

WARRINGTON

MEDICATION GUIDELINES FOR

NURSING & RESIDENTIAL HOMES

POLICIES & PROCEDURES

2018

Updated:2018

Review Date: 2021

CONTENTS

SECTION 1

Page No

Acknowledgement	6
Introduction	6
Responsibilities (also see Section 6 - Training, Delegating Tasks & Competency)	7
Nursing Care in Care Homes	7
Health Care Responsibility	8
Medication Reviews	9
Confidentiality	9
New Admissions	9
Safeguarding	10

SECTION 2

Consent	11
Process of Seeking Consent	11
Consent and Capacity – Needing help with managing medicines	11
Service Users with Capacity	12
Withdrawal of Consent	12
Religious/Cultural/Ethnicity & Diversity Decisions	12
Informed Consent	13
Mental Capacity	13
Advance Decisions	13
Best Interests	14
Covert Administration of Medication see also appendix 20	14

Self Administration of Medicines	15

SECTION 3

Medication Records - MAR, Access & Retention of Records	17
Administration of Medicines	20
Regular Medicines	21
When Required Medicines (PRN)	21
Oral Medicines	22
Crushing Medication	24
Splitting or Halving Tablets and Opening Capsules	24
Suppositories	24
Administration of Buccal Medication	24
Dressings	25
Administration of Medications by use of an Inhaler	25
Changes to or Discontinuation of Medication	25
Telephone Instructions	25
Monitored Dosage Systems	26
Temporary Absence from Home & Respite Stays	26
Anticipatory Medication for End of Life Care	27

SECTION 4

Storage of Medication	28
Medication Refrigerator	28
Medication Trolley	29
Ordering & Checking Supplies	30
Disposing of Medicines	31
Audit of Medication Procedures	31
Homely Remedies & Over the Counter Procedure see also Appendix 21	32

Controlled Drugs	33
Controlled drugs schedules	34
Stock Control, Recording & Administration of Controlled Drugs	34
Service Users Self-Administering Controlled Drugs	37
Disposal of Controlled Drugs	37
Record Keeping & Discrepancies in Controlled Drugs	37

SECTION 5

Communication	38
Providing Information to Service Users & Families	38
Updating Changes	38
Moving between Providers	38
Sharing Information & Security of Data	39

SECTION 6

Training & Competency	40
Delegation of Care Tasks	40
Responding to Incidents: Medication Administration Errors, Adverse Drug Reactions, MHRA Alerts, Losses of Medicines and/or Medicine Keys	41
Illicit drugs in the Home	43

SECTION 7

Guidelines for people working with severe learning disabilities	45
---	----

APPENDICES

1	References & Links	49
2	Glossary of Terms	51
3	Abbreviations used in Writing Prescriptions	53
4	Specimen Signatures	54
5	Homely Remedies Policy	56
6	Fridge Monitoring Chart	73
7	Example MAR Chart	76
8	Warfarin & Other Anti-Coagulants	78
9	Administering Buccal Medication (Medicines that Dissolve in the Mouth)	79
10	Application of Compression (elastic) Hosiery	80
11	GTN Spray / Tablets (Glyceryl Trinitrate)	83
12	Instillation of Eye Drops / Eye Ointment	85
13	Instillation of ear drops	87
14	Guidelines for the Administration of Nasal Drops	89
15	Guidelines for External Application of Creams, Ointments and Gels including Fire Risk Guidance	94
16	Guidelines on Use of an Inhaler	98
17	Guidelines for Use of a Nebuliser	100
18	Guidelines for Oxygen Therapy	104
19	Administration of a Topical Patch	106
20	Warrington Borough Council Medication Errors Policy	109
21	Covert Medication Policy	116
22	Adrenalin Autoinjectors (AAI's or Epipens)	127
23	Thickening products for use in dysphagia	129

SECTION 1

ACKNOWLEDGEMENT

1. Warrington Borough Council Families & Wellbeing Directorate and Warrington Clinical Commissioning Group wish to thank members of the working group for the sterling work they did to undertake the review of the Medication and Policy and Procedures.
2. Many organisations and agencies were given the opportunity to comment on the content of the revised document and we would like to thank all those individuals and organisations that took part.
3. An expression of appreciation is also given to those individuals who provided clinical, legal, practice, technical, clerical and advice and support to the group.

INTRODUCTION

4. This document is based on the NICE guidance for the control, storage, administration, and disposal of medication in residential care homes, domiciliary, and day care services for older people, Managing Medicines in Care Homes (2014). The appropriate recommendations have been referenced throughout the document.
5. The Care Quality Commission has produced guidance for care homes providing nursing care. These are the Fundamental Standards of Care (April 2015)
6. See also NICE guidance 'New standards to help care homes manage medicines safely and prevent falls in older people.'
7. The document takes into account statutory requirements and guidance issued by various official bodies, including the Department of Health, Nursing and Midwifery Council (NMC), the Royal Pharmaceutical Society and United Kingdom Home Care Association and Social Care Institute for Excellence (SCIE).
8. **If in doubt about any matter appertaining to medicines, the registered person should contact the relevant GP, community pharmacist or care home pharmacy team.**
9. Where appropriate, this policy refers to the current Warrington Borough Council Domicilliary Care Services Medication Policy (2014).
10. The term 'care home' refers to both residential andresidential with nursing homes.
11. For convenience and by custom the feminine pronoun is used throughout to refer to officers and the male pronoun to doctors and service users. All statements can refer equally to men and women.The use of the terms 'service user' and 'resident' are interchangeable.

RESPONSIBILITY

12. The responsibilities of the registered manager are clearly stated, in the relevant Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Regulations 2014 with regard to:

- Making arrangements for service users to receive medical services
- Making suitable arrangements for the recording, safe-keeping, handling, administration and disposal of drugs
- Making arrangements for the service to be conducted in such a way as to make proper provision for the care, welfare, treatment and safety of service users
- Making suitable arrangements to ensure that the care home or agency is conducted in a manner which respects the privacy and dignity of service users
- Notifying the Care Quality Commission of events which affect the wellbeing of any service user [Recommendation 1.3.3.]

13. Where we refer to “responsible persons” this is the person within your organisation who is the “nominated individual” with the CQC. [Recommendation 1.1.1]

14. The current legislation that covers the administration and control of medicines in care homes is:

- The Medicines Act 1968
- The Misuse of Drugs Act 1971
- The Misuse of Drugs (Safe Custody) (Amended) Regulations 2007
- Health and Social Care Act 2008 (Regulations 2010)
- Health Act 2006
- Duthrie Report 2005
- COSHH Regulations 2015
- Mental Capacity Act 2005

NURSING CARE IN RESIDENTIAL CARE HOMES

15. The care provided in a residential care home is limited to that appropriate to a care home setting.

16. The provider should satisfy themselves that they can meet a person’s needs and that they can demonstrate how they do this, before admitting or re-admitting any person to a care home who requires:

- Any form of artificial feeding
- The administration of any form of rectal solution

17. The staff of a residential care home are not expected to provide the professional kind of health care that is properly the function of the Primary Health Care Services. Homes registered as nursing should be able to provide this level of care.

18. The staff of a residential care home are not expected to provide the professional kind of health care that is properly the function of the Primary Health Care Services. Homes registered as nursing should be able to provide this level of care.

19. There are procedures and aspects of care which are the responsibility of the Primary Health Care Team but which, with the appropriate process in place, can be delegated to a competent and confident member of staff. Providers must ensure that staff are not only competent but appropriately insured for specific tasks they undertake.
20. These include topical patch administration, ear drops, eye drops and nasal drops.
21. Where it is felt appropriate for this to occur, it is strongly recommended that:
22. New referrals, new admissions to the service, or existing service users who need some form of nursing care or treatment, must initially be referred, via the service users Primary Health Care Team, for a multidisciplinary assessment. This will result in a decision being made regarding the amount and type of nursing input that will be required to ensure that appropriate care and treatment is given. [Recommendation 1.3.3]
23. The training of staff in performing these delegated tasks is the responsibility of the Primary Health Care Team/community nursing team and should be carried out by the latter. Only when staff are deemed confident and competent with performing the delegated task will it be undertaken by care staff. (See Section 6.4 – 6.9 Training). [Recommendation 1.1.7].

HEALTH CARE RESPONSIBILITY

24. The following aspects of care/treatments/procedures remain the responsibility of the Primary Health Care Team/community nursing team and should not normally be performed by staff working in residential care homes that are not registered as care homes with nursing (refer to registration certificate issued by the Care Quality Commission).
25. The administration of:
 - Injections
 - Enemas
 - Suppositories
 - Pessaries
 - Rectal solutions
 - Artificial feeding methods
 - Diabetic injections
 - Blood glucose monitoring
 - Medicated dressings (leg ulcers, pressure sores etc)
26. There may be occasions, however, when this is not the case and these will be considered on an individual basis.
27. Also important and recommended are:
 - That to ensure the correct management of the service users care, documentation detailing the appropriate support and monitoring agreed by the Primary Health Care Team and care manager should be written in the service user's care plan. [Recommendations 1.14.12; 1.14.13]

- A record of consent to treatment, signed by the service user or his representative where an invasive procedure is to be performed (see Section 2.4). His representative must hold legal responsibility to make health and welfare decisions. (See Section 2 Consent) OR
- A record of best interest decision making with appropriate representation (See Section 2.29).

MEDICATION REVIEWS

28. It is recommended that medications prescribed for service users and the method of administration, should be reviewed annually or every 6 months for people over 75 on 4 or more medications. The frequency of review and who should undertake the review should be agreed and documented in the residents care notes. Reasons for a more frequent review may include:

- Entering the end of life phase
- A new diagnosis of a long term condition
- Needing frequent or complex monitoring
- New admission i.e. hospital discharge [Recommendations 1.8.2, 1.8.3, 1.8.4]

CONFIDENTIALITY

29. Care providers should follow the rules on confidentiality set out in the organisations policies and procedures on managing service users information.

30. Where information is shared using a fax this must be a safe haven one. Where information is shared using Information technology or text messaging there should be a process to ensure confidentiality is maintained. Care Providers should have a process for managing information governance covering the rules set out in the Health & Social Care Information Centres A Guide to Confidentiality in Health& Social Care (2013). [Recommendations 1.3.8 & 1.9.8]

NEW ADMISSIONS

31. The care home manager or person responsible for a service users transfer to the care setting should coordinate the accurate listing of all their medicines (medicines reconciliation) as part of a full needs assessment and care plan. They should also consider the resources needed to ensure that this occurs in a timely manner. This process should include an assessment for self-administration of medicines (see section 2) and the management of controlled drugs (see section 4).

32. The information that should be available for medicines reconciliation is:

- Full name, date of birth, NHS number, address, weight,
- GP details
- Other relevant contacts defined by the resident such as family, consultant, specialist nurse etc
- Known allergies or reactions to drugs ingredients and other substances and how these present
- All medicines currently being taken including name, strength, form, dose, timing and frequency, how taken and what for if known.
- Changes to medicines ie started, stopped, dose changed and reason

- Date and time of the last dose of any medication, including PRN and any given less often than once a day ie weekly or monthly
 - Other medication related information such as support needed to take it, review date or monitoring needed
 - Information on any monitoring requirements such as blood tests. This information should be requested by the provider where it has not been made available by the prescriber.
 - What information has been given to the service user/family or carers
 - The care provider should record the name and job title of the person completing the medicines reconciliation
- 33.** The care provider, prescriber and pharmacist should agree with the service user the best time to take their prescribed medicines. Care providers should contact the service users GP to check any allergies and intolerances to medication and ingredients and this information should be accurately recorded on the Medicines Administration Record and shared with the teams providing care to the service user. [Recommendations 1.3.3 & 1.7.3]

SAFEGUARDING

- 34.** Providers of health and social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents.
- 35.** Warrington Borough Council has a Medication Error Reporting procedure in place to ensure that incidents are signposted to the appropriate reporting route and ensures that care staff can contact a health professional so that action is taken to safeguard any service user involved in a medicines-related safeguarding incident. Care staff should follow the process agreed between health professionals and commissioners, which sets out who to contact in normal office hours and out of hours (See section 6 Responding to Incidents). [Recommendations 1.6.2 & 1.6.8]

SECTION 2

SEEKING CONSENT

1. Adults should always be presumed to be capable of taking healthcare decisions unless the opposite has been demonstrated. Age or frailty alone is not a reason for doubting a person's capability.
2. When administering medication staff should ensure they have the service user's consent to what they propose to do if they are able to give it.
3. This respect for service users rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement. DOH guidance, Seeking Consent 2002 updated 2009.
4. Reference Guide to Working with Older People 2001 and Mental Capacity Act (2005)

WHEN SHOULD CONSENT BE IN WRITING

PROCESS OF SEEKING CONSENT

5. Seeking consent should usually be seen as a process, not a one-off event. When seeking a service user's consent to treatment or care, time and support should be given to assist them to make their decision.
6. Independent advocates can be helpful if the service user feels they have a conflict of interest with their family or friends. [Recommendations 1.2 & 1.6]

CONSENT AND CAPACITY – NEEDING HELP WITH MANAGING MEDICINES

7. If the person has the capacity to consent to support being given, it is good practice to obtain their written consent and include this as part of the care plan.
8. They should be given easy-to-read information about the support available and time to think about and reflect on the decision.
9. A consent form should be seen as confirmation that this discussion has taken place; it should fully record what was said and show how the person was helped to make an informed decision. If the person chooses not to give consent staff must not administer medication. If the person has mental capacity but staff remain concerned about the person's ability to take medication without support, staff should carefully:
 - Explain any risks.
 - Together with the person and his or her doctor agree a plan to minimise the risks.
10. The person's consent, or decision not to give consent, must be noted in their care/support plan and reviewed regularly or on any changes to the persons condition. Only the person

receiving the treatment can legally give consent . A family member or someone acting as 'next of kin' cannot give such authorisation, sign for it to happen or make the decision.

11. The person's consent, or decision not to give consent, must be noted in their care/support plan and reviewed regularly or on any changes to the persons condition. Only the person receiving the treatment can legally give consent . A family member or someone acting as 'next of kin' cannot give such authorisation, sign for it to happen or make the decision.
12. Service users with capacity are entitled to refuse the treatment being offered even if this is detrimental to their health. The only exception to this is when treatment is being provided for mental disorder under the terms of mental health legislation (in which case specialist advice from the care manager or an approved social worker should be sought). Detention under mental health legislation does not give a power to treat unrelated physical disorders without consent.

SERVICE USERS WITH CAPACITY

13. For a service user's consent to be valid, the person must be:
 - Capable of taking that particular decision
 - Give consent voluntarily (not under pressure or duress from anyone)
14. The social worker and care manager (mental health) must be advised immediately if a service user with a mental disorder refuses treatment.

WITHDRAWAL OF CONSENT

15. Service users who have capacity and have given their consent to a particular intervention are entitled to change their minds and withdraw their consent at any time. Similarly, they can change their mind and consent to an intervention, which they have earlier refused.
16. The service user should be made aware of these rights to enable them to feel able to change their mind and staff involved in their care or treatment should record these changes on their record sheet and advise the care manager, community nurse or GP involved in their care.

RELIGIOUS/CULTURAL/ETHNICITY & DIVERSITY DECISIONS

17. Service users are entitled to make a decision on consent to health or personal care based on their own religious belief or value system even if the decision is perceived by others to be irrational. Staff should never try to coerce the service user into changing their decision. Seeking consent is about assisting the service user to make their own informed choice e.g. communication problems – a service user or care worker may not have English as a first language and so an interpreter may need to be accessed.
18. The service user should be supported to observe religious festivals by fasting and the timing of their medication may need to be reviewed.
19. Some medication may contain animal products and this should be considered if a service user is vegetarian.

