time they choose to take the medication;
- a young person may be given a tube of cream to apply privately even though care workers give other prescribed medicines;
- a person who has limited understanding and awareness may be able to cope with a days supply of medicines in a compliance aid.

Persons, including those with a physical or mental disability, have the right to choose to manage their own medicines if they want to, with appropriate support from the care provider. It should not be assumed that persons should automatically have their medicine given to them by care workers. This is particularly important for short term respite, or intermediate care, when people may need to be able to manage their own medicines when they return home. The degree of self medication can vary from a person able to completely manage all their medication arrangements themselves to taking one tablet later on at night after the carer has left it with them earlier, this may also include pain killers if they have difficulty settling.

People should always be encouraged to inform staff about any changes relating to their health and medication. A person who wishes to self medicate **must** be assessed by a competent assessor (e.g. care manager), as being capable of managing their own medication. This **should** include the risks to the person themselves and anyone else who may have access to the medicine e.g. visitors, children and other persons.

In care homes locked storage **must** be provided for each person in their own room. If the room is shared, there must be separate storage facilities for each person. Any controlled drugs that they take can be kept in here and do not need to be locked in the home's controlled drug cupboard.

When assessing if a person is able to self administer, or determining the level of support they need, managers and supervisors should discuss with some or all of the following as appropriate to the individual person as well as the individual themselves:

- carer / relatives / advocates;
- social worker / key worker,
- care staff;
- GP;
- consultant;
- specialist nursing staff;
- community nurses;
- community pharmacists;
- any other relevant person involved in the person's care.

The level of support should be recorded in the care plan and must also include how to monitor whether the person is still able to self administer medicines without constantly invading their privacy. If the care provider is responsible for the ordering and receipt of medication for the person, records must be kept as to when the medication is handed over to the person. This will help the continuing risk assessment process. A robust risk assessment and care plan should note that the person will be responsible for their medication. The risk assessment must be reviewed at regular intervals and if there is any change in the person's circumstances.

Suspected changes in a person's capacity and their ability to self-administer should be reported for review to an appropriate manager or GP and recorded in the person's records.

In care homes there is no need for staff to fill in the administration section of the MAR sheet when people self administer medicines, but the form should indicate that the person self medicates. Some care homes choose to use the form to show that they have checked that the medicine(s) has been taken, but it must be clear that this medication has not actually been given by staff.

If a person wishes to take over the management of their medication from Adult Services this must be agreed between that person and a duty manager. The person should understand that they take on the responsibility and this should be recorded in a care plan and risk assessment. There should also be a signed agreement from the person or their representative, accepting responsibility for taking their own medicine. If there is a refusal to sign an agreement it should also be recorded in the care plan.

Medicines Management

Level 1 General Support – Assisting

Staff will support a person who is able to, and wishes to manage their own medication but needs general support as defined above. Assessors should ensure that the person accepts responsibility for the process.

Level 2 Administering Medication

The administering of medication is based on the **'six rights'**:

- the right person receives;
- the right medicine;
- the right dose;
- via the right route (method);
- at the right time; and
- ensuring the right record keeping.

Only designated, appropriately trained workers can carry out administration of medication. They must have received Basic Awareness Training (formerly known as level 2) (see training), and have been mentored by a senior worker and assessed competent and confident to administer. If a staff member has not received training or does not feel confident, they should refuse to administer medication.

All care service providers must obtain an up to date list of the person's medication from an authoritative source for all new persons or persons returning from any period of absence. This should only be done using a secure communication method.

Responsibility

The care worker should not undertake any duties which fall within the responsibility of a GP or nursing staff, e.g. sutures or catheter removal. Care workers must also not make any clinical decisions or judgments (e.g. increase or change of dosage) regarding the administration of medication. If there is any change of circumstances relating to a person's medication care staff must report it to the line manager or a health care professional or a nominated person (e.g. next of kin).

Care workers may not administer medication; into the vein (intravenously), vaginally or via a nasogastric tube (a tube directly into the stomach via the nose).

If it is stated on the care plan that a care worker puts out medication for the person to take themselves at a later (prescribed) time to enable their independence, it should be left in a safe and secure place and recorded on the Medication Administration Record (MAR) sheet. This must have been risk assessed and recorded in the care plan by the competent assessor.

In the following scenarios there are some specific measures which need to be taken:
A person discharged from hospital may have medication that differs from that which they had before admission. A list of current medication should be provided on a copy of the discharge prescription supplied by the hospital. In exceptional circumstances, if this is not supplied, team leaders, supervisors or key workers should clarify with the hospital ward which medicines should be administered. It is recommended that this is provided by fax. Verbal orders must only be used in exceptional circumstances. Verbal consent should be obtained from the person to dispose of discontinued or out of date medication. This consent should be recorded in the person's record.

A person admitted to hospital should have all medication should be sent with them along with a photocopy of the MAR sheet where ever possible.

A person attending an out patient appointment should take a copy of the MAR sheet with them where ever possible.

Administration of medicines away from their home (including residential and community support). Where the person undertakes a planned activity e.g. attends a day centre or is going on holiday, the person planning the activity should approach the pharmacist for a separate supply to be dispensed. In the event of an unplanned activity, two care workers must dispense the appropriate medication into a suitable container and label it with the person's name, the name and the strength of the medicine, the dosage, the date and then they must initial the container. This must also be recorded on the MAR chart and risk assessed before this takes place.

A person regaining independent management of medicines some persons particularly in Reablement or Intermediate Care have a recognised target of becoming independent with their medicine management. A pharmacy technician can complete medicines competence assessment. A planned introduction can then be agreed over short time period when staff will observe and supervise self – administration. During such a planned period the staff retain responsibility for updating the MAR sheet. If successful the MAR sheet will be marked 'now independent' and dated.

Receipt and Supply of medication

All medication must be documented on a MAR sheet (see below) or a similar chart to provide an audit trail of medication received, administered or disposed of as appropriate.

All records should include the name of the person for whom it is prescribed, the drug name, form, strength and quantity, date of receipt and signature of the receiver (see controlled drugs).

The label on the container should be checked against the information given on the MAR sheet. All medicines should be checked to ensure that they are in date and what the storage conditions are. Labels **must** never be altered. In the event of a discrepancy advice must be sought from the GP or pharmacist.

The above procedure should be carried out in other services e.g. domiciliary care and Shared Lives if the care worker collects the medication from the community pharmacy if mentioned in care plan.
Medicines **must** only be used for the particular person for whom they are prescribed.
Bulk supplies of medicines for the use of more than one person **must** not be stored by staff unless covered by the section on Homely Remedies.

MAR sheets

Poor records are a potential cause of preventable medicine errors

Printed Medication Administration Record (MAR) sheets are not essential but they reduce the risk of error and are therefore preferable to hand written charts. Care providers can make arrangements with a pharmacy to provide a MAR chart.

An example of a MAR sheet is included in Appendix 7 although these may vary slightly.

If a hand written MAR sheet is used there must be a robust system to check that it is constructed correctly. This must include Instruction for a second member of staff to check and initial that the MAR sheet is correct before it is used. In domiciliary care the first member of staff must enter the record and initial the entry. The next member of staff that administers the medication must check that the details are correct and initial the record. This also applies to MARS which have been typed by the service.

Some general rules about MAR sheets:

- they must be written in black ink with the name of the medicine written in block capitals;
- staff should not construct charts by sticking duplicate medicines labels onto a blank chart;
- correction fluid must never be used on MAR charts;
- the provider(s) should have a list of sample signatures for all persons recording on the MAR chart (see Appendix 6);
- if medicines are not administered then an explanation must be given for the reason for non administration. This may include the use of differing letter codes on pre-printed MAR sheets. If a code is used this must defined on the chart;
- for variable doses e.g. one or two to be taken at night, the exact quantity must be recorded.

See also section on when required medicines.

When completing a MAR sheet:

- the care worker must confirm that a dose has been administered by entering their initials in the appropriate box on the MAR sheet; this **must** be recorded immediately after administration for that person;
- any changes should be carried out by carefully cancelling the old entry and making a new legible entry or requesting a new MAR sheet from the pharmacist, whichever is appropriate. Guidance should be sought from a senior member of staff if needed. This **should** only occur after direct communication from or with the prescriber;
- when a MAR sheet has been fully completed it must be transferred to the persons file in the care provider's office. Another MAR chart may need to be set up as described above.