INFORMED CONSENT

- 20.** Service users need information before they can make a decision to consent to, or refuse treatment. They need information about:
- What the treatment will involve
 - The benefits and the risks of the proposed treatment
 - What are the implications of not having the treatment
 - What alternative may be available
 - What the practical effect on their lives of having, or not having the treatment will be.
- 21.** This information should be provided by the prescriber in a form that the service user understands. If the service user's first language is not English, an interpreter should translate the information. More information about the medicines prescribed is available from the pharmacy should the service user require it at any time.
- 22.** Information should be presented in a manner that respects the service user's privacy and dignity. An appropriate private place should be used to discuss confidential matters.

MENTAL CAPACITY

- 23.** The Mental Capacity Act 2005 is quite clear that the starting premise for all individuals is the presumption of capacity.
- 24.** If there are doubts about whether a person has the mental capacity to make medication related informed decisions, the principles of the Mental Capacity Act (2005) should be implemented. [Recommendation 1.2]

ADVANCE DECISION TO REFUSE TREATMENT

- 25.** If a service user is not capable of giving or refusing consent, it is still possible for staff to lawfully provide treatment and care unless such care has been validly refused in advance. Such views may have been expressed verbally or in writing as 'advance directives' or 'living wills'. If the treatment being refused is life sustaining, this must be in writing and follow the legal guidelines for advance decisions to refuse treatment.
- 26.** If the service user makes an advance refusal of certain kinds of treatment, then such a refusal is legally binding, if at the time of making the decision, the service user was:
- Deemed competent
 - Over 18
 - The person has not subsequently done anything that suggests they may have changed their mind i.e. stated they do not wish hospital treatment then presented themselves at accident & emergency.
 - The refusal is applicable to their current situation
 - They understood the implication of their decision

27. Advance care plans setting out the kind of care the person would like to receive are not legally binding, but should be influential when deciding what treatment is in the service users best interests.
28. The original copies of these documents should be retained by the service user if at home or in their care notes if in a care setting. A copy should be forwarded to the domiciliary care agency if appropriate. The presence of this document should be clearly noted on the service user's health file and relevant staff fully briefed to ensure their wish is respected.

BEST INTERESTS

29. No one can give consent on behalf of a service user who does not have capacity unless they have Power of Attorney for health and welfare. However, they may still be treated if the treatment would be in their 'best interests'.
30. 'Best Interests' decision making can include factors such as the persons wishes and beliefs when competent, their current wishes, and their general well being and their spiritual and religious welfare.
31. People close to the service user may be able to give the care manager information on some of these factors. Where the service user has never had capacity, relatives, carers, friends, advocates may be best placed to advise on the service user's needs and preferences.
32. Any Best Interests decision making process and outcomes must be fully documented in the care records.

COVERT ADMINISTRATION OF MEDICATION

33. Covert administration applies to the administration of medication to service users who are refusing to take tablets, or liquid medication when openly presented to them and for whom medication is then administered in food or other substances without their consent or knowledge, as a best interests decision.
34. **See Covert Medication Policy which gives guidance on:**
 - Service users able to give consent
 - Service users with capacity who are refusing medication administered in the usual way
 - Service users unable to give consent
 - The Legal Position
 - Multidisciplinary Assessment
 - Crushing Medication
 - [Recommendation 1.15]

SELF ADMINISTRATION OF MEDICINES

- 35.** It is important to stress that the first priority is the person's wishes. Residents are free to choose whether or not to keep and take medicines themselves. This important element of choice promotes independence and dignity.
- 36.** If care homes chiefly promote administration of medicines by care home staff, this can lead to a loss of independence and control for the resident and they may not be aware of the support that can be offered to them. The starting point for medicines management should be that service users are enabled to retain control of their own medicines or as a minimum be involved in managing their medicines (in accordance with their abilities and wishes). Care homes should assess any risk to the person who looks after his/her own medicines and the potential risk to other people in the care home. This assessment must be reviewed regularly.
- 37.** Care home staff should identify whether people who are confused or lack cognitive awareness can safely keep and take their own medicines. The Mental Capacity Act and linked Code of Practice are key documents to consider.
- 38.** Part of the risk management strategy includes providing residents with somewhere secure (lockable) to keep the medicines in their own rooms.
- 39.** Prescription medication belongs to the person they were supplied for, as identified on the label. The care agency/home does not own them even though staff may request and take receipt of medication. They should never be used for other patients.
- 40.** Whenever possible and safe to do so, service users should be encouraged to take responsibility for the care and administration of their own medication. This could be all or some of their medication for oral administration, topical preparations, insulin injection etc.
- 41.** On admission to a care home, a service user who has been looking after his own medication at home should normally continue to do so, within the boundaries of risk assessment and management and if this is their wish. This assessment should also consider how it affects the safety of other service users in the home
- 42.** Prior to admission a care manager and doctor should discuss self-medication with the service user. If all three are in agreement:
 - A self-medication assessment form should be completed and signed by the care manager/assessor and service user A medication administration record must be completed in the normal way, but endorsed 'self-medicating'
 - Where a service user wishes to be responsible for the care and administration of some medication but not others, this must also be clearly recorded and reviewed regularly.
 - It is not necessary for members of staff to record the administration of medication endorsed 'self-medicating'. It is advisable, however, that the date and quantity given to the service user for self-administration be recorded
 - Some service users may find it helpful to keep their own record of administration separate from the official home record

- 43.** The community pharmacy supplying medication should be approached for help where the service user needs advice or information on his/her medication, or needs them packing in a certain way, e.g. in bottles without child-resistant caps, in medication aids or in small quantities or print large labels.
- 44.** In a care home the service user must be advised on the need for secure storage of medication and be provided with a suitable storage area, e.g. lockable drawer or cupboard in their bedroom and be provided with a key for their personal use.
- 45.** If the service user carries his medication with him during the day, he must be counselled on the need to be responsible for its safety and security. It may be appropriate for a service user to carry his medication with him, for example, in the case of an inhaler, angina treatment, or where he does not wish to go to his room to obtain or take his medication.
- 46.** It is advisable (with their permission) that the service user's medication is checked regularly at intervals not exceeding a week to ensure that the service user is coping with them. Tablet counts and discussions will be helpful. If the service user declines to co-operate with this level of monitoring it should be noted on their self medication assessment form and their senior carer or named nurse should be informed. This monitoring should be noted on the administration record and if appropriate, in the service user's care plan. The outcome of the weekly monitoring should also be recorded in the care plan.
- 47.** Where service users or their relatives/visitors purchase medication for personal use, they should be encouraged to keep staff informed. The manager may need to seek advice of the pharmacist or doctor to avoid any problems of interaction or overdose (See section 4.36 Homely Remedies).
- 48.** There must be a regular review (every three months or sooner if necessary) of the service user's ability to be responsible for the care and administration of his own medication and a copy of this must be retained on the service user's personal file.
- 49.** This review process should be recorded. If no change is necessary, this should also be recorded. Should any problems regarding the service user's ability to self-medicate become apparent, that cannot be resolved by the care home, then a referral may be made to the prescriber who will assess and advise appropriate action.
- 50.** It may be necessary for staff to take over the administration of medication during periods of acute illness or permanently if the service user's condition deteriorates. If staff take over the administration of medication, the change must be recorded in the care plan and a Medication Administration Record Chart be prepared and maintained.
- 51.** Under no circumstances should medication be held for staff or administered to staff.

SECTION 3

MEDICATION RECORDS

1. The following records relating to medication must be kept if care staff are assisting in the administration of service users medication.
 - All medication received by the care home.

2. All medication prescribed for the service user.
 - All medication returned to the pharmacist by staff for disposal or transferred out of the home (see section 4.15, 4.16).

3. Medication records should be properly completed in permanent black ink, legible and current. This can be via an electronic system. Gel pens should not be used.

4. There is a statutory requirement for a system of recording medication administered by staff to be operated in all care services. All medicines brought into a care home from whatever source, including a hospital should be recorded on the service user's Medical Administration Record (MAR) chart. This is a working document and should be approved by the registration authority. The date and time medicines arrive at the home should be recorded, **as well as** the date and time medicines are checked in.

5. The MAR must be a record of medicines currently prescribed for each person. These should be signed on the MAR when they are given:
 - It is also important to keep a record when a prescribed medicine has not been given. Differing 'codes' are used to record when medicines have not been given. The MAR must explain what the codes mean. Care must be taken if changing pharmacy supplier as the codes used by different pharmacies may be different.
 - The information on the MAR will be supplemented by the person's care plan. The care plan will include personal preferences, including issues such as should the care worker who gives the medicines be the same sex as the person.
 - The MAR can be a very useful tool for the care provider to use to keep track of medicines that are not ordered every month but only taken occasionally. The provider should use the MAR to record medicines carried over onto a new chart.
 - The MAR should be used to record when non-prescribed medicines are given, for example a homely remedy.
 - Administration of controlled drugs should be recorded on the person's MAR chart as well as the record in the controlled drug (CD) register.
 - Responsibility for providing MAR charts rests with the care provider. The pharmacist or prescribing GP are not responsible.
 - A GP does not have to sign any documents produced by a care provider for medicine administration. The NHS contract for general medical services (GMS) does not require this. There are exceptions when a care provider has a private contract with a GP for medical services that exceed GMS.
 - There are some occasions when it would be appropriate to ask the GP to sign the MAR chart, for example when the doctor visits and changes the dose of a prescribed medicine.

6. Poor records are a potential cause of preventable drug errors. Printed MAR charts are not essential but they are better than handwritten charts. This is because there is less risk of error due to:
 - Clerical error - incorrectly transcribing the details from another document
 - Hand writing that is difficult to read and can be misunderstood.
7. Example: The change of insulin dose for a resident was communicated verbally to staff and then hand written onto the MAR. The instruction was to give 4 units of insulin at night. The nurse who took the message wrote ' 4 i.u.' on the chart (i.u. is an abbreviation for international units). But another nurse misread the dose and gave 41 units of insulin.
8. Ideally, MAR charts should be printed by the community pharmacy. In emergency situations it may be necessary for care staff to write out the MAR chart. In these circumstances writing must be in black ink (not gel pen) and the hand-written chart must be checked against the medication received and endorsed to say it is correct.
 - If a handwritten MAR is the only available option, there MUST be a robust system to check that the MAR is correct before it is used.
 - Printed MAR charts are usually supplied from the pharmacy or prescribing GP practice when medicines are packaged in monitored dosage systems such as Manrex, Venalink and Nomad. This is a complimentary service that the supplier is paying for. Care providers cannot insist on having printed charts.
9. The MAR chart shall contain and specify:
 - a) The service user's full and PREFERRED name
 - b) The service user's date of birth
 - c) The name of the service user's doctor
 - d) The name of the medication and the date the medication was prescribed.
 - e) The quantity and dose of medication to be administered
 - f) The form the medication should take (e.g. tablet, eye drop, topical cream)
 - g) The time or times of day at which the medicines should be given.
 - h) The date and times the medication was administered and the signature of the administering person.
 - h) The route of administration and site of administration (e.g. oral or where it must be applied on the body accompanied by body chart if necessary)
 - i) Where the prescriber intends the dose to be within certain limits (e.g. one or two tablets) this must be clearly indicated within the instructions as written on the MAR chart. The dose actually given on each administration must be noted on the MAR chart.
 - j) The site of application or special treatment (e.g. to eczema, to left eye etc);
 - k) Details of any known hypersensitivity (e.g. allergy to Penicillin) should be noted clearly on the MAR chart
 - l) Any special requirements, e.g. with food (diabetic etc) should also be noted clearly on the MAR chart and the service user's care plan
 - m) Any information provided by the pharmacist on foods which might react with the prescribed medicines, including preparations for external use should be noted clearly on the MAR chart

- n) Details of any homely remedies taken by the service user.
- o) Details of any exclusion from receiving homely remedies (in red or highlighted).
- p) Details of any short term medication i.e. antibiotics (this may be hand written onto the MAR chart, see point 8).
- q) Medication declined by the service user and reason for refusal if known.
- r) If more than one MAR chart is being used, care staff MUST number consecutive sheets i.e. 1 of 1, 1 of 2 etc.

10. Once a medication round has been completed, the MAR charts should be returned to a place of safe keeping in a locked cabinet or drawer.

11. Problems associated with printed MAR charts that care providers need to be alert to:

- The chart is correct at the time it is printed and supplied. But the dose of a medicine may change at some point. When this happens, the care provider must keep the chart up to date.
- New prescriptions can be issued at any time in the monthly cycle. This may result in the person having several MAR charts in a file, and some may start on different dates.
- Medicines that are prescribed for 'as required' use may not be needed every month. If the MAR chart only has a list of medicines that have been requested and prescribed that month, it may not list the 'as required' medicines previously supplied for that person.
- The MAR chart should be supplemented by information that clearly describes the circumstances when 'as required' medicine may safely be given i.e. a PRN protocol.
- The MAR chart may include a medicine that has not been supplied. The care provider must check whether the prescriber has stopped the medicine and if so cross it off the chart, date and sign. If the treatment is to continue, the care provider must check why there is no supply.

WRITING ON THE MAR CHART:

12. The care provider should have a system to check the source and accuracy of changes to a MAR chart. A cross reference to the daily notes is recommended.

13. When a resident's medication is altered, care staff are responsible for amending the MAR chart:

- Cancel the original direction
- Write the new directions legibly and in ink on a new line of the MAR chart
- Write the name of the doctor or other prescriber who gave the new instructions
- Date the entry and sign (including a witness when this is possible).

14. If the GP issues a new written prescription there should be a new MAR chart. But a new prescription is not always necessary.

15. Example: Mr Brown has been taking 2 furosemide tablets (40mg) each morning. At the medication review the GP decides that this can be reduced to one tablet each morning. Mr Brown has a good supply of furosemide 40mg. The doctor will record the change at the surgery so that when Mr Brown asks for a repeat prescription the new dose will be prescribed.

16. Medication Administration Record charts used in care homes and domiciliary care look similar to 'prescription' charts used in hospitals but they are not equivalent to the prescription

chart. The MAR chart is only a record of what care workers administer to people who use care services and belongs to the care provider. It is not a chart for prescribing medicines. [Reference 1.14]

SPECIMEN SIGNATURES

17. A list of specimen signatures of staff administering medication should be held in the medication file, a copy should also be retained by the registered manager. This should be kept up to date. (see Appendix 4).

ACCESS TO RECORDS

18. The record of medication taken, including homely remedies, should be made available to visiting health and social care professionals.

RETENTION OF RECORDS

19. When the medication administration record is fully completed, a fresh Medication Record chart should be used and the completed form should be retained for a minimum period of 3 years.[Reference 1.4]

ADMINISTRATION OF MEDICINES

20. Medication must be administered to service users only in accordance with the written instructions of a medical or nurse practitioner. See section 4 of this document for guidance on the administration of 'Homely Remedies'.
21. Medication must not be administered to a service user unless it is an identified task on their care plan or is one of the Homely Remedies held by the organisation.
22. The registered manager of a nursing/residential care setting must take all reasonable steps to ensure that at all times the storage, administration and disposal of medication are strictly controlled and that safety, efficacy and accuracy are maintained with respect to:
 - The right person
 - The right route
 - The right dose
 - The right form - e.g. tablet or cream
 - The right time
 - The right to refuse medication
23. Administration is defined as physically assisting a service user to take their medication. In circumstances where a service user has capacity and is unable to self-administer medication due to a physical disability, the medication may be placed in their mouth following assessment and the task is clearly indicated on their individual care plan. Pharmacy advice should be sought in these circumstances, as aids are available to assist service users.