Managers must carry out a periodic check of MAR sheets to ensure they are completed correctly. Any discrepancies that are identified must be addressed with the individual care worker or at the team meeting.

MAR sheets in residential care homes, day services and supported living

When a person is admitted to a residential service, they and / or their informal / formal carer should be requested to bring with them all medicines. They should be the ones currently in use, in their original containers as labelled by a pharmacist for that person. The medication should be checked to ensure that it is in date and has not been tampered with. Staff in the service should obtain a current list of medication from the person's GP and confirm with the duty manager and / or GP any discrepancies. For a person arriving from hospital, a current list of medication should be provided on a copy of the discharge prescription.

If, on admission, there are any doubts about what medicines are to be administered the GP or hospital ward should be contacted as soon as possible and the medication reviewed. In the event of an admission out of surgery hours the advice of a pharmacist / 111 should be sought and recorded.

On admission if a printed MAR sheet is not available then a hand written sheet should be completed by the designated officer in respect of each person detailing:

- name;
- date of birth;
- name of the GP;
- any known allergies or 'nil known';
- name, form, strength of each medicine;
- the instructions on how to take each medicine (this should match the Label on the medicine).

This hand written record **must** be checked and countersigned by a second competent member of staff.

For a person who is on an established system then all medicines received in a residential service should be checked against the printed MAR sheet to confirm the name of the person for whom they were prescribed, the name of the medicine, strength and quantity, date of receipt and signature of the receiver.

If possible a photograph of the person should be obtained and attached to the current MAR sheet. If this is not possible staff must ensure that they are confident that they have the right person. If the care worker is unsure they must speak to a senior member of staff for advice.

Any visiting GP / Consultant should be encouraged to record any changes to medication on the MAR chart. NB. A GP does not have to sign any documents produced by a care provider unless there is a private contract with the GP. If a GP refuses to record any change in dose then a competent member of staff must cancel the original direction, write the new directions legibly and in ink on a new line of the MAR, write the name of the Doctor or other prescriber who gave the new instructions and initial the entry. A second competent member of staff must check and countersign the entry.

MAR sheets in domiciliary care services

A printed or hand written MAR sheet should be obtained for each person as indicated in the care plan. Their current MAR sheet should be kept in the person's home or room. The care worker must send completed MAR sheets to the service provider's office for storage on the person's file once completed for auditing purposes by the service, along with any empty blister packs where the information has been transcribed onto a MAR. In exceptional circumstances, where there are two service providers the primary provider should take the chart for their own files and send a copy to the other provider.

If relatives, friends or other carers administer medication then they should be asked to make an entry on the MAR sheet to ensure that a double dose is not given. If they do not record on the MAR sheet then it should be reported to the line manager for a risk assessment to be carried out. Due to this overdose risk friends and relatives are not encouraged to administer medication. If they do a written agreement with the family should be considered.

In Shared Lives/Supported Living if anyone other than the approved carer administers medication then they should be asked to make an entry on the MAR sheet to ensure that a double dose is not given. Failure to do so should be reported to the Shared Lives/Supported Living service for a risk assessment to be completed.

Prescriptions

Intermediate Care

In Intermediate Care Services, the consultant / GP will be responsible for the ordering, storage and supply of prescription pads.

Verbal changes to prescribed medication can be accepted provided there is written authorisation of the changes, supplied by the prescriber, usually by fax, at the first opportunity.

Whenever possible written confirmation of the change i.e. a new prescription or a fax of the new instructions should be obtained. If a fax is not available then the first person must record the changes by the Doctor and hand the phone to the second member of staff who should repeat the details to the GP.

The following information should be recorded:

- name of the person;
- name of the medicine;
- dose and frequency of the medicine;
- name of the doctor;
- time and date;
- special instructions i.e. for two doses only;
- signature of person taking orders and if possible a witness;
- if possible try and obtain a new prescription and the details of the person sending it.

Ordering of prescriptions in residential care services

A designated officer will be appointed to ensure continuity of supplies of medication as appropriate in the most efficient manner.

The designated officer will assess each person's medication on arrival and on a weekly basis to identify any items which have between 7 and 14 days supply left. Repeat items will be ordered using the prescription request form from the person's GP or the Intermediate Care GP as appropriate. The necessary information will be supplied with the request to enable the prescribing GP to carry out this task safely. On receipt, all medicines should be double checked with existing records to ensure that they are correct.

On admission to **Intermediate Care**, the designated officer will supply the temporary GP with a copy of the following information:

A person admitted from hospital

- Bournemouth and Poole Hospital Medication Record Card;
- discharge summary;
- single assessment documentation;
- letters as appropriate.

If there is any doubt about the person's medication, the hospital ward should be contacted and a copy of the medication record should be requested.

A person admitted from home

- copy of repeat medication from the person's GP;
- single assessment documentation;
- letters as appropriate.

The designated officer will also inform the Intermediate Care GP on a weekly basis of any persons that are discharged.

Ordering of prescriptions in domiciliary care services

(including Shared Lives and Supported Living)
If it is identified at the assessment stage that care workers are responsible for ordering prescriptions and / or collecting from the GP practice / community pharmacy then this must be documented in the care / support plan. This must include the criteria for reordering **ensuring** the person does not run out of medication.

If medicines are required outside working hours then a competent member of staff must contact the urgent care services on 111 or contact a local pharmacy for advice.

Storage

This applies to medication **not needing any special storage** e.g. refrigeration (see below) or **controlled drugs** (see below). Care workers must check the individual labels or leaflets to ensure that medicines are stored appropriately.

In residential services, all medicines must be stored in a locked cupboard or medicine trolley. If used, a trolley should be secured to a wall or immovable object when not in use.

The supplies for each person should be kept segregated in a suitable reserved container (internal use and external use medicines should be stored separately).

All keys are the responsibility of the designated officer on duty. Keys for medicine cupboards, trolleys and clinic areas must be kept separately from any other keys and separately from the master key. The number of duplicate keys should be minimised.

A person in a residential service who is self-medicating must be provided with a lockable cupboard in their own room to store medicines. The person will take responsibility for the key.

In domiciliary care services, Shared Lives and Supported Living medication should be stored appropriately according to the individual circumstances. If there are special requirements then this should be stated in the Care Plan. It is advised that a risk assessment is carried out to ensure that the medicines are kept safely and securely and do not pose a risk to the person or to anyone else entering the premises e.g. children visiting. Arrangements for storage should be agreed with the Person or carer if involved. In Shared Lives or Supported Living settings the same principles apply to storage arrangements although it is recognised that individual settings and circumstances may differ. An agreed approach involving all parties should be made for that setting or on a case by case basis.

Refrigeration

The pharmacist's label, container or patient information leaflet will indicate if an item needs refrigeration.

In care homes medicines that require storage between 2 and 8 °C need to be stored in a lockable refrigerator. The minimum and maximum temperature should be monitored and recorded daily and the refrigerator defrosted regularly. If the temperature falls outside of the range then the care worker must speak to a senior member of staff for advice. The senior member of staff must check with the Pharmacist to confirm that it is appropriate to use the medicine.

In all other settings medication needing to be refrigerated should be stored separately from food e.g. in a separate plastic container. If the care worker suspects that the fridge is not working correctly e.g. too hot or too cold, then advice must be sought from the pharmacist.

Controlled Drugs

The Misuse of Drugs Act 1971 controls the availability of drugs that are considered sufficiently 'dangerous or harmful' with a potential for misuse. These drugs are termed Controlled Drugs (CDs) and it is a criminal offence to possess, possess with intent to supply or administer these drugs without authorisation. If any problems are identified in the handling of controlled drugs you must inform CQC.

Controlled drugs are likely to cause dependence or misuse in varying degrees. They are classed according to the extent of harm they may cause when misused. There must be strict

controls for the prescribing, administering, safe custody, dispensing, record keeping and disposal of controlled drugs.
There are special legal requirements for CD prescriptions so you should always allow extra time for these to be written. A prescription that does not comply with these requirements may have to be sent back to the prescriber for altering before it can be dispensed
If care workers collect CDs from a pharmacy on behalf of someone else, they may be asked to provide identification.

A list of commonly used controlled drugs is included in appendix 8 and further advice about them may be sought from the community pharmacist. The list should be available to staff for reference purposes e.g. on a controlled drugs cupboard. Oramorph (morphine sulphate) liquid 10mg/5ml should be treated as a controlled drug.

Controlled Drugs in Care Homes and Day Services

Receipt, storage and recording

A CD register (a bound book or register with numbered pages) must be used to record the receipt, administration and disposal of CDs held in the service in addition to the regular records made on the MAR chart. Each drug, for each person, should be recorded on a separate page, with the name, dose and strength of the drug written clearly at the top of the page.

On receipt of the CD, in addition to the MAR sheet, the date and quantity must also be entered into the CD register and initialled by the authorised member of staff, with a second member of staff countersigning the entry as a witness. The correct balance should be verified each time.

When transferring the drug record to a new page in the CD register, the amount remaining must be identified with 'brought forward from page x' written clearly on the new page. It is good practice to keep CD registers for longer than the mandatory two years.

Controlled drugs must be stored in a designated Controlled Drugs cupboard. See appendix 8 for further details. This designated cupboard must not be used to store anything else. The requirements for CD storage are:

- metal cupboard with a specified gauge;
- specified double locking mechanism;
- fixed to a solid wall or a wall that has a steel plate mounted behind it fixed with either rawl or rag bolts.

It is not the case that controlled drugs have to be stored in a cupboard within a cupboard.

Persons who are risk assessed as competent to look after their own medicines are permitted to store controlled drugs with the rest of their medicines. Through monitoring and review of the risk factors, it should be identified that controlled drugs are not left lying around where they could be taken by someone else. There is no need to keep a record in the CD register when the person is wholly independent. That is, he or she is responsible for requesting a prescription and collecting the controlled drugs personally from the pharmacy. But if the person does not arrange the supply and collection of controlled drugs but relies on the care workers to do so, there should be clear records in the CD register including:

- receipt from the pharmacy;
- supply to the person;
- any subsequent disposal of unwanted controlled drugs.

Controlled drugs are a target for theft and it is good practice to regularly check them. The CD register should include the balance that remains, which can be compared with the quantity in the CD cupboard. The service manager should carry out an audit on a on a regular basis to

ensure that entries have been made correctly and that the balance is correct if a discrepancy is noted, the service manager should investigate and establish what has happened. For example, has a care worker forgotten to complete the record or have the controlled drugs been stolen. If controlled drugs are missing, this is a serious incident and CQC must be notified. It may also be necessary to contact the police to discuss how to deal with the situation.

If an **error occurs** when a controlled drug is given, this may have serious consequences for the person involved. The care worker **should** contact 999 or the person's GP for advice. In the event that the GP cannot be contacted advice should be sought from a pharmacist.

Administration of Controlled Drugs – Care Homes

In care homes, CDs should be administered by competent care staff, and this should be witnessed by another appropriate member of staff.

The use of a witness is intended to reduce the possibility of an error occurring. To be effective, the witness must understand what the care worker is doing and therefore needs the same level of training.

Before administering the medicine the witness should confirm that:

- the care worker selects the correct controlled drug;
- the name on the label attached to the controlled drug is the same as the person the care worker intends to give it to;
- the care worker has prepared the right dose, included on the label and in the MAR chart;
- the care worker gives it to the right person;
- the administration is recorded in the CD register as well as signed on the MAR chart.

In care homes (personal care), any controlled drugs given by injection are the responsibility of community nurses. It is important to make sure that the care home retains a record of all controlled drug administration, especially when the community nurse completes a record that is not left in the care home. If the community nurse is not willing to make a duplicate record in the home's CD register, the witness (carer) should complete this record.

The person's name, plus time and dose given, should be recorded in the CD register after carefully checking the administration sheet. Once the trained care worker has witnessed the resident taking the medication, the person's MAR sheet must be initialled by the care worker. The care worker and the witness should then initial the CD register, after verifying that the remaining balance is correct. The administration process should be fully completed for each person, before moving on to the next person.

Records of this kind are not required if the patient self administers their medicines. It is good practice to record details of medicines that have been handed over to the patient.

Administration of Controlled Drugs – Domiciliary care

A controlled drugs register is not required in domiciliary care. Details of administration should be recorded on the MAR chart. However wherever two staff deliver care (e.g. for moving and handling purposes) they should both witness the administration of a controlled drug and sign the MAR sheet.

Controlled Drugs in Shared Lives or Supported Living

As these settings vary, each individual circumstance should be considered in a risk assessment with all involved. Persons who are risk assessed as competent to look after their own medicines are permitted to store controlled drugs with the rest of their medicines in agreement with the service provider and other involved agencies. There is no need to keep a record when the person is wholly independent, for example is responsible for requesting a prescription and collecting the controlled drugs personally from the pharmacy. But if the person does not arrange

the supply and collection of controlled drugs but relies on the care workers to do so, there should be a clear record maintained including:

- receipt from the pharmacy;
- supply to the person;
- any subsequent disposal of unwanted controlled drugs.

Disposal of controlled drugs or if a person leaves a service

Controlled drugs that are no longer required should be returned to the pharmacy for disposal. This should be discussed with the pharmacist in advance and the returned medication recorded in the controlled drugs register. In care homes records must be made in the CD register in addition to the usual records for the disposal of medicines. In other settings it is strongly advised that two members of staff witness the removal and record accordingly.

If the person leaves a care service, any medicines handed back to the person or a new care provider must be recorded in the CD register and disposal form (see disposal of medicines). It is good practice to get a receipt from the person / new care provider.

Administration Procedures

In all care settings (except nursing homes) all medicines including controlled drugs, (except those for self administration) must be administered by designated and appropriately trained staff.

In care homes (nursing) all medicines, including controlled drugs for persons receiving nursing care are administered by a medical practitioner or registered nurse.

Care workers should only administer medicines from the original container dispensed and labelled by a pharmacist. This includes monitored dosage systems and multi-compartment compliance aids. Staff must not fill multi-compartment compliance aids themselves.

It is not acceptable for one carer/ nurse to prepare the medicine and give it to another care worker to take to the person. If the care worker giving the medicines does not have the container with label they cannot be sure that the person receives the right dose of the right medicine at the right time, as prescribed.

NB. Monitored dosage systems (MDS) / multi-compartment compliance aid (MCAs) have been promoted as a safe system of medicine administration. However these systems are merely a convenient form of packaging for a limited group of medicines. Safe practice is not guaranteed by use of a system alone but is promoted by only having staff who are trained and competent to give medicines.

It should not be presumed that medicines must be in a multi-compartment compliance aid for staff to be able to administer/ assist with medicines.

Medicine should be given to one person at a time. It should be drawn up according to the directions, taken directly to the person and given immediately. Staff and managers should do everything possible to allow the person administering medicine to do so uninterrupted. The care worker administering the medication should not be distracted until the task is complete. E.g. if a phone rings or assistance is required somewhere else the medication procedure should be completed first.

Prescribed medication should have clear and concise instructions, which include the maximum dose and how it should be taken. For ‘when required’ medicines clear instructions must be

obtained from the prescriber as to when the medicine should be administered, how often this may be repeated and what the maximum dose is over 24 hours.

If it is a new prescription for the person, staff should ensure that they have the right information for safe administration. This information should be from the pharmacist, GP or hospital. Further information regarding the medication can be found in the patient information leaflet.

Some medications (such as warfarin and prednisolone) may have variable doses, which will need to be checked with separate charts or booklets. If this is the case, every time, before administration of the medicine the care worker must check the separate booklet for the correct dose and the dose administered should be entered on the MAR sheet.

It is almost **impossible** to swallow tablets or capsules without drinking some water. Even if people say they can manage without, taking tablets and capsules with a drink of water is a good habit to encourage. A hot cup of tea instead of water is **not** a good idea because many medicines are badly affected by heat.

It is very difficult to swallow tablets or capsules when lying down. It is very likely that the tablet or capsule could get stuck in the throat or gullet where it could cause difficulty with swallowing or could damage the lining of the gullet.

When a person has difficulty swallowing, there may be rare occasions when it is necessary to break a tablet in half to comply with the prescribed amount, as there is no liquid alternative. This must only be carried out if instructed by the prescriber either in the label or via written instruction. This must be double checked with the community pharmacist before administration and recorded. (see Swallowing difficulties).