REGULAR MEDICINES

24. Medication that is intended to be given regularly should be given as prescribed at the times specified, until the prescription is cancelled or instructions are given to the contrary by the prescriber.
25. Treatment should be kept under regular review and the prescriber should be contacted if there is evidence that this is no longer indicated.
26. When the Medication Record Chart has been filled, a fresh administration record sheet (provided by the pharmacist) should be used.
27. Service users discharged from hospital may have medication that differs from those retained in the home prior to admission. The care provider must ensure that the correct current medication is available at the point of discharge to the home.
28. Abbreviations frequently used by prescribing professionals are to be found in Appendix 3 . [Reference 1.14]
29. New prescriptions should be checked against allergy information and the prescriber contacted if there are any queries.

'WHEN REQUIRED' MEDICINES (PRN)

30. 'As before' or 'as directed' are not acceptable instructions and should be replaced by specific instructions as to when medication should be taken. The prescriber or community pharmacist must be contacted for detailed instructions for use.
31. PRN or 'as required' medication may be administered under the direction of the GP/Prescriber with a detailed care plan in place.
32. All PRN or 'as required' medication must have the following clearly documented on a PRN protocol or similar:
 - a) The maximum dose & frequency over a 24-hour period & where the dose is in a range i.e 1 to 2 tablets.
 - b) The minimum interval between doses
 - c) The reason for the treatment (e.g. for nausea or headache) See also Section 7.
 - d) Any alternative actions to be considered before administering medication to ensure it is a last resort where appropriate.
 - e) A review date agreed by the prescriber.
33. When the service user is being administered PRN medication on a regular basis, care staff should refer to the prescriber.
34. If the instructions are not clear, the help of the doctor, practice pharmacist, community pharmacist or the medicines management team **must** be sought prior to any administration. [Recommendation 1.14.3]

SHORT TERM MEDICATION

35. Short term courses of medication i.e. antibiotics, steroids, should have a short term care plan which describes the term, reason etc for the medication. Where these are urgent and cannot be obtained using the usual electronic process, it is the homes responsibility to obtain the script and the medication at the earliest opportunity. This may be from a local pharmacy rather than the one the organisation usually uses for regular medicines.

THE 'MEDICINE ROUND'

36 .Staff conducting a medication round **MUST NOT** ask other staff to give medication that they have prepared. This is considered to be secondary dispensing and the use of 'runners' is unacceptable and deemed to be bad practice in any circumstances.

37.It is not permissible for medication to be put out for service users to take themselves at a later time.

38. If the prescriber changes the instructions,a new prescription may need to be obtained from them.

39.It is advantageous for all of the routine medication to be obtained from one particular community pharmacy (urgent acute prescriptions may need to be accessed from other pharmacies if this is the quickest route).

40. If the service user leaves the home to live elsewhere they may take with them the medication in use, which has been prescribed.

41. Oral medication may be administered by a suitably trained member of staff who has satisfied the registered person of their competence and confidence in this area of responsibility.

42. Prescribed medication and pharmacy only products should be administered to the service user directly from the container in which they were supplied.

- Medication should not be decanted into other containers.
- Administration should only be from the container labelled with the service users name
- Where several medicines are to be administered to one service user, however, it may be convenient to collect these into a medication cup immediately prior to administration to that individual service user, in their presence

43. The recommended procedure for the safe administration of oral medication in a nursing or residential home is as follows:

- Identity of the service user should be established by asking them 'what is your name' or confirming their identity with another member of staff if the person does not have capacity or is unknown to you. A photograph of the service user, with their consent where possible,

should be kept with the MAR sheet and these should be reviewed at least 12 monthly or more regularly where there are any changes.

- Ensure that the dose has not already been administered (check on MAR chart, ask the service user if appropriate, or a relative or other care worker)
- Take the medication and MAR chart to the service user with a tumbler of water. Check they are ready to take their medication
- Check the instructions on the label against those on the MAR chart, including allergy information, especially if this is a new drug, or backing sheet on a monitored dosage system. Any discrepancy must be discussed with the pharmacist or doctor before administration. The label on dispensed medication should indicate:
 - The name of the service user
 - Name, form and strength of the medication
 - Date and amount supplied
 - Instructions for use
 - It may also indicate expiry date

44. The label on medication **MUST NOT BE CHANGED**. If it becomes detached or obliterated, the contents **MUST** be disposed of in accordance with the advice in the section on Disposal (See section 4.15, 4.16). The GP should be contacted and a fresh supply of medication obtained.

- If there are gaps or omissions on the MAR chart check why this has occurred before the medication is administered
- Any gaps or omissions or other discrepancies on the MAR Chart should be reported in accordance with internal quality assurance procedures.
- When there is a choice of dosage e.g. 1 or 2 tablets, record the number administered on the MAR chart
- Administer the medication, encouraging the service user to take tablets and capsules with water
- Administer liquid medication in a medication cup or oral syringe
- The person administering the medication should ensure the medication has been taken and under no circumstances should the medication be left with the service user to be taken later

45. **NOTE: Oral medicines should not be administered when the service user is lying down. The service user should be sitting upright, standing or lying with the head of the bed raised to a level to avoid choking. Where this is a concern a care plan should be in place to support safe administration.**

- Refusal to take medication, or omissions, should be recorded on the Medication Administration Record (MAR) with appropriate symbols indicated on the MAR chart provided by the pharmacy.
- Further explanation of omissions must be referred to and entered on the reverse of the medication sheet and/or the service user's care record. The entry should be dated and signed by the person administering the medication
- Where medication is omitted on a regular or frequent basis, the therapeutic benefit/risk to the service user should be considered and discussed with the GP/Prescriber in a timely manner.
- Any problems encountered, e.g. difficulty in swallowing, side effects, whether observed or mentioned by the service user, should be recorded on the service user's record sheet and brought to the attention of the doctor and the manager

- When the medication has been administered, the MAR chart must be initialled by the person administering it.
- Complete the MAR chart for one service user, before moving on to the next service user to administer his medication and complete that record
- Staff who fail to complete the MAR chart cannot complete this retrospectively but should record on the back of the MAR chart the reason for the omission in recording
- [Recommendations 1.11.3, 1.14.1,1.14.4, 1.14.5, 1.14.10, 1.14.13, 1.14.14, 1.14.15, 1.14.19]

CRUSHING MEDICATION

(See also policy relating to Covert Administration of Medication appendix 20) [Recommendation 1.15]

46. Crushing tablets and hiding in food is seen as Covert Medication.
- Crushing tablets must only be done where explicit instructions have been given in writing by the prescriber or pharmacist. This should be clearly documented in the service users care plan.
- 47. Staff must not crush tablets in order to make them easier to give to service users, without these instructions, for the following reasons:**
- It may change the way in which the tablet works within the body – this is especially pertinent if the tablets are a slow release formulation. It should also be noted that if the chemical compound is changed, the medication is no longer licensed.
 - If the service user has difficulty swallowing tablets then they may have difficulty in swallowing food as well. This may indicate an underlying problem requiring investigation. Medication in an alternative form should be explored with the prescriber or pharmacist
 - Crushing tablets may cause harm to staff. When a tablet is crushed it will give off an almost invisible cloud of microscopic particles. If these should settle on a staff members hands or face they may cause a skin rash or an allergic reaction. The person will then become sensitised to that drug possibly causing a reaction the next time they are exposed to the medication
 - Where it has been formally agreed that a tablet may be crushed, instructions should be clearly documented in the care plan including the prescribers/pharmacists advice about the need to wear appropriate personal protective clothing (gloves/apron).

SPLITTING OR HALVING TABLETS AND OPENING CAPSULES

48. Changing the way a tablet/capsule is administered can alter the performance, effectiveness or safety of a drug and so this should only be done where the prescriber or pharmacist has instructed that a capsule should be opened or a tablet should be halved. Where this instruction has been given, care staff can support a service user, who has the capacity to self-medicate (see section 2.31), to halve, split or open a capsule. This must have been discussed and agreed with the prescriber/pharmacist and care manager, have clearly documented administration instructions, and be written in the care plan.

49. If it has been formally agreed that a tablet may be halved, split or a capsule opened, staff should follow the prescribers/pharmacy advice about the need to wear appropriate personal protective clothing (gloves/apron) and how to perform the task. This information should be noted in the care plan.

SUPPOSITORIES

50. Only staff that are qualified, registered nurses or have been deemed competent by a community nurse, may administer suppositories. (See Section 6.4 – 6.9 Training). [Recommendation 1.1.7].

ADMINISTRATION OF BUCCAL MEDICATION (medication that dissolves in the mouth) (see appendix 10)

DRESSINGS

51. Staff may apply first aid dressings to minor injuries (small cuts or abrasions) i.e. plasters. The application and treatment must be recorded, at the time, on the service user's health records. These may be supplied by the provider or the service user and allergies should be checked before application.
52. Specialised dressings, e.g. for leg ulcers or pressure sores, where required in a residential setting, are the responsibility of the community nurse, and will not be delegated to care staff.
53. Should a specialised/medicated dressing fall off in a residential setting, prior to a community nurses visit, the care provider should have access to a supply of clean, dry dressings to cover the wound, the community nurse should be immediately advised and actions recorded in the service user's health records.
54. Where a care setting has qualified nurses on duty, they are responsible for tissue viability, risk assessment and care planning in relation to wound care and dressings. Where appropriate support should be sought from the Enhanced Care Home Support Service (ECHSS) who can then escalate to the local specialist tissue viability service.
55. Dressings should be in the local wound care formulary unless a tissue viability specialist has advised otherwise, be used as prescribed, be in date and not prescribed for other service users.
56. **Administration of medication by use of an inhaler (see appendix 17)**

CHANGES TO OR DISCONTINUATION OF MEDICATION

57. If the prescriber changes the instructions of a medication, a new prescription MAY need to be obtained from them.

58. The prescriber should ideally sign and date the discontinuation of medication or any changes to the service user's medication made following a domiciliary visit on their MAR chart. Where this does not happen, care staff can update the MAR chart. See section 3.5 & 3.12.

TELEPHONE INSTRUCTIONS

59. In the event of a doctor requesting medication changes over the telephone, consideration should be taken of the urgency and a signed and dated letter should be received as soon as possible after the telephone order. This can be sent by secure fax or email and must be retained by the service and kept with the individual's care records. The MAR chart should be updated to reflect the changes. [Recommendations 1.9.6, 1.9.7 & 1.9.8].
60. Medication prescribed for one service user must not, under any circumstances, be given to another service user, member of staff or used for a different purpose. (Recommendation 1.10.1)

MONITORED DOSAGE SYSTEMS (MDS)

61. Service users living in a care home who have been assessed as being unable to administer their own medication due to physical frailty or lack mental capacity may, in conjunction with the supplying community pharmacist, use a monitored dosage system. This will usually be in a residential care homeshetting.
62. An MDS must:
- a) Meet the requirements of the Care Quality Commission and satisfy the requirements of the Royal Pharmaceutical Society of Great Britain for an original container
 - b) Clearly indicate the name of the service user
 - c) Clearly indicate the times of administration
 - d) Be accompanied by clear and comprehensive documentation which forms the prescriber's prescription
 - e) It is a requirement that a card, or similar, providing details of physical appearance of the contents of the monitored dosage system is kept with it to facilitate identification
 - f) The requirements for labelling a dispensed monitored dosage system include the date of dispensing to be on the label and therefore any old labels must be removed from the container. On each occasion that a medication is dispensed into the container, a new label must be affixed
 - g) indicate when a 'when required' medicine or a medicine not contained in the system (e.g. liquid) is To be administered.
 - h) Be stored in a secure place
 - i) Make it apparent if the container has been tampered with between closure and sealing by the pharmacist and the time of administration
 - j) Transfer of medication – it is not acceptable, in lieu of a pharmacist filled monitored dosage system container, to transfer medication from an original container into an unsealed container for administration at a later stage by another person. This practice carries risks for staff and service users. Similarly, it is not acceptable to interfere with a sealed section at any time between its closure by the pharmacist and the scheduled time of administration.

TEMPORARY ABSENCE FROM HOME

63. Care home providers should have a process to ensure that a service user has the medicines they need when they are away from the home. A process should be in place to ensure medication needs are discussed with the service user and family/carer for when they are temporarily absent from home. This should include an assessment of the need for medication due during the absence and whether this can be delayed or needs to be taken out for administration during the period outside the home. Advice may need to be sought from the prescriber. Medication that must be given at a set time may need to be supplied in individual boxes rather than a nomad system to facilitate this.

64. The process should cover:

- Which medicines need to be taken out with the service user
- Clear directions and advice on how, when and how much medicine the service user should take
- Time of the last and next dose of each medicine
- A contact for queries about the service user's medicines such as the care home, GP or supplying pharmacy
- Details of the medicines taken should be recorded in the service users care plan.
- [Recommendations 1.14.17 & 1.14.18]

ANTICIPATORY MEDICATION FOR END OF LIFE CARE

65. People approaching end of life should be prescribed anticipatory medication to ensure their symptom control needs are met without delay. Care home staff should refer to the ECHSS and follow local processes for the obtaining and administration of anticipatory medication. Refer to local policies for end of life care. [Recommendation 1.95]

SECTION 4

STORAGE OF MEDICATION

1. All medication must be stored in one or all of the following locked cupboards, as appropriate:
 - Controlled drug cupboards (see section on Controlled Drugs)
 - Internal medication cupboard
 - External medication cupboard. The decision of where to store medication should take into account the size of the home and nature of medication supplied. Examples of places considered as not suitable include kitchen, bathroom, toilet and sluice. Care must be taken to ensure that medicinal items are stored off the floor at all times.

2. Providers of adult care homes must comply with the Misuse of Drugs Act 1971 and associated regulations when storing controlled drugs. Care home providers should include the following information in their process for storing medicines safely:
 - Storage should be secure with only authorised care home staff having access
 - OR**
 - Where service users self administer medication, care home providers should assess each resident's needs for storing their medicines and should provide storage that meets the resident's needs, choices, risk assessment and type of medicines system they are using.[Recommendations 1.12.1, 1.12.2, 1.12.3, 1.13.6]
 - Staff responsible for medicines must be aware of the temperatures for storing medicines and how the storage conditions should be monitored.

MEDICATION REFRIGERATOR

3. Medicines that require refrigeration should be stored in a separate, secure and dedicated refrigerator that should be available in the home. A refrigerator containing medicines must not be used to store food/drink.

4. The temperature of the medication refrigerator should be checked with a minimum/maximum thermometer and recorded daily by the responsible member of staff onto a refrigerator temperature chart (Appendix 6).
 - The refrigerator cabinet should have sufficient space around it for air to circulate and not be obstructed with papers, files etc
 - Staff should have a clear understanding of the action to be taken if the temperature is outside the normal range. The normal range is usually between +2c and +8c. If the temperature rises above 8° or falls below 2°, try to ascertain how long the temperature has been outside this range and seek advice from the pharmacist on whether the medication can still be used. Adjust the refrigerator temperature control and monitor frequently until satisfactory.
 - If regular readings below 2° and over 8° are obtained, review the training and competence of staff taking the readings and/or ensure the refrigerator is working properly
 - The refrigerator should be cleaned and defrosted once a month. Keep medication in a cool and secure place whilst defrosting takes place. Record the date defrosted on the temperature monitoring record sheet
 - Medication should not be stored in the door of the refrigerator as the temperature there is not as cool
 - Keep medication away from the freezer compartment and do not freeze ANY medication.
 - Medication subjected to temperatures 0°c and below **must** be discarded
 - Records should be retained for one year
 - Staff should have evidence of up to date training on how to use and read a thermometer.
 - Regular random spot checks of medication procedures should be undertaken by senior staff and management and records kept.

MEDICATION TROLLEY

5. Medication in current use may be stored in a lockable medication trolley which is fixed securely to the wall, or locked in a lockable cupboard, when not in use.
 - Cupboards or trolleys should be large enough to allow the orderly and separate storage of each service users medication.
 - Where medications are kept in service users rooms, there must be suitable secure storage for their medication. Where service users self-administer, and with their permission, both the service user and the manager shall hold keys to this drawer or cupboard.
 - Nutritional supplements should be stored according to manufacturers instruction and room temperature needs to be observed.
6. Medication awaiting disposal should be separated from those in use and stored safely in a locked cupboard in the medicines room.
7. All cupboards and trolleys used for medication storage should be situated away from sources of heat and moisture, particularly in hot weather.
8. Medication cupboards and trolleys should be used for the storage of medication alone. Medication should be stored in an orderly manner. The storing of medication should not be compromised by the the cupboard being used for non-clinical purposes e.g. housing electrical equipment
9. The medication storage facilities should be kept clean and tidy.

10. Spillages should be cleaned up immediately and bottles wiped to avoid contamination and deterioration of the medication.
11. Medication cupboards must be kept locked. The keys to the controlled drugs, internal medication cupboards and drug trolleys must be held in the personal possession of the appropriate person on duty. No other person should have access to this medication without their permission and presence.
 - The medication trolley must be kept locked and all medication returned to the trolley following administration
 - The registered person must retain a duplicate set of spare keys
 - Keys for the medication cupboard should not be part of the master system for the home
 - The trolley should be returned to a place of safe keeping, locked cupboard or secured to the wall, when not in use
 - If the medication round is not completed the trolley must be locked away and not remain on the unit/lounge or in a corridor
 - Prescribed dressings and ostomy products which do not fit in the medicine trolley must be stored on a shelf in a lockable room which houses the medicine trolley.
12. Once a dose of any medication has been removed from its container, it must never be returned. If not required, it must be placed in an empty bottle or an envelope, labelled, 'discarded medication' and returned to the pharmacist. This disposal must be recorded in accordance with the section on disposal of medication.
13. All medication has a limited life. Care should be taken that medicines are removed and disposed of when treatment is discontinued, or when the shelf life has elapsed. It is good practice to write the date the medication was opened onto the box or label and the person administering the medication should check expiry date prior to administration.
14. More detailed information may be obtained from the community pharmacist who supplies medication to the home, the Enhanced Care Home Support Service (ECHSS), pharmacist or GP. [Recommendation 1.12]

ORDERING AND CHECKING SUPPLIES:

- Care home providers must ensure that medicines prescribed for a resident are not used by other residents.
- Care home providers should ensure that care home staff (registered nurses and social care practitioners working in care homes) have protected time to order medicines and check medicines delivered to the home.
- Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by 1 member of staff and practice succession.
- Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy.
- Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

- The date and time medication arrives at the home should be recorded in addition to the date and time it is actually checked in.
- Staff should know how to contact the supplying pharmacy when necessary
- [Recommendations 1.10.2, 1.10.3, 1.10.4, 1.10.5]

15. Dispensing and supplying medicines:

- Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. If needed, they should seek the support of health and social care practitioners.
- Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accurately check medicines for residents.
- Supplying pharmacies should produce medicines administration records wherever possible. Pharmacies and doctors supplying medicines to care home providers should ensure they keep records and provide an audit trail for their processes.
- [Recommendations 1.11.1, 1.11.2, 1.11.3, 1.14.8]

DISPOSING OF MEDICINES

16. Care home providers must ensure that a medication that is still being prescribed for a resident, is only disposed of if out of date or has exceeded its shelf life, to avoid unnecessary waste.
17. When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:
- Medicines that exceed requirements
 - Unwanted medicines (including medicines of any resident who has died). Medicines for deceased residents should be kept for 7 days following a death.
 - Expired medicines (including controlled drugs).
 - Care home providers should keep records of medicines (including controlled drugs) that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy.
 - A weekly check of medicines for disposal should be completed.
 - [Recommendations 1.12.4, 1.12.5, 1.12.6]

AUDIT OF MEDICATION PROCEDURES

18. A nominated person should check all medication for expiry dates and deterioration on a weekly basis. Checks should be recorded.
19. The nominated person should check the Homely remedy stock, expiry dates and documentation (including stockbook) on a weekly basis.

- They should ensure that any medication held in stock for service users is rotated so that the old stock is used first
 - The nominated person should check the Homely Remedy stockbook
 - A weekly check of controlled medication and medication for disposal should be completed (see section on Controlled Drugs)
 - An audit of the medication procedures in operation in the service must be completed. The manager should check the medication procedures every 3 months and audit the procedures in the home twice a year. These audits should be recorded and retained in a medication audit file
 - A competent person should regularly check that staff are working to procedures and guidelines on the safe administration of medication. They should spot check the medication monitoring sheet against the medication being administered by staff. The checks should be recorded on the review sheets and staff supervision notes
 - Evidence of actions in response to audits should be recorded
20. Stocks of medicines, records and other relevant documents, should be readily available for inspection by the Care Quality Commission or commissioners of service. With the service users consent, access should also be given to the community pharmacist. [Recommendation 1.5.1]

HOMELY REMEDIES & OVER-THE-COUNTER PRODUCTS

21. Non-prescription medication or homely/household remedies refer to medication which is available over the counter in community pharmacies. For people living in a care setting which is their home, homely remedy products may be stocked by the home, brought in by residents or relatives or purchased by the home on the instructions of a health professional such as a GP.
22. See appendix 21 Homely Remedies Policy

OVER THE COUNTER PRODUCTS

23. Providers must encourage all people using the service to inform staff of any non-prescribed medication kept or requested. Non-prescribed medication should be recorded on the care/support plan and entered on the MAR chart indicating if the person is self-administering and if it is kept in their room. It is important that the MAR chart provides a complete list of all the medication used by the person as it may be used to monitor treatment regimes, decide if a change of treatment is required or identify any interaction with prescribed medication or diet and check for adverse effects.
24. Providers must encourage all people using the service to inform staff of any vitamin supplements they are taking and these should also be recorded in the care plan
Staff on duty may need to seek the advice of a pharmacist or doctor to avoid or identify any interaction with prescribed medication or diet and check for adverse effects.
25. If a person is able to choose and wishes to buy their own products for minor ailments etc, they should be supported in the decision and encouraged to speak to a pharmacist or their

GP.

26. If the GP/pharmacist has checked that there is no interaction with other medications or other reasons not to take it then the person should be supported to administer the product. It should be recorded that they are taking the product in case their medication or condition changes and should be recorded when it's taken either in a separate document or on the reverse of the MAR chart.
27. If the person requires assistance to take an over-the counter product due to physical inability, and has the capacity to consent to support being given, it is good practice to obtain their written consent and include this as part of the care plan. Should a service-user wish to take over-the-counter products against their GP or pharmacist's advice and they have capacity, this should be documented in the care plan. [Recommendation 1.16.1, 1.16.2].
28. Residents or relatives may bring in their own homely remedies. These are different to those purchased by the home, are not for general use in the home and must remain specific to that resident. They should be recorded in the same way as all other medication on a medication administration chart.
29. A GP or other health professional may instruct the home staff to purchase a specific product to treat a minor ailment for a particular resident, such as olive oil for treatment of ear wax. This is no different to a person treating themselves in their own home and can be actioned according to instructions accompanying the product, provided by a nurse or community pharmacist or, where necessary, given by the GP and only apply to the individual named. This should be written in a care plan and recorded on the reverse of the MAR chart when administered. This can be a long term or short term care plan depending on the predicted term of use of the medication.

CONTROLLED DRUGS

DEFINITION:

30. Controlled drugs (CD) are prescribed medicines used to treat severe pain, induce anaesthesia or treat drug dependence. Some people abuse them by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations.
31. Different controlled drugs cause dependence or misuse in varying degrees. They are classed according to the extent of harm they may cause when misused. They are listed in different schedules (1-5) according to the legal requirements concerning prescribing, storage and record keeping. See Appendix 1 reference: Controlled Drugs & Misuse of Drugs Act (2007).
32. You must have a policy or standard operating procedure which details how you manage controlled drugs within your home. This should include what to do if there's a discrepancy (see point 70). Some large organisations will have an accountable officer for controlled drugs who should be informed of any significant incidents i.e. harm to a patient, loss or theft of CD's.

33. Should a significant event occur, this should be reported to CQC –i.e. death of patient, police, or major incident, reported via the usual ECHSS medication error process and via the NHSE portal. Link to CD portal: <https://www.cdreporting.co.uk/>

Storage of Schedule 2 and above Controlled Drugs in a Care Home Setting [Recommendation 1.12.1; 1.12.2; 1.12.5; 1.12.6]

34. All controlled drugs must be stored in a locked cupboard or trolley, kept in a room not generally accessible to service users or visitors to the home. The registered manager will be responsible for ensuring that arrangements are in place to ensure the safe management of controlled drugs within the home or service.
35. Controlled drugs should be kept in a designated controlled cupboard when staff are responsible for the administration of them. The 2007 amendment to regulations makes this mandatory for all care homes. In brief, the requirements for CD storage are:
- Metal cupboard of specified gauge
 - Specified double locking mechanism
 - Fixed to a solid wall or a wall with a steel plate mounted behind
 - Fixed with either rawl or ragbolts
36. Care homes should request formal confirmation that the CD cabinet meets legal requirements when purchasing a cupboard.
37. None of the medicine refrigerators on the market meet the Misuse of Drugs Safe Custody Regulations. Store those controlled drugs which need to be refrigerated in a medicines fridge. You can store them in the same medicines fridge as other medicines. You must store them separately within the fridge. For example, you might store them in a separate lockable box.

Controlled drugs schedules

Schedule 2

38. You must store schedule 2 medicines in a cupboard. Keep records of these medicines in your controlled drugs register. Common examples include morphine, diamorphine, methadone, fentanyl, alfentanil, oxycodone, methylphenidate, dexamphetamine, ketamine and tapentadol.

Schedule 3

39. You do not need to record schedule 3 medicines in the controlled drugs register. Some services may choose to do so. You must store certain schedule 3 medicines in the controlled drugs cupboard. This includes, for example, buprenorphine and temazepam.

40. There are other schedule 3 medicines that you do not need to store in the controlled drugs cupboard. Common examples include midazolam, tramadol and barbiturates (phenobarbitone).

Other schedules

41. You do not need to store certain schedule 4 and 5 medicines in the controlled drugs cupboard. And you do not need to record them in your controlled drugs register. Some services may choose to do so. Examples include morphine sulfate solution (Oramorph®) 10mg/5mL, zopiclone, codeine and benzodiazepines.

Managing controlled drug stocks

42. Check stocks regularly, as a minimum on each administration and weekly.
For good practice, two staff members should sign for schedule 2 and above drugs when:
receiving controlled drug stocks
checking stock balances
administering the medicines
disposing of these medicine stocks
43. If you have controlled drugs awaiting disposal, separate them from those in use.

RECORDING AND ADMINISTRATION OF SCHEDULE 2 AND ABOVE CONTROLLED DRUGS

IN A CARE HOME SETTING

44. In addition to recording the administration of controlled drugs on the MAR chart, a separate page in a Controlled Drug Record Book must also be kept for each controlled drug for each person. This record should include recording the quantity remaining and should include a check by a second member of staff. Examples of a Controlled Drugs record book can be found on the internet.
45. Keep comprehensive records when administering topical controlled drugs, for example as patches. These should include the site of application and the frequency of rotation of the site
46. Although normally the second signatory should be another registered health care professional (for example doctor, pharmacist, dentist) or student nurse or midwife, in the interest of patient care, where this is not possible, a second suitable person who has been assessed as competent may sign. It is good practice that the second signatory witnesses the whole administration process. For guidance, go to www.dh.gov.uk and search for safer management of controlled drugs: guidance on standard operating procedures.
47. When transferring the drug record to a new page in the CD register, the amount remaining should be identified with 'brought forward from page x' written clearly on the new page.
48. Controlled drugs records should be stored in a locked cupboard, with the drugs to which they relate.

49. When recording controlled medication from the pharmacy, the number of units received must be recorded in words not figures e.g. ten, not 10 to reduce the chance of entries being altered.
50. If a mistake is made in recording, it should be cancelled by the person making the error by drawing a single line through the original recording and ensuring it is still clearly legible. This should be signed, dated and witnessed by another member of the senior care assistant team or registered manager. The witness should also sign the correction.
51. When treatment is to be discontinued, or it is necessary to change the form or dose of the medicine, there should be clear written instructions from the prescriber, the MAR chart should be amended as appropriate and the drugs disposed of as per guidance (see Section 3.56; 3.57; 4.15; 4.16).
52. In an emergency a general practitioner can be asked use a secure email or safe haven fax to send their directions regarding cancellation or changes to controlled drugs direct to the senior officer on duty in the home. The GP must clearly write or type the instructions, and record on it the date, time and their signature The date and time of receipt of the directions must be noted on the MAR chart and the fax/email attached by the care home staff.
53. The procedure for the administration of all controlled drugs is the same as for all other medication, with the following additions:
 - a) A second member of staff should witness the administration of the medication. The use of a witness is intended to reduce the possibility of an error occurring. To be effective the witness must understand what the person administering the drug is doing.
 - b) The witness will confirm that:
 - The correct drug is selected
 - The name on the label attached to the controlled drug is the same as the person the staff member intends to give it to
 - The right dose included on the label and on the MAR chart is prepared
 - It is given to the right person
 - The administration is recorded in the CD register as well as signed on the MAR chart
54. Details of the administration should be recorded in the Controlled Drugs Record Book together with the full signatures of the witness and the person administering the drug.
55. A check of the remaining stock should be recorded.
56. If a controlled drug is wasted or partly used and the remainder requires wasting, this must be recorded and the wasting process should be witnessed. The witness and person wasting the controlled drugs must sign to confirm the procedure. Records of wasted controlled drugs can be kept at the back of the CD register.
57. Where service users are self-administering controlled drugs, each individual dose taken does not need to be recorded.
58. A full controlled drugs check should be completed at least weekly by the senior nurse or care assistant with lead responsibility for medication and another member of the supervisory team.

This check should be rotated periodically and should consist of checking the balance in the controlled drugs record book against the contents of the controlled drug cupboard, not the reverse, to ensure balances are correct.

59. It is not necessary to open packs with intact tamper seals for stock taking purposes.
60. Stock balances of liquid medication should generally be checked by visual inspection, the balance must be confirmed to be correct on completion of a bottle.
61. A record indicating the check has been completed should state on the relevant sheet the date, time of reconciliation and include wording such as 'check of stock level' and be signed by a competent person and a witness.
62. [Recommendations 1.12.1, 1.12.2, 1.14.16]

SERVICE USERS SELF-ADMINISTRATING CONTROLLED DRUGS

63. Service users can keep and take controlled drugs themselves. There is no need to keep a record in the CD register when the service user is wholly independent i.e. he is responsible for requesting a prescription and collecting the controlled drug from the pharmacy personally.
64. If the service user relies on staff to supply and collect controlled drugs, there should be clear records including:

A receipt from the pharmacy
Supply to the service user
Any subsequent disposal of unwanted controlled drugs
This information should be recorded in the CD register

64. For self-administration, the process of risk assessment is important and an assessment of the service users' ability to self-medicate should be completed (see section 2).
65. The storage requirements are the same as for other medication in the service user's bedroom. They must be stored in a locked drawer/cupboard and the service user retains the key.
66. A controlled drugs cabinet is not required in each bedroom.
67. The risk assessment process places responsibility on the person who keeps the controlled drug. Staff, through monitoring and review of the risk factors should be able to identify that controlled drugs are not left unattended where they could be taken by other service users.

DEALING WITH NON-PRESCRIBED CONTROLLED DRUGS

68. See section 6 illicit drugs.

RETENTION OF RECORDS

69. It is good practice to keep Controlled Drug Records for longer than the mandatory 2 years, as cases often come to court at a much later date, by which time the records would have been destroyed.