Preparation

Before administering any medicines the care worker carrying out the administration should wash their hands, clean the medicine preparation area and gather the following equipment:

- the persons Medicines Administration Record sheet (MAR)
- a pen (this must be black)
- a jug of water and clean glass / glasses.
- clean and dry medicines measure/s

The MAR sheet should be checked for the following:

- the persons name;
- the dose has not already been administered;
- any instructions, noting in particular any recent changes;
- what time the medicine is due;
- select all of the correct medicines for this time of day for that person. Even when medicines are supplied in MDS, there may be other medicines in the fridge and remember that this person may have different medicines since the last time you were on duty. This is why it is so important to refer to the MAR chart instead of relying on memory;
- the pharmacists' label on the medication container corresponds with the instruction on the MAR sheet. If these two differ, then clarify the instructions with the duty manager;
- note any special instructions to be followed, e.g. before or after food, chewed or dissolved in water.

You should then:

- ask the person if they want their medicines before you take them out of the pack. People can refuse medicines for different reasons. When this is an important medicine, it may be better to wait a little while and ask them later. If the person continues to refuse, you

must never force the medicine on them and this means that hiding medicine in food or drink is not acceptable practice in any setting;
- some medicines are meant to be taken occasionally when there is a specific need, for example, tablets for pain. If the directions say 'to be taken as required', you need to find out whether the person has any pain before you prepare and offer the tablets. Other medicines like this include treatments for constipation, indigestion, and anxiety;
- make sure that there is a glass (tumbler) of water to wash the tablets or capsules down;
- encourage the person to sit upright or to stand;
- if the tablets/capsules are in a monitored dosage or multi-compartment compliance pack open the appropriate section and empty the tablets/capsules into a medicine pot and hand it to the person. If the tablets/capsules are in bottles or strip packs transfer the appropriate number of tablets/ capsules into a medicine pot and hand it to the person.

It is very important not to handle any medicines. So you need to prepare them by a 'clean' technique'; that is pushing a tablet or capsule out of the blister directly into a medicine pot.

Some medicines **may be harmful to the care worker** if they have direct contact with them. It may be advisable to wear plastic gloves if you know there is a health and safety risk.

The dose of some medicines depends on the results of blood tests. An example is warfarin. Each setting should have a system to let the care worker, or the people providing care, know what the correct dose is. The latest information needs to be kept with the MAR sheet.

Always make a record of exactly what you have done at the time. This includes a record when the person refuses the medicine.

Swallowing difficulties

If a person is experiencing difficulty swallowing any medication then the care worker must report it to their manager who should contact the person's GP or community pharmacist for further advice. It may be appropriate to change the formulation to a liquid or soluble tablet, if there is one available. This could be a liquid version of the original medicine or a different medicine that has the same effect. In either case, this will have to be discussed with the prescriber or pharmacist.

Normally tablets should not be crushed particularly if it is a 'long lasting' formulation (Retard, Modified Release, Slow Release etc). (see below). Capsules should not be opened either to make them easier to swallow or to hide them from the patient because this may affect the way that the medicine works. Some foods or drinks may affect the active ingredient of the tablet or capsule or how it is absorbed, if they are taken together. This is **not** considered as safe practice unless professional guidance of a pharmacist is obtained or it is written in the patient information leaflet.

If there is no alternative then written consent must be obtained from the prescriber and a risk assessment should be carried out by an appropriate member of staff stating that the care staff are acting on advice from the GP and it should be recorded in the care plan. This advice should be checked with a pharmacist to ensure that it is appropriate to crush the medication. A procedure must be put in place as to how this will be undertaken and recorded in the care plan.

Administering different forms of medication

Liquid medication

This should be administered using 'liquid measures' which are available from the pharmacist.
NB. Liquid medicines should not be poured out in advance.
These include:

- oral syringes;

- calibrated medicine pots;
- measuring spoons (do not use teaspoons); (If the medicine is a syrup or mixture make sure that you use the medicine spoon or measure that the pharmacist provided — do not just guess or use any spoon or allow the person to drink from the bottle).

When a bottle is opened the date **should** be recorded ensuring that instructions on the label have not been covered. The item **should be returned** back to the pharmacy for disposal if the **expiry date** has been reached unless otherwise stated on the product or in the Patient Information Leaflet (PIL).

Creams, ointments and lotions

Checks should be made to ensure the correct medicine is being used and that directions and any warnings are understood. It is important to confirm where the product needs to be applied. When a new tube or jar of cream or ointment is opened the date should be recorded ensuring that instructions on the label have not been covered. The item **should be returned** back to the pharmacy for disposal if the **expiry date** has been reached unless otherwise stated on the product or in the Patient Information Leaflet (PIL).

If there are any queries about how to apply these medicines, a pharmacist should be consulted.

If you are applying medicines to the skin it is really important to use gloves both for your own protection and also to prevent cross-infection (see infection control policy). These medicines are directly absorbed through the skin. If you do not protect yourself, your body will also absorb the medicine.

If two or more different preparations have been prescribed check with the GP or pharmacist if the order of administration and timing are important and this information be included on the MAR/Care plan. Guidance should include how much cream/ointment should be applied.

Use each container only for a specific patient, as this will prevent cross infection

A MAR sheet/cream chart should be completed for all prescribed creams/ointments. It is good practice to use a body map to identify clearly where cream/ointment should be applied.

Procedure

Hands should be washed before and after a procedure and **gloves must always be worn** to apply the cream. This is good infection control and good practice and will prevent cross contamination and microbial contamination of the cream.

The affected skin area should be clean and any residue of a previous application should be removed by gentle cleansing of the area.

The cream, ointment or lotion should be applied making sure that enough is taken from the container to complete the application. If too much is taken the remainder should not be returned to the container as this will contaminate the remaining medicine.

The prescription label should always explain how to apply the medicine, if the label says, “apply as directed”; the medicine should not be applied without first checking what “as directed means”.

The cream should be spread over the surface of the skin or **gently** massaged into the affected area until absorbed. Some medicines need to be applied sparingly. Again, the pharmacist’s label should say if this is the case. If there is no information on the label check the patient information leaflet or ask the pharmacist. Remember emollients should not be rubbed in but be

applied in a sweeping motion, rather like applying butter to toast. Apply gently in an upward direction finally swipe gently down the length of the limb to replace the hairs to their natural direction of growth. This prevents the cream clogging hair follicle.

If a further application is needed remove the glove and replace with a clean one. Any excess cream should be left on the glove and not returned to the pot. **Gloves should be disposed off appropriately**.

Any clothing should be replaced.

Eye Drops and Eye Ointments

The directions should be read carefully and this guidance followed:

- two different types of eye drops should never be administered into the person's eye at the same time, or the second drop will run out;
- the persons head should be tilted back slightly;
- the lower lid should be pulled down and one drop allowed to fall into the space between the lid and the eye;
- if more than one drop of the same eye drop is required in the same eye, there may need to be an interval before putting in the second drop depending on the type of eye drops being used – refer to the medication's directions or instructions. Wipe away any excess from the person's face;
- when drops are prescribed to be put into both eyes, it is good practice to have separate bottles marked left and right to reduce the possibility of cross contamination;
- the procedure is similar for eye ointments; allow about half a centimetre length of ointment. Unless stated differently in the patient information leaflet;
- the person's eye should not be touched with the dropper or applicator;
- the container should be discarded 28 days after opening unless it is stated otherwise on the leaflet or container e.g. preservative free.

NB. If two or more different preparations have been prescribed, they should not be given at the same time. Check with the pharmacist or GP if the order of giving and the timing are important.

Nose Drops

- The persons head should be tilted well back and the correct number of drops allowed to flow down into the nose. The person's head should be kept tilted for a few minutes to allow the drops to be absorbed;
- wipe away any excess from the person's face

Ear Drops

- The person's head should be tilted to one side or ask the person to lie on their side. Gently pull their ear lobe down. The required number of drops can then be administered into the ear;
- the persons head should be left tilted for 3 – 4 minutes after administration of the drops;
- wipe away any excess from the person's face

Transdermal Patches

At the moment these patches are limited to the treatment of angina, hormone replacement therapy, analgesia and smoking cessation. Although they are applied to the skin, they do have a systemic, not a topical effect, i.e. they are absorbed. Depending on their use, some patches are applied daily, every three days, weekly or twice weekly. Always make sure that the directions are followed.

Patches are similar in appearance to a sticking plaster and they are usually applied in much the same way. Always check the Patient Information Leaflet for detailed instructions as to how and where the patch should be applied. This information may include how to safely remove the

patch from the external packaging as well as applying and disposing of the patch once used. As with other routes of administration, only staff who have been trained and have been assessed as being competent in applying patches may undertake this task.