DISCREPENCIES

70. Discrepancies should immediately be reported to the registered manager or person in charge and via usual reporting process. See point 33 & Appendix 19. [Recommendation 1.15]

DISPOSAL OF CONTROLLED DRUGS – CARE HOMES

71. Controlled drugs which have been obtained on individual NHS prescriptions may be disposed of by returning to the supplying community pharmacy. It is recommended that a signature of receipt be obtained from the pharmacist (or delivery driver accepting the return to the pharmacy).

72. A record of the return of medication for disposal should be made in the controlled drug register and signed by the authorised person and a witness.

73. The nursing home will need to make arrangements for the collection of waste medication with a licenced waste disposal company.

74. [Recommendations 1.12.6; 1.13.7; 1.14.14]

75. Care homes with nursing waste their own controlled drugs, see 68.D.

SECTION 5

COMMUNICATION

PROVIDING INFORMATION TO PATIENTS & FAMILIES ON ADMISSION TO A CARE HOME

1. The care home manager or person responsible for a residents transfer into a care home should involve the resident and/or their family members in accurately listing a residents medicines on admission to the setting. This may include informing a new GP practice of the patients medications if they need to be registered with a new GP, either temporarily or permanently. This information should include....
2. Care home staff should give residents and/or family members information on:
 - How to report a medicines related safety incident
 - How to report a medicines related safeguarding incident or concern
 - How to discuss their concerns about medicines
 - How to use the home's complaints process, local authority or local safeguarding processes and/or a regulator's complaints process
 - How to use advocacy and independent complaints services.
 - [Recommendations 1.6.10; 1.7.2]

UPDATING CHANGES

3. Care staff should ensure that records about medicines are accurate and up to date by following the guidance on record keeping in section 3.
4. Care home managers should ensure that there is a process for everyone involved in a residents care to know when medicines have been started, stopped or changed [Recommendation 1.3.7 & 1.4.1]
5. Information about a resident's medicines should be made available when a resident attends appointments outside the care home.

MOVING BETWEEN PROVIDERS / SERVICES & RESPITE CARE

6. Care managers must ensure that there is a process in place to share, obtain and record accurate information when a service user moves from one provider to another, including who is responsible for prescribing in the future. This should be organised in a timely manner to ensure that there is no negative impact on a service user/residents medication routine. [Recommendation 1.3.3, 1.3.4, 1.3.5]
7. On admission to a new care setting the care home manager or person responsible for a service user's transfer must coordinate the accurate listing of all the residents medicines as part of a full needs assessment and care plan, including information relating to allergies, and should consider the resources needed to ensure that this occurs prior to admission/accepting the care package. There should be no delay in the ability of the care provider to ensure the service user receives their required medication.
8. If a service user leaves home to live elsewhere or access respite services, they may take with them the medication in use, which has been prescribed. [Recommendation 1.3.6]

9. Where a service user changes residence, either temporarily or permanently, care must be taken to ensure that medications provided by prescribers/dispensers who do not provide Medication Administration charts, are included in the handover process.

SHARING INFORMATION & DATA SECURITY

10. All care providers must follow the current relevant legislation to ensure the appropriate sharing and storage of records as per general data protection regulations (GDPR 2018). This will include following the organisation's and local policy on confidentiality, storing records for the appropriate length of time and secure destruction.
11. The organisation should give information to service users/relatives on the processes for the secure sharing of data.
12. Organisations should monitor and audit their processes for sharing and transferring information about a service user's medicines. [Recommendation 1.3]

SECTION 6

TRAINING & COMPETENCY

1. People using care services need to receive medication in a safe and timely manner. For many care workers, medication training is an important part of their induction. Without this training, it is not possible for care staff in a care home registered with the Care Quality Commission (CQC) to administer medication. Medication training must be delivered by suitably trained individuals and whilst resources such as e-learning and videos can complement such training, they should ideally not be the main delivery method.
2. Care staff must have the training and skills to use systems adopted in the organisation for administering medications in line with regulation 22 of the Health & Social Care Act (2008)
3. Professionally qualified health professionals employed by the care home must have current registration with their professional body and continue to meet registration requirements. They must work to standards set by their professional body and ensure they have the appropriate skills and knowledge. [Recommendation 1.17.6]
4. All staff should undertake an introduction to medicines management training on induction by an accredited learning provider. Competency must be reviewed every three years. This should include giving medicines:
 - Into the mouth (tablets, capsules, liquids)
 - Ear, nose and eye drops
 - Inhalers
 - Medicines applied to the skin (topical)
 - [Recommendation 1.17.3 & 1.17.4]
5. Staff responsible for administration of medication should have their competency assessed at **least annually** or following any medication related safety incident.
6. There should be a process for staff who do not have the skills and competency to administer medicines to stop taking part in this procedure and have a management plan to develop and maintain competency if possible.
7. Because each care organisation may have service users with different needs, there is not a definitive list of what should be covered as part of medication training. As a minimum training should cover:
 - The supply, storage and disposal of medicines
 - Safe administration of medicines including what to do in case of an adverse reaction, error or incident
 - Quality assurance and record-keeping
 - Accountability, responsibility and confidentiality.
 - Care providers should identify any other training needed by staff responsible for managing and administering medicines. [Recommendation 1.17]

8. A record of the individual's training and assessment should be kept, and all refresher or continuing education and training should also be routinely kept.

DELEGATION OF CARE TASKS

9. This document assists providers of services to be clear about their respective roles and responsibilities in terms of medicines management. It does not cover every eventuality; the purpose of it is to address some of the typical and regular areas of joint working within community care.
10. This document identifies the tasks which may be delegated to care staff. Assessment by a health professional is a pre-requisite to any of these tasks being delegated to social care staff, and the responsibility for monitoring and reviewing the task remains with the Primary Care Team or qualified staff where referring to a nursing home.
11. The important issues are:
 - The person consents to a care worker giving this treatment
 - The care worker(s) agree to do so
 - Clear roles and responsibilities are agreed and documented by the agencies and the people involved in providing care.
12. The qualified nurse (registrant) delegating should be satisfied that the individual has an appropriate level of education and training and has been assessed as competent. Where this is not the case, the registrant may refuse to delegate, even when requested to do so by another health professional. The registrant is accountable for her own actions including delegation.
13. The overall rationale used for this agreement is the appropriate management of risk to the individual user of services, risk to the informal carers and staff involved in their care. It is therefore necessary that in every case the assessor completes a risk assessment form from their perspective. Within this framework, the assessors will then agree how such risks will be managed and agree roles within this process and record and implement the care plan.
14. All care plans will be monitored and reviewed at regular intervals since all risk assessments are, by definition, time limited. The actual method and frequency of such monitoring would be a varied decision based on the overall circumstances within the individual situation at that particular time. It should be clear however that whilst social care staff have an overall duty to feed back changes in a service users condition, there is not, in legal terms, a duty to monitor a health condition which remains the responsibility of the Primary Care Team or qualified staff where referring to a nursing home. See Section 1 Health Care Responsibility [Recommendations 1.14.12, 1.14.13]

RESPONDING TO INCIDENTS

ADVERSE DRUG REACTIONS

15. In the case of serious reaction emergency medical attention should be accessed immediately via 999. Any adverse drug reaction (ADR) or suspected ADR should also be reported to the ECHSS via the incident reporting process GP and supplying pharmacist for that individual person and discussed before further administration of the drug in question.
16. If a service requires advice or support in response to an adverse reaction, that is not considered an emergency situation, they should seek advice from ECHSS in hours or 111 if out of hours. What constitutes an emergency situation must be covered in Medicines Management training. (See section 6.1 & 6.2)
17. Any adverse drug reaction (ADR) should be:
 - Recorded in the person's notes
 - Notified to the prescriber
 - Notified by the Yellow Card Scheme if appropriate (see below)
18. Reporting Scheme (Yellow Card Scheme) using the electronic form or by telephone on 0808 100 3352 10am-2pm Monday to Friday only.
19. The care provider should ensure that the GP or the Pharmacist is reporting the adverse reaction using the Yellow Card system. If not, the care provider must take on this responsibility. [Recommendations 1.5; 1.6]

LOSSES OF MEDICATION AND / OR MEDICINE KEYS

20. If there is any loss of medication, the registered person must notify the nominated person within the organisation immediately and local quality assurance procedures followed. Where indicated, the Care Quality Commission must be notified without delay of its occurrence, including information about the circumstances of the loss and follow up action taken. This notification must be followed up in writing on a Notifiable Incident report record form.
21. If the loss of medication or medicine cupboard keys results in the inability of a service user to receive their medication advice should be sought from ECHSS or 111 if out of hours.
22. Loss of medicine cupboard keys should be reported to the registered person immediately.

ERRORS OF ADMINISTRATION

23. It is important that all services maintain an open 'no blame' policy where staff are encouraged to report errors without delay.
24. All incidents should be carefully investigated by the registered manager taking full account of the context, circumstances, position and experience of the member of staff involved.
25. The root cause of medication related incidents must be shared with care staff to promote a culture of learning from incidents and improve safety.

26. Care providers should ensure that there is a process to monitor trends in medication errors and evidence learning from these.

27. Errors in the administration of medicines may include:

- a) A medicine given to the wrong service user
- b) The wrong medicine given to a service user
- c) An incorrect dose of a medicine given to a service user
- d) A medicine administered at the wrong time

28. In the event of an error in administration care homes must use the WBC Notification of medicine errors (Appendix 19).

29. Warrington Borough Council Medication Error reporting system requires errors in nursing and residential homes to be reported to the Enhanced Care Home Support Service/Out of Hours who will triage the incident, give the appropriate advice to the home and record the incident for audit purposes.

30. There is no requirement to notify CQC about all medicine errors, but a notification would be required if the cause or effect of a medication error met the criteria to notify one of the following:

- A death
- An injury
- Abuse or an allegation of abuse
- An incident reported to or investigated by the police

31. Where relevant you should make it clear that a medicine error was a possible cause or effect of these incidents or events being notified.

32. The regulations say that the 'registered person' must submit notifications. This will often be the registered manager and they will be committing an offence if they fail to do so. Any arrangements for delegation of this task must therefore be very clear. Similarly, where a medication error results in significant harm or has the potential to cause significant harm, an alert should be made under the local authority safeguarding procedures. Additionally, service users / significant others should be supported if they wish to make a complaint. Staff should signpost them to the organisation's complaints policy. [Recommendation 1.5; 1.6]

33. The person responsible for administering medication should immediately advise the following people:

- ECHSS (or 111 out of hours) for the appropriate action
- The registered person/Manager
- The service user or their significant other should also be advised of the error and the follow up action taken.
- A written report of the incident, actions taken and lessons learned may be required by commissioners and/or monitoring agencies.

HAZARD NOTIFICATION & DRUG ALERTS

34. A record of the error must be made in the service user's health care record and the daily log, together with details of any action taken. A copy of any report should also be retained on the service user's file.
35. In the event of a medicine being recalled, the supplier will be able to provide the home with further information.
- Upon receipt the designated person will take responsibility of the Hazard
 - Notification and/or CAS or Drug Alert.
 - It must be then brought to attention of all relevant staff.
 - Recommended remedial action must be implemented within the time scale specified.
 - In some cases no action will be necessary or the bulletin will not apply.
 - All appropriate staff must sign to say that they have seen the Alert.
36. **If the bulletin does apply then action must be taken.**
37. The action taken must be recorded and attached to the Alert and signed by the designated person/s and incidents occurring as a result of the alert should be reported in the usual way. (Sections 6.22 to 6.28).

ILLCIT DRUGS BROUGHT INTO THE HOME

38. This must be reported to the person in charge of the home. The RPSGB document 'The Handling of Medicines in Social Care' suggests that if a person brings illicit substances into the care home, the care setting should take advice from local police and if necessary the serious and organised crime agency concerning appropriate procedures. Care providers must also advise the commissioners and responsible monitoring agency (RPSGB The Handling of medicines in Social Care)

SECTION 7

ADDITIONAL GUIDELINES FOR STAFF WORKING WITH PEOPLE WITH SEVERE LEARNING DISABILITIES

1. As with all service users, the principles of the Mental Capacity Act must be followed in relation to consent, capacity assessment and best interests (see section 2) where a person has severe learning disabilities.
2. All the aforementioned requirements relating to medicines management must be adhered to.
3. **PRN or as required medication** (also see section 3.35 – 3.39) Where 'as required' medication is prescribed for the management of behaviours that challenge, there should be a clear, written protocol for its use in the service users care plan, including options that should be considered before medication is used. The protocol should consider reversible causes of the behaviour such as pain or constipation and refer to person centred strategies to support the service user where possible.
4. The prescriber should document:
 - Rationale for use
 - Dose
 - Frequency
 - Maximum in 24 hours
 - Review date and who is responsible for the review
5. Records should be kept of the use of PRN medication and why it was given which should be part of the review.
6. Staff should also refer to their organisation's Standard Operating Procedures and Policies.
7. Where appropriate it may be necessary to administer rectal medication and the following guidelines should then also be considered:
 - All other options to administer the medication must be considered and explored before prescribing a rectal preparation as a last resort i.e. buccal (See Appendix 8).
 - The prescription must clearly state the route
 - The medication must be administered by an appropriately trained and qualified practitioner i.e.
 - A first level nurse with current registration
 - OR
 - A member of the care staff who has undergone training and been assessed as competent in the administration of rectal medication by an appropriate professional . This competence must be reviewed at intervals not exceeding 12 months by the employing organisation. Written evidence of competence must be retained by the organisation.

8. The need for this medication and route must be clearly documented in the service users care plan.
9. The prescriber must state a review date and who is responsible for the review.

APPENDICES:

- 1. References & links**
- 2. Glossary of Terms**
- 3. Abbreviations used in writing prescriptions**
- 4. Specimen signatures**
- 5. Homely Remedies**
- 6. Medication Refridgerator Temperature Monitoring documents**
- 7. MAR chart example**
- 8. Warfarin and other anticoagulants**
- 9. Administration of Buccal medication**
- 10. Application of Compression (elastic) hosiery**
- 11. GTN Spray / Tablets (Glyceryl Trinitrate)**
- 12. Eye drops/ointment**
- 13. Ear drops/ointment**
- 14. Nose drops/ointment**

15. External creams, ointments & gels including sunscreen

16. Using an inhaler

17. Nebulisers

18. Oxygen

19. Topical patches

20. Medication Errors Reporting Process in Care Homes

21. Covert administration of medicines policy & guidelines

22. Auto-adrenaline injectors (Epipen)

23. Thickening Agents

APPENDIX 1

REFERENCES & LINKS

Advance Decisions to Refuse Treatment <http://www.adrt.nhs.uk/>

Best Interests Decision Making <http://www.scie.org.uk/publications/mca/files/lancspct.pdf>

British Pain Society and British Geriatrics Society, Guidance on the assessment of pain in older people, 2007, <http://www.bgs.org.uk/Publications/Publication%20Downloads/Sep2007PainAssessment.pdf>

Care Quality Commission, 'What providers should do to comply with the Section 2.0 regulations of the Health and Social Care Act 2008' in Essential Standards of Quality and Safety, March 2010
<https://www.cqc.org.uk/guidance-providers/adult-social-care/storing-controlled-drugs-care-homes>

Controlled Drugs http://www.npc.nhs.uk/controlled_drugs/resources/controlled_drugs_third_edition.pdf

Information on controlled drugs schedules;

<https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html>

COSHH <http://www.hse.gov.uk/coshh/>

DOH guidance, Seeking Consent (2002) updated (2009)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653_1_.pdf

Duthrie Report (2005) <http://www.dhsspsni.gov.uk/the-safe-and-secure-handling-of-medicines.pdf>

Fundamental Standards of Care (April 2015)

<https://www.cqc.org.uk/content/fundamentalstandards>

General Data Protection Regulation (GDPR) (2018)

<https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation>

The Handling Of Medicines In Social Care (2012) Royal Pharmaceutical Society of Great Britain

hmsc@rpsgb.org

Health Act 2006 <http://www.legislation.gov.uk/ukpga/2006/28/contents>

Health & Social Care Act (2008) www.legislation.gov.uk/ukdsi/2010/9780111491942/regulation/22

Health & Social Care Information Centres A Guide to Confidentiality in Health& Social Care (2013)

<http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf>

Managing Medicines In Care Homes (2014) National Institute for Health and Care Excellence (NICE, March 2014)

<http://www.nice.org.uk/guidance/sc/SC1.jsp>

The Medicines Act (1968) <http://www.legislation.gov.uk/ukpga/1968/67>

Mental Capacity Act (2005) <http://www.legislation.gov.uk/ukpga/2005/9/contents>

The Misuse of Drugs Act (1971) <http://www.legislation.gov.uk/ukpga/1971/38/contents>

The Misuse of Drugs (Safe Custody) (Amended) Regulations (2007)

<https://www.gov.uk/government/publications/misuse-of-drugs-and-misuse-of-drugs-safe-custody-amendment-regulations-2007>

‘New standards to help care homes manage medicines safely and prevent falls in older people’ http://www.nice.org.uk/news/article/new-quality-standards-to-help-care-homes-manage-medicines-safely-and-prevent-falls-in-older-people?utm_source=NICE+Newsletter&utm_campaign=2fe83e2d50-NICE_News_March_20153_25_2015&utm_medium=email&utm_term=0_8b79289514-2fe83e2d50-168958933

NICE guidance for the control, storage, administration, and disposal of medication in residential care homes, domiciliary, and day care services for older people Managing Medicines in Care Homes (2014). <http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes>

NPSA. Rapid Response Report 4. Fire hazard with paraffin-based skin products. November 2007
Paraffin-based skin emollients on dressings or clothing: fire risk <https://www.gov.uk/drug-safety-update/paraffin-based-skin-emollients-on-dressings-or-clothing-fire-risk>

Nursing and Midwifery Council (NMC)

<http://www.nmc.org.uk/globalassets/siteDocuments/NMC-Publications/NMC-Standards-for-medicines-management.pdf>

Adapted from PrescQUIPP bulletin 49/May 2013/v 2

<https://www.prescqipp.info/resources/send/92-cost-effective-emollients-with-no-or-low-paraffin-content/1306-bulletin-49-cost-effective-emollients-with-no-or-low-paraffin-content> Date accessed 14/8/18.

Reference Guide to Working with Older People (2001)

<http://www.scie.org.uk/publications/guides/guide03/process/capacity.asp>

Royal Pharmaceutical Society of Great Britain, The handling of medicines in social care,

<http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf>

The Yellow Card Scheme

<http://www.mhra.gov.uk/Safetyinformation/Howwemonitorthesafetyofproducts/Medicines/TheYellowCardScheme/index.html>

Social Care Institute for Excellence http://www.scie-socialcareonline.org.uk/?q=*&f_subject_terms=medication

APPENDIX 2

GLOSSARY OF TERMS

For the purpose of this policy the following definitions apply:

Acute:	Of rapid onset. May or may not be severe.
Anus:	The opening at the lower end of the alimentary canal at the rectum through which faeces are discharged.
Artificial Feeding:	Any means of feeding other than by mouth
Blister Pack:	Monitored dosage system
BM Sticks:	Reagent strips which may be used for blood glucose monitoring, providing a visual reading. They provide a measure of assessing diabetic control.
Buccal (also known as sublingual);	The oral administration of a drug, usually in the form of a tablet, by placing it between the cheek and the teeth or gum until it dissolves
Chronic:	Of long duration. Slow changes or gradual onset.
Community Nurse:	A nurse working in the Primary Health Care Team, e.g. District Nurse and Community Psychiatric Nurse.
Controlled Drug:	Any substance controlled by the Misuse of Drugs Act 1971 Schedules 2 & 3 & subsequent updates.
Controlled Drugs Cupboard:	One which complies with the regulations of the Misuse of Drugs Act.
Enema:	A substance introduced into the rectum to evacuate the bowel or to administer drugs or nutrients, e.g. barium or contrast enema in which barium is used to enable the outline of the bowel in x-ray study.
Gastrostomy or PEG:	A direct method of providing nutrition directly into the stomach that has advantages for long term feeding in preference to nasogastric or parenteral infusion. PEG- percutaneous endoscopic gastrostomy
Inhaler:	A device which delivers medicines to the lungs.
MAR:	Medication Administration Record.
Medicine:	The science of preventing, treating and curing disease. A therapeutic substance.
Monitored Dosage: (Medicines System)	A system which enables packaging of medicines into individual doses i.e. nomad or blister pack system.
Nebulizer:	A device to deliver a solution of drugs in a fine mist to the lungs, through a mask or a mouthpiece.
Nomad System:	A monitored dosage system.
Nursing Care	Care given or supervised by a qualified nurse. This includes assessment, supervision and intervention.
Oral Medicines:	Tablets, capsules, or liquid medicines intended to be taken by mouth.

Pessary:	A medicated suppository or vaginal tablet used to treat vaginal infections or as a contraceptive.
Post-operative:	Following surgery.
Prosthesis:	Fitment of artificial part of the body.
Rectum:	The end of the large intestine. Faeces are stored in the rectum before defecation.
Rectal Solution:	Polythene tubes containing liquid medicine which can be squeezed into the rectum giving an individual dose
Registered Person:	The person registered under the Care Standards Act 2000 or subsequent update.
Sub-lingual	See Buccal
Suppository:	Medication presented in a base that melts at body temperature when inserted into the rectum
Thickening Agent	A thickening agent or thickener is a substance which can increase the consistency of a liquid without substantially changing its other properties.Used for people with difficulty swallowing to improve control and reduce risk of aspiration.
Topical Preparation:	A medication applied to the skin e.g. creams and ointments.This can also be in the form of a patch.
Vagina:	The genital canal in the female – a sheath-shaped musculomembranous passage extending from the cervix to the vulva (front passage in a female).

APPENDIX 3

ABBREVIATIONS USED IN WRITING PRESCRIPTIONS

Latin Abbreviations & Terminology
a.c. = ante cibum = before food
p.c. = post cibum = after food
mane = morning
nocte = night
o.d = once daily
b.d= twice daily
t.d.s. (tid) = 3 times a day
q.d.s(qid) quarter die = 4 times a day
stat = immediately
PRN = pro re nata = when required

APPENDIX 4

SPECIMEN SIGNATURES

All staff trained to administer medication must complete the attached form in **black ink**.

A clear photocopy of the form should be placed at the front of the medication file in a plastic wallet and the original retained by the team manager.

It is the team manager's responsibility to ensure the form is updated regularly and checked monthly when they undertake their audit of medication.

APPENDIX 4

SPECIMEN SIGNATURES - MEDICATION ADMINISTRATION

Name (Block Capitals)	Full Signature	Initials	Job Title

HOMELY REMEDIES

GUIDE TO THE USE OF HOMELY REMEDIES IN NURSING & RESIDENTIAL HOMES

APRIL 2016

Contents

	Page No
What is a homely remedy?	3
Why stock homely remedies	3
Managing homely remedies	4
Flow Chart List	6
Chart 1 Indigestion / heartburn	7
Chart 1 Product information	8
Chart 2 Pain (mild or moderate)	9
Chart 2 Product information	10

Chart 3	Dry cough	11
Chart 3	Product information	12
Chart 4	Constipation	13
Chart 4	Product information	14
Chart 5	Diarrhoea	15
Chart 5	Product information	16
Chart 6	Skin problems	17
Chart 6	Product information	18
References		20

PRINCIPLES OF MANAGING THE USE OF HOMELY REMEDIES

What is a homely remedy?

- 1. There are many times at which a resident may develop a minor ailment that needs to be treated. It is important that staff are able to respond in a timely way and help the resident to feel well. Many people living in their own home purchase remedies from the chemist or the local shop and generally do this without involving the GP. Pharmacists will also provide advice on the best treatment and give advice on its use.**
- 2. For people living in a care setting, which is their own home, we now refer to this approach as using homely remedies. A homely remedy is a medicinal preparation used to treat minor ailments; it is purchased over the counter and does not require a prescription. These homely remedy products are kept in the home to allow access to products that would commonly be available in any household.**
- 3. Homely remedies fall into two legal categories, GSL (general sales list), which are available widely and sometimes referred to as over the counter medicines or pharmacy (P) medicines which are available only from a pharmacy.**
- 4. It is good practice on admission to discuss health needs and medicines with the resident and their family. This should also include the use of homely remedies. Residents and their families should always be involved in these discussions and the resident's consent should always be sought. If a person lacks capacity to make decisions then the decisions may be made involving those closest to the person at a best interest meeting. It is advised that this discussion may also need to take place on admission, with the residents own GP, including where they lack the capacity to make decisions about taking homely remedies or where there is any risk to the resident from any of the homely remedies likely to be given.**
- 5. Residents or relatives may bring in their own homely remedies. These are different to those purchased by the home, are not for general use in the home and must remain specific to that resident. They should be recorded in the same way as all other medication on a medication administration chart.**
- 6. A GP or other health professional may instruct the home staff to purchase a specific product to treat a minor ailment for a particular resident, such as olive oil for treatment of ear wax. This is no different to a person treating themselves in their own home and can be actioned according to instructions accompanying the product, provided by a nurse or community pharmacist or, where necessary, given by the GP and only apply to the individual named. This should be written in a care plan and recorded on the reverse of the MAR chart when administered.**

Why Stock homely remedies?

- 7. The Care Quality Commission agrees that a small range of products may be kept in stock in a care home for residents for the treatment of minor ailments. Homes who agree to stock such products must develop their own policies with an approved list of products and minor ailments which will be treated in this way.**
- 8. Staff need to be able to respond quickly to symptoms of a minor nature, such as toothache or headache. Sometimes this may occur out of hours. This guidance is intended to help in such situations.**

Recommendations

- Only stock purchased by the care home for administration under the homely remedies policy may be used in this instance. This is different to residents with capacity purchasing their own over the counter products.
 - Only the named preparations listed in the policy may be administered as Homely Remedies.
 - Products labelled for a particular resident (ie for whom a prescription has been issued), brought in by the resident or recommended solely for a particular resident must not be given to another service user as a homely remedy.
 - All administered doses of homely remedies must be recorded and indicated as a homely remedy on the mar sheet and other medication recording documents in accordance with the medicines policy in the home.
9. At times residents may develop a minor ailment which in their own home would be easily treatable by accessing a local pharmacy for an OTC product. If a resident does not have a suitable remedy on their normal prescription the staff may feel that the only course of action is to call the GP or the out of hours service. This may be for something like a headache. By having homely remedies in the home, an immediate need can be met and the GP is only called if the symptoms persist.
10. The pharmacist, visiting nursing service or NHS Choices will also provide necessary advice. It is generally advised that homely remedies should only be used for 48 hours and then a referral to the service users GP via the Enhanced Care Home Support Service (ECHSS) should be made.

Managing homely remedies

Administration

11. This guidance helps to clarify the actions required by the senior staff of the home who are responsible for the administration of medicines. All staff must recognise and act within the parameters of safe practice. Professional accountability for updating knowledge of homely remedies will lie with the lead person for the management of medication within the home; this is usually the manager, deputy or lead nurse.
12. The manager is responsible for ensuring that appropriate training and support is made available to all staff involved in the administration of medicines.

Storage

13. Homely remedies should be stored in the same location as all other medication but designated clearly to show they are not resident specific.
14. The contents of the homely remedies cupboard should be date checked at least every six months and on administration. The date of opening should be marked on liquid medicines which should then be replaced as advised by the manufacturer.

Process

15. The use of homely remedies for the minor ailments named in this document is supported by a flow chart decision aid and it enables staff to use stocked medication appropriately.

16. Homes, individual residents or families may need to purchase a homely remedy. If the staff are unsure if a homely remedy is suitable, they must seek the advice of the nurse visiting service, doctor or pharmacist before use.

17. The flow charts included in this document provide a decision making tool for some specific minor ailments.

18. When using the flow charts the carer/nurse must ascertain:

- **That the resident has no potentially serious symptoms**
- **Past medical and drug history**
- **Any known allergies**
- **What the resident has used in the past for these particular symptoms**
- **That the resident consents and is aware that the medicine is not prescribed**
- **That the homely remedy medicine will be used for up to 48 hours only**

19. The senior carer/nurse will regularly review and reassess the resident's response to the medication. Further doses can be administered in accordance within the medicinal products GSL or P licence guidelines, for a maximum of 48 hours. If the symptoms persist then a referral should be made to the single point of access.

Record keeping

20. The carer/nurse will record details of the assessment, homely remedy administered and outcome in the resident's care plans and the mar sheet.

21. Monitor the usage of all homely remedies.

Adverse reaction

22. In the rare event of any adverse reactions, the GP must be informed immediately.

23. The yellow card adverse drug reaction reporting scheme is a voluntary scheme through which doctors notify suspected adverse reactions to medicines. It is for the GP to decide, following discussions with the senior staff/nurse, whether to submit a yellow card to the Medicines Control Agency/Committee on Safety of Medicines.

24. In the event of a serious life threatening adverse reaction the nurse/carers will carry out emergency treatment and refer the resident direct to the accident and emergency department.

FLOW CHARTS

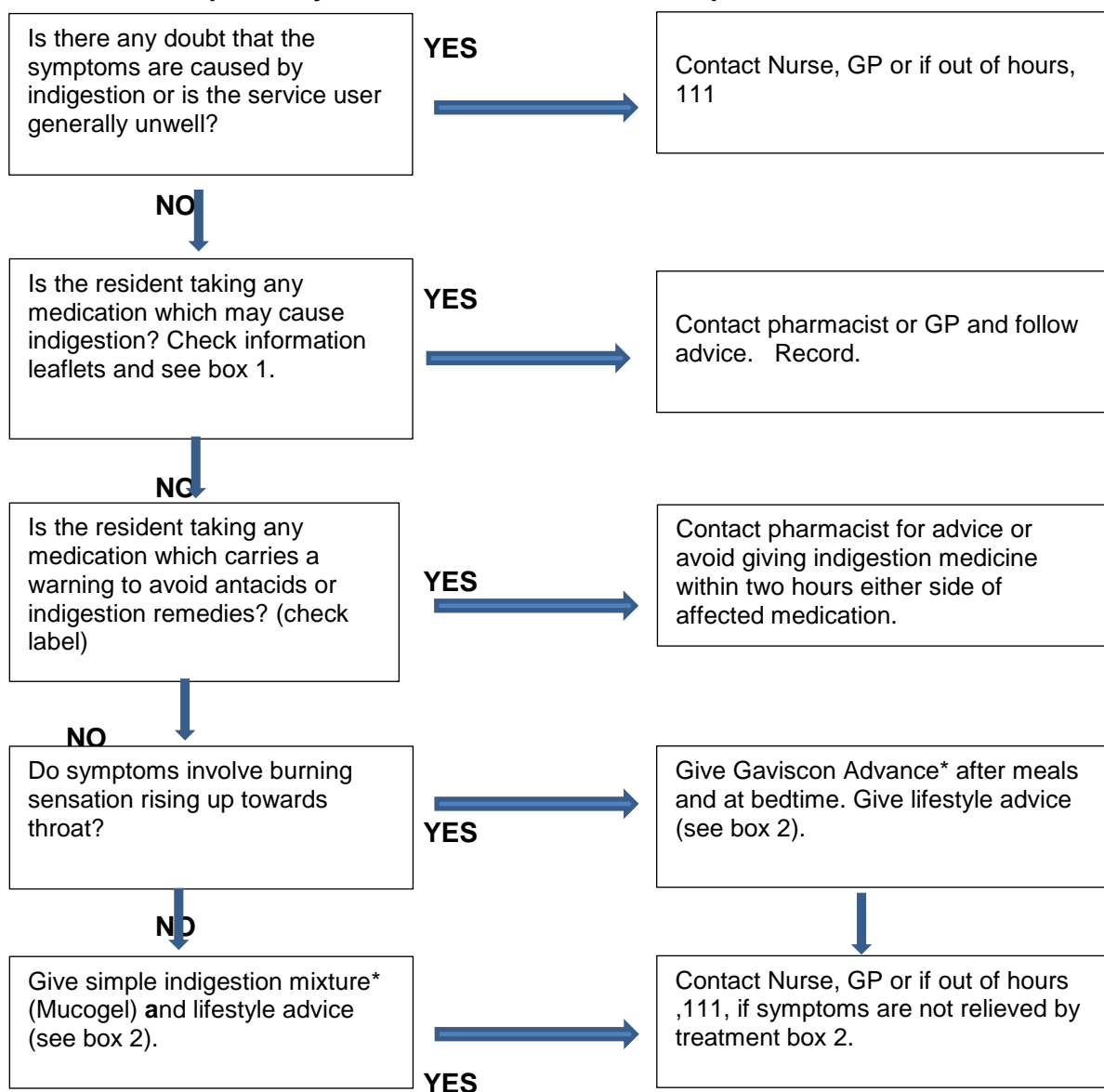
Flow charts relating to the following symptoms are provided below.