Advice should be taken from the Pharmacist, prescribing GP, or Community nursing Service, if in any doubt about how it should be applied. If more than one service is involved the care of a person the service manager is responsible for ensuring that staff have clear guidance as to who should carry this out.

To apply, the skin must be clean, dry and undamaged and the patch applied firmly. The site should be varied for each new application, preferably a non hairy site if possible, so that the skin does not get sore from repeated application in the same place. Always check that the old patch has been removed before applying a new patch. It may be that the old patch is on a different site of the body e.g. other arm. A full body map should be used to indicate where the current patch has been placed. This supports the safety and dignity of the individual when there are repeated applications, administered by staff.

If a rash is noticed contact the GP/ prescriber for further advice.

Inhalers

There are many different types of inhalers available; they are usually prescribed for conditions such as asthma or chronic obstructive pulmonary disease (COPD). The manufacturer's instructions should always be referred to. Listed below are the general points to follow for using a **metered dose inhaler:**

- shake the inhaler before use;
- the person should breathe out as fully as possible;
- the mouthpiece of the inhaler should be placed between the lips;
- the person should start to inhale slowly;
- the inhaler should be pressed down once to spray one dose into the mouth;
- the person should continue to inhale until their lungs are full;
- the person should try to hold their breath for 10 seconds if possible or as long as they can without feeling uncomfortable but for no longer than 10 seconds; they should then exhale slowly;
- if two puffs are required the process should be repeated after 30 seconds;
- if more than one different inhaler is to be administered, there may be a requirement to administer in a particular order. If this is not indicated on the label, please check with a pharmacist or the prescriber;
- the person may be required to use a spacer device with the inhaler, such as a volumatic or and aerochamber;
- if you identify any problems using the device contact the pharmacist, nurse or doctor.

Refusal

It is an individual's right to refuse medicines. The general consent given by a person does not give a care worker the right to administer medication against a person's wishes. Care workers should record the reason for refusal, with the appropriate code on the MAR sheet. If the refusal continues for 24 hours then the manager of the service, the prescriber and/or the pharmacist should be contacted for further advice.

When Required Medication (PRN)

'When required medications' (PRN) are those that a doctor has prescribed to be given only when certain conditions or criteria are met e.g. pain relief. In such circumstances the person may not need the tablets every day. Consideration should be given to the person's capacity to refuse the medication. When providing care workers with information, the needs of the person **must** be identified. (e.g. if signs of pain are expressed in a non-verbal way).

There **must** be clear guidelines in the person's plan of care, particularly if the person is not able to make the decision themselves about when they have the 'when required' medicine. To ensure that the medication is given as intended a specific plan for administration must be recorded in the care plan and ideally kept with the MAR sheets. The care provider must ensure that they check with the prescriber:

- what the medication is for;
- when should the dose be administered;
- what dose needs to be administered;
- how often the dose can be repeated;
- what the maximum dose can be administered within 24 hours;
- when the prescriber needs to be contacted.

The care provider should ensure that an adequate supply of medication is available and that the medication is in date.

All administration of 'when required medication' **should be recorded on the MAR sheet** with the exact time and quantity it is given to make it easier to see when it is appropriate to give another dose.

It is recommended that this information is recorded and made clear on the MAR sheet. Advice should be sought if any of this information is not available. If 'when required' medication is taken on a regular basis the prescriber should be informed to review the person's medication.

'When required medication' must be listed on the MAR sheet with the maximum daily frequency and or the time lapse between any administrations and any special conditions to trigger a review.

In residential settings a record does not have to be made at each medical round to show the person has been offered the medication. However the care plan should demonstrate that staff know what the medication is for and have made an assessment on whether the person requires the medication.

PRN medication should not be offered or given only at the times listed on the MAR chart or at specific medication rounds. As it is for occasional use the person should be offered the medication at the times they are experiencing the symptoms either by telling a member of staff or by staff identifying the person's need as outlined in the care plan. The exact time the medication was given and the amount given should be recorded on the MAR.

If PRN medication is given regularly then a referral to the prescriber should be considered for a review of the person's medication, as their medical condition may have changed and the treatment required may need altering. Similarly if the medication is not having the expected effects the prescriber should be contacted. In both cases the response to the medication should be clearly recorded.

PRN medication that is still in use and in date should be carried over from one month to the next and not disposed of. A record of the quantity carried over should be recorded on the new MAR so there is an accurate record of the quantity in stock and to help when performing audits.

PRN medication is best supplied in an original box rather than a monitored dosage system (MDS). This allows for a check on the expiry date and reduces waste.

In domiciliary care the administration of PRN medication may not be at the time of the care worker's visit. In such circumstances the care plan must detail how the person's needs are to be

met. For example the medication may be left out for the person to take at a time suitable for them. Robust records kept of what medication was left, who by, where and in what container.

Non – prescribed medicines (Homely Remedies)

It is recognised that there is a need to be able to treat minor ailments without necessarily consulting with the persons GP.

A homely remedy is treatment for mild to moderate symptoms that need immediate relief for example toothache or indigestion. Use of a homely remedy must not be extended beyond 48 hours without medical advice being sought.

There may be occasions when the person requests you to purchase some over the counter medicines on their behalf. If this occurs then it is important to ensure that you check with the Pharmacist or GP whether it is safe for them. If you notice that a person purchases a lot of medication, it is important to try and encourage them to tell staff what they are taking and when they are taking them. This would include any medication, vitamins, homeopathic and herbal remedies.

Always check the dose, precautions and any other important information that is available on the person information leaflet or check with a Pharmacist.

Any administration of a homely remedy should be recorded on the reverse of the MAR sheet or on a separate record sheet (Appendix 9). This record should include the reason why the homely remedy was administered, the medicine name, strength and dose administered.

Care homes and Day Centres that wish to keep any stocks of homely remedies must ensure that they have a procedure and a list (an example is included in appendix 10) that staff can administer in place. This must be specific to that service.

Care workers should not offer advice to a person about over the counter medication or any complementary therapy.

Disposal of medication or when a person leaves the service

Medicines should be returned to the pharmacy when any of the following occur:

- a course of treatment has been completed or discontinued;
- the expiry date has been reached.

If a person dies (these medicines should be retained for 7 days before disposal) NB: In the event of sudden death medicines should be kept securely until it is known whether or not an inquest is to be held.

Any medication returned to the pharmacy should be recorded on the MAR sheet or appropriate form (see Appendix 12 and / or Appendix 13). If possible verbal consent should be obtained and recorded on the person's record. It is good practice to ask for a receipt of any medicines returned to the pharmacy. In domiciliary care it is good practice to have two signatures when returning medicines back to the pharmacy.

NB. This process is different in care homes providing nursing care. In care homes (nursing) the home is responsible for making arrangements for the removal and safe disposal of waste medicines. Two members of staff must witness the disposal.

If the person leaves a care service, any medicines handed back to the person or a new care provider must be recorded on the MAR sheet or appropriate form. It is good practice to get a receipt from the person / new care provider.

Errors - Protection of employees and persons

Errors can occur in the prescribing, dispensing or administration of medicines. Most medication errors do not harm the individual although a few errors can have serious consequences. It is important that errors are recorded and the cause investigated so that we can learn from the incident and prevent a similar error happening in the future.

Carers **must immediately report any error** or incident in the handling and administration of medicines. This would be to your line manager or person in charge of the setting.

Any procedures, policies and training must be implemented in a supportive workplace environment / team. They are also intended to reduce risk of medication error and the associated risks to persons and employees.

It is good practice for care settings to investigate and put in an action plan to prevent the error occurring again. See Incident report form – Medication key prompts (Appendix 11).

Those administering medication should expect:

- not to be asked to administer medication until suitably trained;
- to receive training in accordance with the policy as part of their induction and medication training with refreshers every 18months to two years as part of the Social Services Department's mandatory training;
- pharmacists should comply with the medicines policy by presenting medication in suitably labelled and packaged containers;
- to be supported by colleagues, persons, relatives and managers when they are administering medication by creating an environment, which enables employees:
  - to undertake this task free of any expectation that they will undertake any other duties;
  - to be free of interruptions;
- the medication must be secured in the event of an emergency.

It is advised that people over 75 should have a 6 monthly medication review, if on 4 or more medications, or annually if on less than four types of medication. Employees should record if they have asked the health professional to review the medication.