These charts should be used in conjunction with the homely remedies toolkit.

Chart No	Symptom	Medicine
1	Indigestion/heartburn	Maalox or Mucogel (co-magaldrox) Gaviscon Advance (low in sodium at normal doses)
2	Pain (mild to moderate)	Paracetamol (other medicines containing Paracetamol may have been prescribed for some residents and this must be carefully checked.
3	Dry cough	Simple linctus for non-diabetic residents, or sugar free simple linctus for diabetic residents.
4	Constipation	Senna, Senakot, Movicol
5	Diarrhoea	Oral rehydration therapy, eg Dioralyte
6	Sunburn	Calamine Lotion

**Chart 1 - Guidance for treatment of minor ailments with household remedies:
INDIGESTION / HEARTBURN**

Indigestion is experienced as discomfort, or a burning pain in the central chest region. When this burning rises up towards the throat it is referred to as heartburn. Flow chart for use when resident has mild pain only. All cases of acute or severe pain must be referred immediately.



Treatment box 1

Some medicines that commonly cause indigestion:

- Anti-inflammatory medicines, eg aspirin, ibuprofen, diclofenac, naproxen
- Oral corticosteroids, eg prednisolone

Treatment box 2: Lifestyle advice

- Eat small regular meals, chew food well
- Avoid bending or stooping during and after meals
- Cut down or stop smoking, alcohol, caffeine (contained in coffee, cola drinks, tea and some pain killers) if possible
- Avoid spicy foods, eg curries
- Avoid clothing which is tight around the waist

PRODUCTS NAMED IN FLOW CHART 1 – INDIGESTION / HEARTBURN

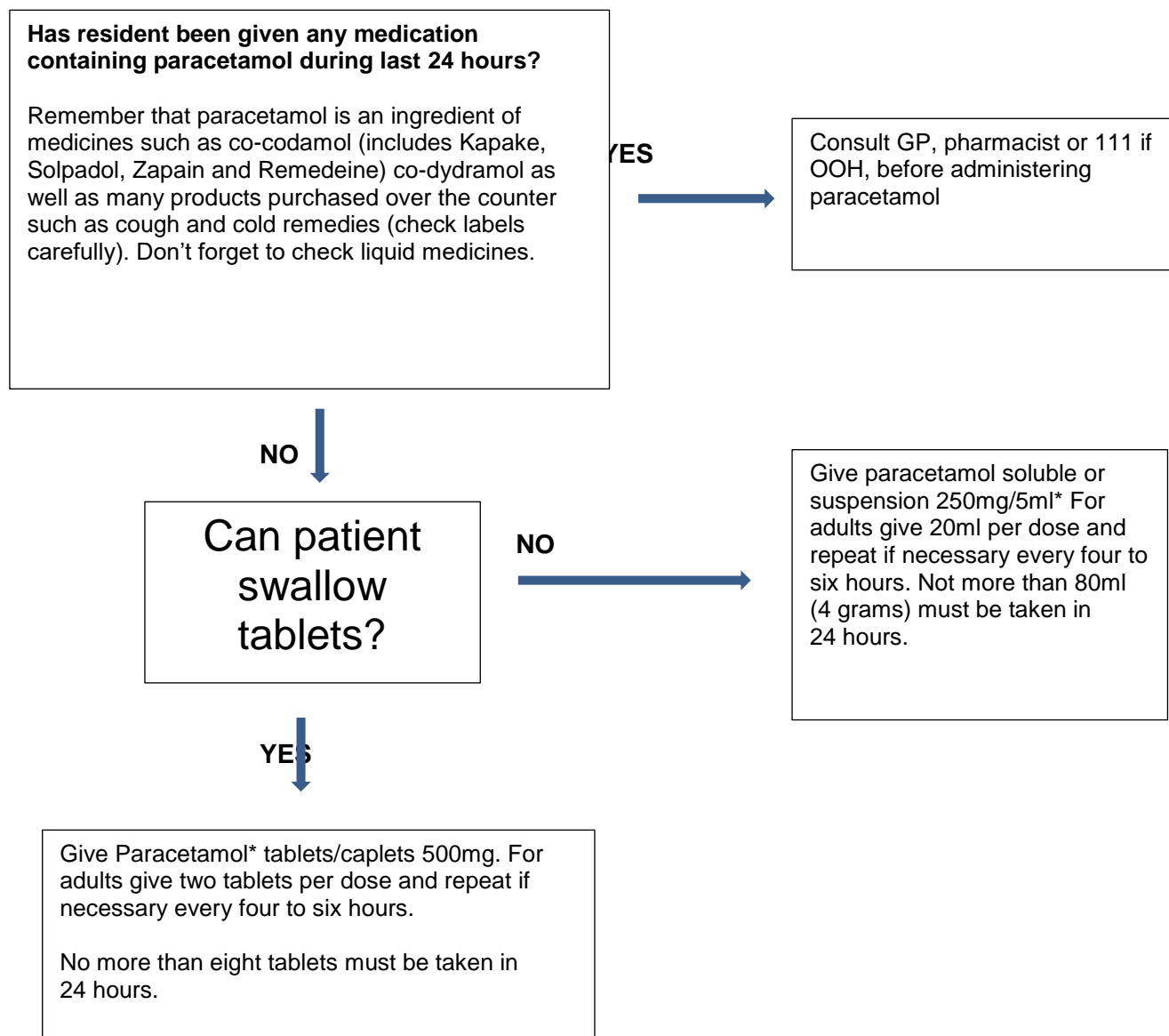
Drug	Gaviscon Advance suspension
Indication of use	Heartburn and indigestion
Strength	N/A combination product
Dose	5 – 10 ml after meals and at bedtime
Maximum dose in 24 hours	40 ml in divided doses
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	Contains sodium (4.6 mmol in 10 mls), avoid in hypertensives or where sodium restriction is indicated
Additional information	Shake well before use Sugar free so suitable for diabetics
Additional resources	BNF 1.1.2 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Drug	Maalox or Mucogel (co-magaldrox)
Indication of use	Heartburn and gastric hyperacidity
Strength	N/A combination product
Dose	10-20ml three times daily 20 minutes to one hour after meals, and at bedtime, or as required
Maximum dose in 24 hours	100ml daily
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	Should not be used in patients who are severely debilitated or suffering from kidney failure. Antacids inhibit the absorption of tetracyclines and vitamins and should not be taken together. Leave at least two hours between doses.
Additional information	Shake well before use Sugar free so suitable for diabetics Must be discarded 28 days after opening
Additional resources	BNF 1.1.1 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Chart 2

Guidance for treatment of minor ailments with household remedies – PAIN such as headache

Flow chart for use when service user has mild pain only. All cases of sudden onset severe pain must be referred via ECHSS or 111 if out of hours, or 999 if a medical emergency.



Communication of pain is not just verbal. Look for facial signs, sighing, groaning, calling out, aggression and withdrawal which is out of character.

PRODUCTS NAMED IN FLOWCHART 2 – PAIN

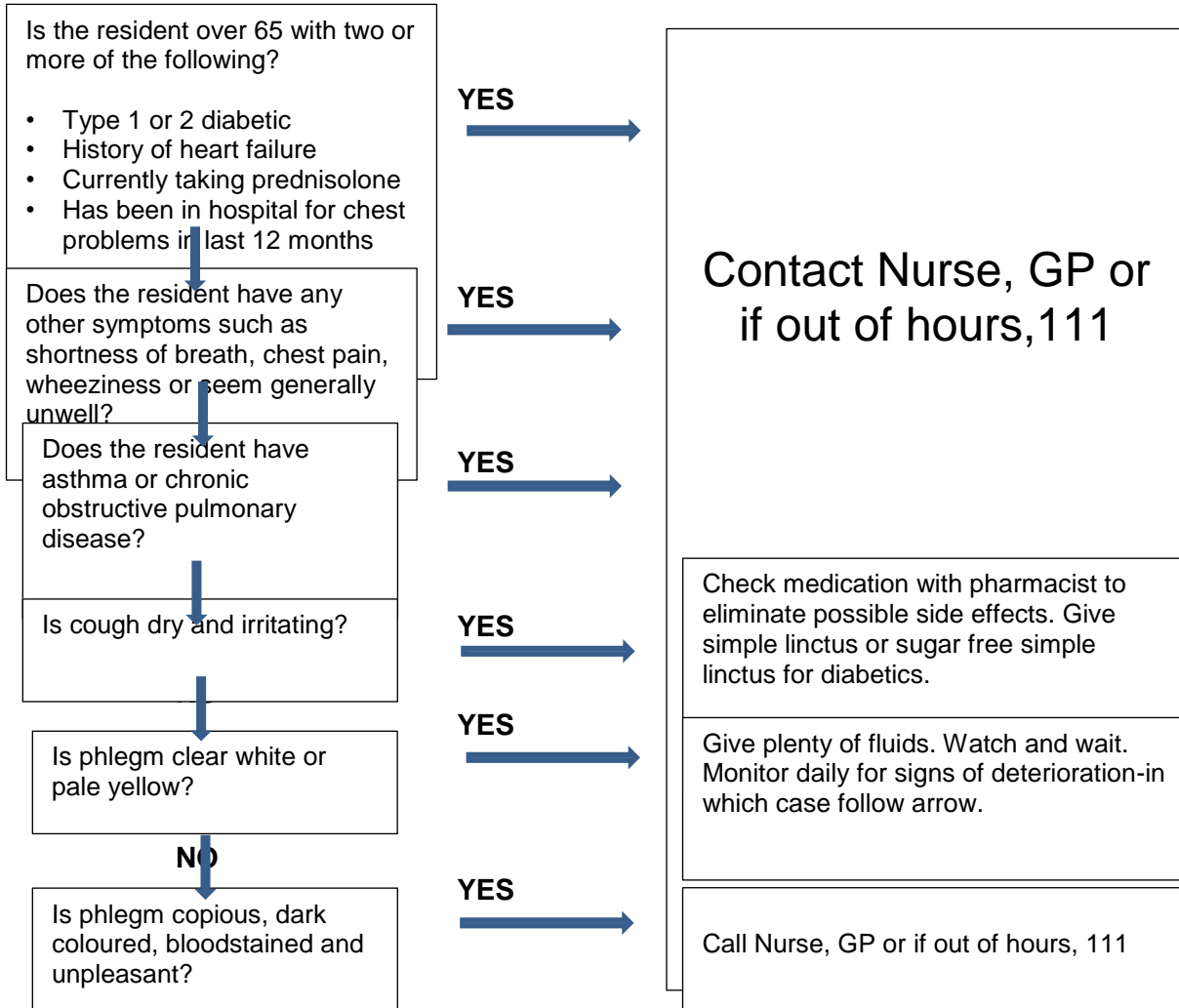
Drug	Paracetamol
Indication of use	Relief of mild pain
Strength	500mg tablets/capsules/caplets
Dose	Two tablets up to four times a day
Maximum dose in 24 hours	8 tablets (4g) in divided doses (maximum of two tablets or 1g, in any four hours)
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	Do not administer with other paracetamol containing products (check all current medication taken). Not suitable if history of severe liver disease or alcohol abuse if body weight is <39kgs, consider giving one tablet up to four times a day.
Additional information	Many medicines also contain Paracetamol. If in doubt check with pharmacist.
Additional resources	BNF 4.7.1 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Drug	Calpol
Indication of use	Relief of mild pain
Strength	250mg/5ml suspension (Calpol six plus)
Dose	Four 5ml spoonfuls (20ml) up to four times a day
Maximum dose in 24 hours	80ml (4g) in divided doses (maximum of 20ml or 1g, in any four hours)
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	Do not administer with other paracetamol containing products (check all current medication taken). Not suitable if history of severe liver disease or alcohol abuse If body weight is <39kgs, consider giving 10ml up to four times a day
Additional information	Many medicines also contain paracetamol. If in doubt check with pharmacist. Sugar free is also available for diabetics.
Additional resources	BNF 4.7.1 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Chart 3

Guidance for treatment of minor ailments with household remedies - COUGH

Flow chart for onset of cough. Antibiotic treatment is not indicated for the majority of otherwise well patients with coughs.