When errors are reported or identified by an audit the appropriate manager will undertake a fact-finding audit with the intention of ensuring remedial action, i.e. to systems and procedures are implemented retrospectively.

Managers may wish to consider consulting with a pharmacist when carrying out an audit.

If it is found from the investigation that employees have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in line with Bournemouth Borough Council and Borough of Poole's disciplinary Procedures.

In certain circumstances medication errors may present a safeguarding risk in which case managers should refer to the Multi-Agency Safeguarding Policy and Procedures.

Training Care Workers to Safely Administer Medication

In all social care services, all medicines, (except those for self administration and nursing homes), should be administered by designated and appropriately trained and competent staff.

It is the employer's responsibility to ensure that the care workers have been trained and have been assessed as competent to undertake the tasks that they are required to perform. Specialist techniques will be judged by the health care professional who delegated the task.

Adult Services must establish a formal means to assess whether the care worker is sufficiently competent in medication administration before being allowed to give medicines and this process must be recorded in the care worker's training file.
The training for care staff must include:

- basic knowledge of how medicines are used and how to recognise and deal with problems in use;
- the principles behind all aspects of the policy on medicines handling and records.

Care workers may, with the consent of the person, administer prescribed medication, so long as this is in accordance with the prescriber's directions (The Medicines Act). However, when medication is given by invasive techniques, for example insulin injections, care workers will need additional specialist training.

There are three levels of training for care workers, and additional training for supervisors:

- Induction Level (formerly level 1 training) should be received by all care workers;
- Basic Awareness (formerly level 2): Any care workers who are administering medicines must complete this level;
- Advance Training: Administering Medication by Specialist Techniques - will only apply in specific situations and training must be provided by the healthcare professionals involved.

Additional Training for Supervisors and Competency Assessors: to support senior staff with how to assess competence, complete audits and assure safe practice within their service.

Refresher training should take place at a minimum frequency of 18 months to two years for each member of staff involved in medication unless otherwise stated by the training provider.

Induction Level (formerly level 1 training)

Induction training should raise awareness of the management of medicines within the home. It should also identify what the care worker is **not** able to do before completing Basic Awareness Training.

Basic Awareness (formerly level 2): Administering Medication

This may be described as basic training and should be carried out by a recognised trainer. This should provide the care worker with knowledge and practical skills to safely select, prepare and give different types of medicines, a process that is referred to as 'medicine administration'. A senior worker must always mentor a care worker until he / she is both confident in giving medicines and competent to do so correctly. This is the level of training that the term 'accredited' relates to.
Basic training is necessary for the following:

- establishing from the service records which medicines are prescribed for a person at a specific time in the day;
- selecting the correct medicine from a labelled container including monitored dosage system and multi-compartment compliance aid;
- measuring a dose of liquid medicine. Applying a medicated cream/ointment; inserting drops to ears, nose or eye: and administering inhaled medication;

- recording that a person has had the medicine or the reason for not administering it;
- what to do if a person refuses medicine that the care worker offers;
- who to inform if a medication error occurs;
- who to inform if the resident becomes unwell after taking his/her medicines;
- how to dispose of medication.

Advanced Training: Administering Medication by Specialised Techniques

This relates to those circumstances following an assessment by a healthcare professional, when a care worker is asked to administer medication by a specialist technique including:

- rectal administration, e.g. suppositories, (diazepam for epileptic seizures);
- use of Epipen;
- use of oxygen;
- Buccal administration (e.g. Midazolam);
- Insulin by injection;
- administration through a Percutaneous Endoscopic Gastrostomy (PEG).

Please note that this list is not exhaustive. In most instances this additional training is person specific and person specific. I.e. if you have been trained to support one person you cannot assume that you can transfer those skills to support another person without checking with the health care professional who is delegating the task. This must be recorded in the care plan. The provider and the healthcare professional must make certain that adequate arrangements are in place to ensure continuity of care.

This must be discussed with the person, carer and their line manager before this is undertaken. Consent must be obtained from both the person and the carer involved and recorded in the care plan.

Records must show that each individual care worker has been trained by a healthcare professional (usually community nurse, CPN etc) for the administration of a particular medicine in a particular dose to a particular person. The care worker must have agreed to undertake the task and the person must agree to allow the carer to perform the task. In addition the care provider must have detailed guidelines as to when it should or shouldn't be given and who to contact if they are concerned. If the dose is changed the nurse must re-train or perform the task themselves (particularly in the case of insulin). Care staff must also be aware of any other relevant policies in place (e.g. infection control, needle stick injury, epilepsy guidelines etc).

Training for Supervisors and Competency Assessors

This training provides advice and support to senior staff responsible for safe handling of medicines in social care settings and for assessing competency of administration, risk assessments on medicines, carrying out audits and problem solving e.g. dealing with questions asked by care staff.

References and related information

Related Legislation

Department of Health, *Care Act 2014*
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Health and Social Care Act 2012
The controlled Waste (England and Wales) Regulations 2012
Care Quality Commission (Registration) Regulations 2009
Mental Capacity Act 2005
Data Protection Act 1998
Equality Act 2010
The Human Medicines Regulations 2012
The Misuse of Drugs (Safe Custody) Regulations 1973
Misuse of Drugs Act 1971

National Guidance

National Institute for Clinical Evidence (NICE)
Managing medicines for adults receiving social care in the community.
Managing medicines in care homes - NICE Pathways
Managing Medicines in Care Homes Guidance full document-pdf
Other more general resources and guidance are also available on the *NICE website*
Office of the Public Guardian, *Mental Capacity Act Code of Practice*
Royal Pharmaceutical Society of Great Britain, *http://www.rpharms.com/social-care-settings-pdfs/the-handling-of-medicines-in-social-care.pdf*

Related Local Procedures

Bournemouth Borough Council and Borough of Poole, Medicines *Guidance*
Bournemouth, Dorset and Poole Safeguarding Adult Boards:
Multi Agency Safeguarding Adults Policy
Multi Agency Safeguarding Adults Procedures

Contact Information

Lead

Author

Kevin Moore | Policy Officer
Borough of Poole | Adult Social Care - Services
01202 261098
kevin.moore@poole.gov.uk
Adult Social Care - Services| Borough of Poole | Civic Centre Annexe | Park Road | BH15 2RT
www.poole.gov.uk

Appendix

Appendix 1 Glossary

Term	Definition
Administering medicines	In this situation the carer will be responsible for selecting the correct medicine and giving it to the correct person without being requested to do so by the person.
Advance Decision	An advance is where a person makes a decision about refusing treatment at a future time when they may lack capacity. A copy of the Advance Decision should be held in the persons Case Notes
Assisting a person	In this situation the patient will exercise varying degrees of responsibility for taking their own medication, and staff will need to provide varying degrees of assistance short of full administration.
Competent Assessor	A nominated person e.g. a social worker or a care manager who is setting up a care package. A care service provider may assess a person to ensure that they are able to meet the needs of the person/ whether the care package is appropriate.
Formal Carer /care worker	Paid carers e.g. carers employed by the service. These carers have defined responsibilities set within their own organisation's policies and procedures. Can include paid Support Workers in some settings.
Homely remedies	Medicines that have **not** been prescribed but that have been purchased.
Informal Carer	Unpaid carers e.g. relatives / neighbour - may or may not be related to the patient.
Medicine/medication / drug	Any medicinal product prescribed for the purpose of treatment or prevention of any condition, disease or illness, including drugs, vaccines, dressings and wound care products.
Primary Health Care Team	E.g. nurse, physiotherapist, pharmacist etc
Self administration	In this situation the patient has been risk assessed as being able to manage their own medication.
Person /person	A person receiving services irrespective of the environment in which they are residing.
Vicarious Liability	Vicarious liability is liability of one person for the acts or omissions of another. The most frequent form of vicarious liability is that of an employer for the acts and omissions of an employee.

Appendix 2 Competency Assessment

Competency Framework for the Administration of Medication to Individuals

	Performance Criteria (What I have to do)	Examples / Evidence (How I do it)	Competent Yes / Not yet Date Observed	Comments / Further training needs identified	Carer signature	Assessor signature
	Prepare to administer medication to individuals					
1	Routinely applies standard precautions for infection control and any other relevant health and safety measures	Washes hands before assisting with medicines. Wears gloves when helping with creams				
2	Checks all medication administration records are available, up to date, legible and understood.	Direct observation / discussion				
3	Reports any discrepancies, ambiguities or omissions to the line manager.	Specific incidents / possible questions / discussion				
4	Reads the medication administration record accurately, referring any illegible directions to the line manager before it is administered.	Specific incidents / possible questions / discussion Further information can be found in the medication Information leaflet.				
5	Checks that the individual has not taken any medication recently, and is aware of the appropriate timing of doses	Checks the administration record, confirms with the individual.				
6	Obtains the individual's consent and offers information, support and reassurance throughout, in a manner which encourages their co-operation and which is appropriate to their needs and concerns.	Direct observation / discussion with individual				

	Performance Criteria (What I have to do)	**Examples / Evidence (How I do it)**	**Competent Yes / Not yet**	**Comments / Further training needs identified**	**Carer signature**	**Assessor signature**
7	Checks the identity of the individual who is to receive the medication before it is administered, and selects, checks and prepares correctly the medication according to the medication administration record (T**he six rights**) The right person receives: ▸ the right medicine; ▸ the right dose; ▸ via the right route (method); ▸ at the right time; ▸ and ensuring the right record keeping.	Confidently and accurately: 1. Checks the individual's name matches that on the pack and on the administration record. 2. Selects the medication, checking that the name on the pack matches that on the administration record. 3. Selects the correct dose, according to the pack and the administration record. 4. Selects the correct timing of the dose according to that on the pack and on the administration record 5. Selects the correct route of administration. 6. Records the actions on the MAR sheet.				

	Administer, report on and monitor individual's medication					
	Performance Criteria (What I have to do)	**Examples / Evidence (How I do it)**	**Competent Yes / Not yet**	**Comments / Further training needs identified**	**Carer signature**	**Assessor signature**
8	Selects the route for the administration of medication according to the care plan and the drug and prepares the individual appropriately	Offers a full glass of water with tablets and capsules. Ensures individual is sitting upright for oral medicines. Notes any special instructions, e.g. do not crush, allow to dissolve under the tongue etc				
9	Safely assists with the medication: ▸ following the written instructions and in line with legislation and local policies; ▸ in a way which minimises pain, discomfort and trauma to the individual.	Direct observation / discussion with individual.				
10	Reports any immediate problems appropriately	May include refusal, inability to take medication et				
11	Checks and confirms that the individual actually takes the medication	Direct observation				
12	Monitors the individual's condition throughout, recognises any obvious adverse effects and takes the appropriate action without delay	Adverse effects may include swelling, skin rash, fainting / giddiness, constipation, drowsiness. Checks medication information leaflet.				
13	Clearly and accurately enters relevant information in the correct records.	Accurately documents assistance given, doses refused or missed for other reasons				

Responsibility of Care Staff

Care staff have a responsibility to work within their areas of training and competence. They must not place themselves or the person at risk.
If they have any concerns they should contact their line manager in the first instance.

Glossary

1. **Individual:**
   Person who is being assisted with medication.

2. **Medication Administration Record** - Also known as the "Home Medication Record" and the "Administration Record":
   Form agreed by management to record the administration of medication

3. **Line Manager:**
   The person who directly manages the person giving the care

4. **Medication Information Leaflet:**
   Information leaflet supplied with the medication.

5. **Route for administration of medicines:**
   Whether medication is to be taken by mouth, inhaled, applied to the skin, given rectally, injected etc.

Manager's Comments:

Manager's Signature: **Date:**

Appendix 3 Medication Administration Authorisation

Assisting / Administration of Medication Authorisation (Please circle)

Name of person ……..……..

Address ……..……..…..
……..
……..

Please tick one the following options

☐ I give authorisation for Bournemouth Borough and Poole Borough Adult Services to arrange for a care worker **to assist me** with my medication as prescribed by my GP, dentist, nurse prescriber or other authorised healthcare professional. I also give authorisation for the care worker to assist me with non prescribed medication in accordance with the list of homely medicines.

☐ I give authorisation for Bournemouth Borough and Poole Borough Adult Services to arrange for a care worker **to administer** my medication as prescribed by my GP, dentist, nurse prescriber or other authorised healthcare professional. I also give authorisation for the care worker to assist me with non prescribed medication in accordance with the list of homely medicines.

☐ **I do not require** any assistance in assisting / administration (please circle) of my medication

The type of assistance I might need has been explained to me and is written on my care plan. I understand that the carer will always check that I give my permission before supporting me to take my medication. I also understand that I am free to refuse this assistance at any time.

I hereby give authorisation for information relating to the support given to me with my medication to be recorded.

Signature of person: ……..…….. **Date:** ……..……..……

NB. The person should only sign this form if they have the capacity to consent to assistance.

To be completed by the assessor:

Name of assessor: ……..……..……

Tel No: ……..……..…

Date of assessment: ……..……

(continued overleaf)

Either:

1. I have explained the assistance to be offered and believe that the person understands and consents to this assistance at the time of completing this form.

Signature of assessor: …….....

Or

2. I do not believe that the person understands and can consent to the assistance that is being offered at the time of completing this form.

It has been decided that **it is / it is not** (delete as appropriate) in the person's best interest for medication to be administered. The following people have contributed in making this decision.

(Include contact details and relationship to person)

……..……..……..

……..……..

…….……

Signature of assessor: …….…….....

If the person lacks capacity to consent, is there a welfare attorney (Lasting Power of Attorney) or a Deputy* in place? **Yes/No**
If yes, please give details:

Name: ……..……..

Contact Details: ……. …….……

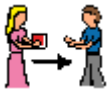
Does the attorney or Deputy consent to assistance with the administration of medication on behalf of the person? **Yes/No**

Signature of attorney/deputy: ……..…… **Date:** ……..…...

This authorisation should be kept on the person's file and a copy in their home.
*See Mental Capacity Act 2005 Code of Practice

Appendix 4 Pictorial Medication Administration Authorisation

Bournemouth Borough and Borough of Poole Adult Services


Medication Administration Authorisation

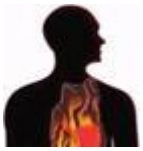


I will let a care worker help me with my medication.


Medication from my Doctor, or a homely remedy e.g. ;

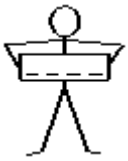






Simple Linctus, Senna, E-45, Paracetamol, Gaviscon

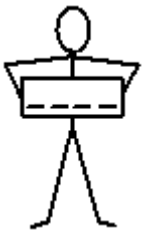

If my medication changes, I will have to sign another form.



Name of person ……

Address of person ……

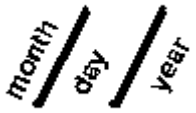
Signature of person ……



Name of assessor ……..

Signature of assessor …….

Contact number ……..



Date of assessment ……..

Name of GP ……..

Appendix 5 Letter informing GP of service input

Date

Dear *Doctor*

Please be advised that _____ care service are

Assisting / administering* medication for the following Person.
**(Delete as appropriate)*

Insert person's name

Please sign and return the counterfoil to acknowledge that you have been informed of the action we are taking. Please retain a copy for your records.

Yours sincerely

Care Manager

I have been advised by_____ that the care staff are Assisting / administering* medication for *person's name* whose details are attached.
**(Delete as appropriate)*

Print name: ……

Signature: …….. Date: ……

Practice Stamp

Appendix 6 Signature record sheet

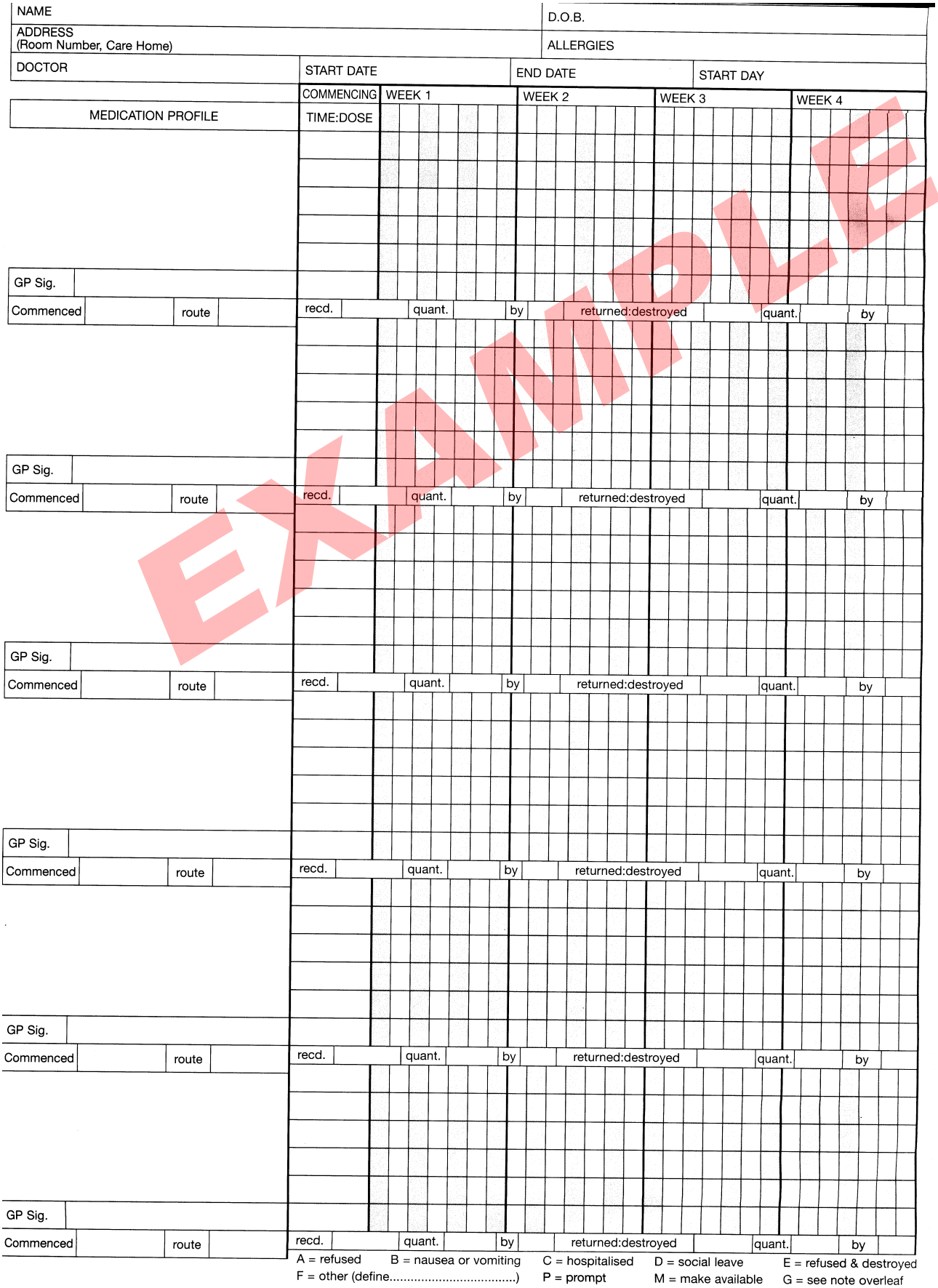
Signature record sheet

To be completed by any member of staff who administers medication or is involved with the completion of a MAR sheet.

Date	Name	Sign name	Initials

To be kept in the provider office.

Appendix 7 Example of a Medicines Administration Record (MAR) chart



NAME | D.O.B.

ADDRESS (Room Number, Care Home) | ALLERGIES

DOCTOR | START DATE | END DATE | START DAY

MEDICATION PROFILE | COMMENCING | WEEK 1 | WEEK 2 | WEEK 3 | WEEK 4

TIME:DOSE

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

GP Sig.

Commenced | route | recd. | quant. | by | returned:destroyed | quant. | by

A = refused B = nausea or vomiting C = hospitalised D = social leave E = refused & destroyed

F = other (define.....) P = prompt M = make available G = see note overleaf

Appendix 8 Controlled Drugs storage requirements.

Schedule 2:

CD	Brand names	Legal Requirements
Morphine	MST	• Store in a CD cupboard • Record in the CD register. **(** Oramorph** oral solution **10mg/5ml** is not a controlled drug. However, CD storage and CD records are a good practice recommendation.)
	Zomorph	
	Oramorph Concentrated oral solution **100mg/5ml **	
	MXL	
Dexamphetamine	Dexedrine	
Diamorphine		
Pethidine		
Methadone	Physeptone	
Methylphenidate	Ritalin, Concerta XL	
Oxycodone	OxyNorm OxyContin	
Fentanyl	Durogesic, Matrifen, Fentalis	

Schedule 3:

CD	Brand names	Legal Requirements
Buprenorphine	Temgesic, BuTrans, Subutex, Transtec	• Buprenorphine and Temazepam must be stored in a CD cupboard. Other schedule 3 controlled drugs do not need CD storage. None of the controlled drugs in this schedule need to be recorded in the CD register but this is a good practice recommendation.
Temazepam		
Pentazocine tablets	Fortral	
Midazolam	Hypnovel	
Phenobarbital Tramadol		• No legal requirements for storage

Schedule 4:

CD	Brand names	Legal Requirements
Diazepam	Valium	• No legal requirements for storage

Appendix 9 Homely remedies record form

To be administered for a maximum of 48 Hours before Contacting the Person's G.P.

Name:					**D.O.B.**
Address:					
					Allergies:
G.P.					
Date:	**Time:**	**Initials:**	**Medication:**	**Dose:**	**Reason:**

Appendix 10 Example of Home Remedies List

Drug	Use	Dose	Precautions
Paracetamol tablets and capsules	Mild pain relief Feverishness	1 or 2 tablets to be taken every 4 – 6 hours when required. Maximum of 8 in 24 Hours. Leave at least 4 Hours between Doses.	Liver or kidney disease. Alcohol dependence Person already taking a paracetamol containing product e. g. Co-codamol
Simple Linctus	Dry – irritating cough Sore throat	5ml to be taken three or four times a day	Diabetic – use sugar free version Liver disease May cause headache, upset stomach, diarrhoea
Gaviscon Advance Liquid	Heartburn and acid indigestion	5-10ml (one to two 5ml spoonfuls) after meals and at bedtime	Low sodium diet Avoid taking at the same time as other medication especially special coated formulations, antibiotics, Digoxin. Check with Pharmacist first
Strepsils Lozenges	Sore throat	Dissolve one lozenge slowly in the mouth every 2 to 3 hours. Maximum of 12 in 24 hours	Diabetic Allergic to aspirin
Senna Tablets (Sennakot)	Mild constipation	Take 2 tablets at night. Maximum of 2 in 24 hours.	May cause mild stomach pains. May also colour the urine or stools

I agree to the above list of home remedies being prescribed at the discretion of the trained member of staff for my residents currently residing at …… **For the period of 48 Hours.**

Signed…… Date……Review Date……

Doctor ……Practice …….

Appendix 11 Incident Report Form – Medication Key Prompts

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

About the Incident

- When did the incident occur?
- When was the incident discovered?
- Who was involved?
- Has the person / next of kin been informed?

What was the error?

- Wrong person
- Wrong medicine
- Wrong amount given
- Wrong strength
- Wrong form
- Medicine not given
- Medicine out of date
- Recording error
- Wrong Time
- Prescription error
- Pharmacy error
- other

Brief description of the circumstances/ what do you think went wrong?

- interruption by another member of staff
- Medicine poorly labelled
- Administration of medicine not recorded by previous carer
- interruption by the person
- interruption by another person
- phone ringing

Who did you contact?

- Did you contact the GP / Pharmacist / NHS Direct /Out of Hours GP Service?
- Did you contact your line manager?
- When did you contact the above for advice?
- What advice was given?
- Did you act on the advice given?
- Was any medical treatment necessary?
- Did you / service manager inform the patient?
- Did you contact a relative / carer if the person consented?
- Does the person wish to take the matter further?

Action taken to prevent a reoccurrence?

- Review of systems / procedures
- Employee training
- Medication review
- Separating the products
- Photos of persons
- Adjustment of staffing levels to meet the needs of the service
- Two members of staff to administer medicines especially if complicated regimen.

Appendix 12 Disposal of Medication (care homes, day centres etc)

Date	Person Name	Name, form and strength of medicine	Quantity	Signature	Signature

Accepted by: ……

Pharmacist: ……

Date: ……

Appendix 13 Disposal of medication (domiciliary care)

Removal of Old/Unused Medicines
I give consent for the removal of the following medicines for disposal:

Drug Name	Strength	Quantity

Patient Name: ……

Patient/Carer signature: ……

Date: ……

Removed by: ……..

Print name: ……

Pharmacists Signature: ……..

Pharmacy: Checked/Unchecked