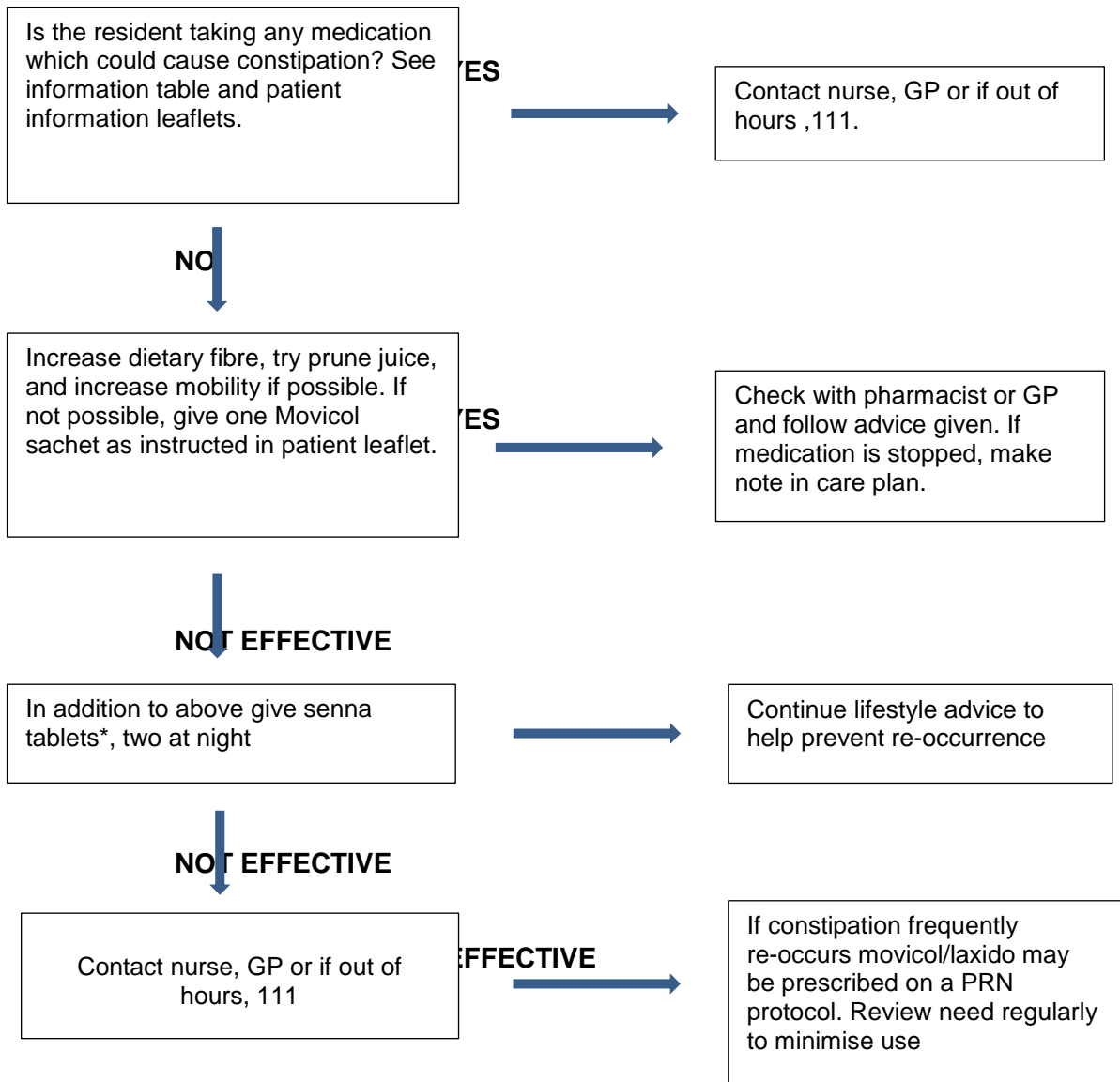
PRODUCTS NAMED IN FLOW CHART 3 - COUGH

Drug	Simple linctus
Indication of use	For relief of occasional non-persistent cough
Strength	N/A
Dose	5-10ml up to four times a day
Maximum dose in 24 hours	5-10ml up to four times a day
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	High sugar content, do not use for diabetics
Additional information	More soothing if taken with warm water
Additional resources	BNF 3.9.2 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Chart 4

Guidance for treatment of minor ailments with household remedies - CONSTIPATION

Initial changes in bowel habits should be reported via ECHSS.. Bowel charts should be kept in care plans for monitoring purposes. Constipation in the elderly is often due to insufficient fluid intake so ensure people are supported to take adequate fluids, little and often is more effective in older people than large glasses.



Information

Some common drugs which can cause constipation:

- Indigestion remedies containing Aluminium
- Antidiarrhoeals eg loperamide (Imodium)
- Antihistamines eg chlorphenamine (Piriton), promethazine (Phenergan)
- Antipsychotics
- Cough suppressants eg codeine and pholcodine
- Diuretics eg bendroflumethiazide, furosemide (if dehydration occurs)
- Iron and calcium supplements
- Pain killers containing opiates eg codeine, dihydrocodeine, morphine, tramadol
- Some antidepressants eg amitriptyline, dosulepin, imipramine
- Some Parkinson's drugs eg levodopa
- Some drugs to treat high blood pressure

PRODUCTS NAMED IN FLOW CHART 4 - CONSTIPATION

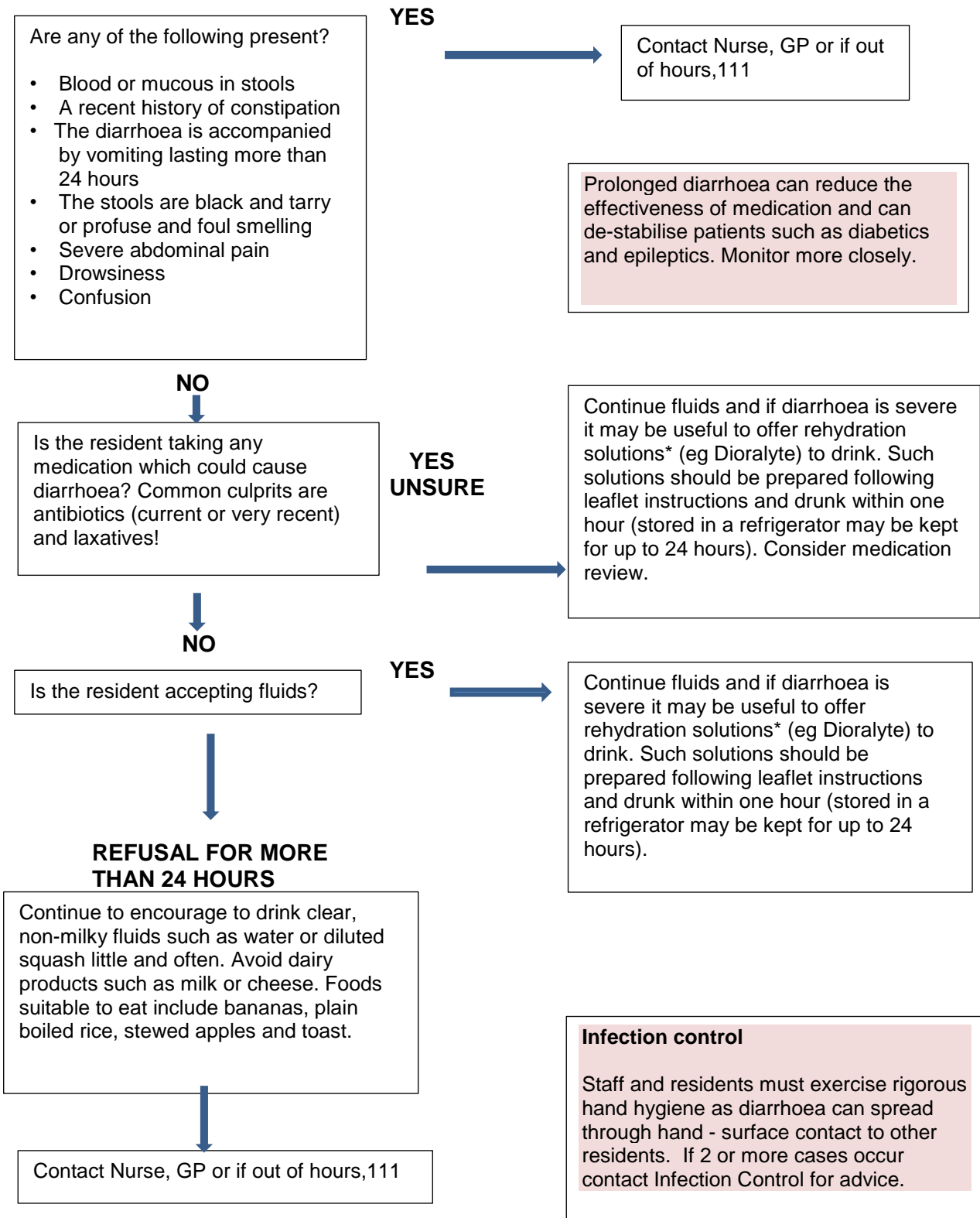
Drug	Macrogols '3350' Movicol sachets
Indication of use	For relief of constipation
Strength	N/A
Dose	One sachet daily
Maximum dose in 24 hours	One
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	As a precaution administer at least an hour after other medication. One sachet contains 65mmol/l of sodium and other electrolytes.
Additional information	Must be made up in 125ml of water (half a glass). Can be mixed with any juices of preference. Reconstituted sachets must be discarded after 6 hours if not taken. Can be chilled in fridge before giving.
Additional resources	BNF 1.6.4 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Drug	Senna tablets
Indication of use	For relief of constipation
Strength	7.5mg
Dose	Two tablets at night
Maximum dose in 24 hours	Two
Maximum duration of treatment as homely remedy	Up to 48 hours then seek advice of GP
Cautions	
Additional information	Can cause abdominal cramps Available as a liquid also as Senokot syrup for those who cannot take tablets
Additional resources	BNF 1.6.2 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

Chart 5

Guidance for treatment of minor ailments with household remedies - DIARRHOEA

Diarrhoea in the frail elderly can quickly lead to dehydration and deterioration in health.



PRODUCTS NAMED IN FLOW CHART 5 - DIARRHOEA

Drug	Dioralyte sachets
Indication of use	For fluid and electrolyte replacement
Strength	N/A
Dose	One or two sachets after each loose stool
Maximum dose in 24 hours	N/A
Maximum duration of treatment as homely remedy	Up to 24 hours if refusing to drink –seek advice form ECHSS Up to 48 hours if diarrhoea is persistent then seek advice of GP
Cautions	
Additional information	Contents of each sachet should be dissolved in 200ml of drinking water. The solution may be stored for up to 24 hours in a fridge, otherwise any solution remaining an hour after reconstitution should be discarded.
Additional resources	BNF 9.2.1.2 Patient leaflet http://www.medicines.org.uk/EMC/default.aspx

APPENDIX 6

MEDICATION REFRIGERATOR TEMPERATURE MONITORING

In order to maintain the cold chain of supply and to protect service users, a written record of the daily maximum and minimum temperatures of your medication refrigerator should be maintained. This will ensure that the correct conditions for the storage of products can be demonstrated.

Readings should be made daily using a maximum-minimum thermometer, in accordance with the manufacturer's instructions. A record should also be made of the dates when the refrigerator is defrosted, which should be at regular intervals. A hardback notebook is a suitable means of recording temperatures against dated entries. All pages should be consecutively numbered, suggested headings are detailed below. This task should be delegated to a senior care assistant and monitored by the senior care assistant with lead responsibility for medication and the team manager.

The temperature of the refrigerator must be kept between the range of +2°C and +8°C. Appropriate action should be taken to ensure that this range is maintained.

A refrigerator containing medicines **should not be** used to store food and drinks in order to limit the chance of changes in temperature and to limit and minimise the risk of contamination. Insulin should not be stored near the freezer unit.

The refrigerator cabinet should have sufficient space around it for air to circulate and not be obstructed with papers, bags etc.

The following actions should be taken:

- Make sure staff know how to use and read your thermometer – guidance on how to use both mercury and digital thermometers can be found at <http://www.rpsgb.org/pdfs/restoolusethem.pdf> The reset button is pressed after recording the temperature each day in order to obtain a new baseline
- Ensure when using a digital thermometer that the probe is in a suitable position – this could be inside a box of medicine for example
- If regular readings below +2°C and +8°C are obtained, review the training and competence of the member of staff reading the temperatures and/or ensure your refrigerator is working correctly
- Delegate the task of taking daily readings to a trained senior care assistant but review the readings on a monthly basis
- In the case of a power cut or if the refrigerator temperature is outside of the stated range, then assess the integrity of the stock by contacting the pharmacist

Date/Day	Max Temp C	Min Temp C	Action taken if outside range 2-8 C	Checked by (initials)	Thermometer reset (tick)
Monday or 5 th	9	1	Ensured thermometer working properly – informed pharmacist	ST	4

REFRIGERATOR TEMPERATURE RECORD

Please record the date(s) the refrigerator was defrosted:

Review:

Has the refrigerator been checked every day: Yes No (circle)

Has any necessary action been taken? Yes No (circle)

If yes, what was the action?

Reviewed by:.....Date.....

Lead Senior Care Assistant.....Date.....

Team Manager.....Date.....

If the refrigerator temperature is outside o the stated range (+2°C and +8°C) then assess the integrity of the stock in the refrigerator seeking manufacturer’s advice where appropriate.

APPENDIX 8

WARFARIN & OTHER BLOOD THINNING MEDICATION

Warfarin is an anticoagulant used to prevent and treat the formation of harmful blood clots within the body by thinning the blood and/or dissolving clots.

- Service users should have an anticoagulant record book and should always carry it with them and take with them to any health check e.g. dentist, chiropody appointments
Service users will have regular blood tests to check the level of Warfarin in their blood - these tests are very important
- Service users should avoid drinking cranberry juice and grapefruit juice while taking this medication as it may effect the levels of warfarin in the body
- Alcohol should only be drunk in moderation as it can effect the levels of warfarin in the body
- Follow the instructions provided by the GP or Warfarin clinic
- Take dose at the same time every day as detailed in the service users record book
- The dose may be made up of more than one strength tablet. Each strength is a different colour. This should be clearly recorded on the service users MAR chart and must account for changes made by the prescriber or anticoagulant clinic with immediate effect
- The dose may be reduced/increased subject to the outcome of a blood test. (International Normalised Ratio or INR– a measure of the ability of blood to prevent clotting)
- If unusual bleeding, bruising, blood in urine or blackened stools occur, contact the prescriber as soon as possible.
- MAR chart and care plan must have WARFARIN printed in red ink where possible or highlighted.
- Ensure service user takes their record book with them if they leave the care home
- All dose changes must be confirmed in writing by the prescriber or the anticoagulant clinic. This can be recorded on the service user's yellow record book or sent by fax or secure email to the care home
- Warfarin should not be administered using monitored dosage systems but must be given from the boxes in which they are dispensed by the pharmacy.
- Should a resident return from an appointment without their yellow book, care staff should obtain written confirmation of any dosage change i.e by fax or email, the same day to enable them to administer the dose based on the most up to date information.

Other common anticoagulants now in use are:

- **Apixaban**
- **Dabigatran**
- **Edoxaban**
- **Rivaroxaban**

These drugs do not require regular blood tests and are not affected by moderate alcohol.

APPENDIX 9

ADMINISTRATION OF BUCCAL MEDICATION (MEDICATION THAT DISSOLVES IN THE MOUTH)

Service users who experience seizures may be prescribed buccal medication to ensure prompt response as this type of medication absorbs quickly into the bloodstream through the oral cavity (between gums and side of mouth).

The aim is for safe and effective administration of medication for service users who experience severe seizures.

Staff working with service users at risk of seizures who are prescribed buccal medication must be trained and competent in its administration. Competency should be reviewed at least annually in line with medication training procedures (See section 6). Qualified nurses and care workers who undertake this procedure must take responsibility for their skills, competence and actions. Qualified staff who delegate and train care workers must undertake risk assessment and are accountable for their actions and omissions (see section 6 Training , Delegation of tasks).

The task must be written into the service users care plan following discussion with the service user, relatives where appropriate, care manager and prescriber. Staff must adhere to their organisations policy and procedures and local guidelines (see also Section 2 capacity & consent).

This medication must always be accompanied by a detailed care plan describing;

- signs and symptoms the service user may experience
- Other Useful Information (Triggers, Seizure Frequency, Time of Seizure etc.)
- Medication details (name,dose, frequency, route, when to administer)
- Description of how to administer
- Allergy information, cautions & contra-indications
- Service Users response to medication, side effects
- What to do if difficulty in administering
- What to do if no response to medication
- What is an emergency situation and how to respond
- A review process and who is responsible for the review

See also:

Section 3 re documentation and temporary absence from home

Section 4 re the safe storage of medication and procedures for Controlled Drugs.

APPENDIX 10

APPLICATION OF COMPRESSION (ELASTIC) HOSIERY

Staff should only apply compression hosiery if they have been trained and deemed competent by a district nurse.

Compression hosiery is a prescribed on-going treatment. It is not the same as compression bandaging which must be done by a qualified practitioner.

AIM

To ensure compression hosiery is applied correctly and safely.

To promote service user comfort and health promotion.

EQUIPMENT

Hosiery – **as prescribed by doctor or consultant**

Aid (if appropriate)

Please note:

- Compression hosiery is a **prescribed** ongoing treatment for the prevention of venous leg ulcers.
- The monitoring of its effectiveness and review is the responsibility of the prescribing health professional.
- Should the service user's legs become red, itchy, or painful or the service user is refusing to wear hosiery contact the named health professional immediately.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of service user. Takes account of health & safety.
2	Explain procedure to service user. Wash hands.	To obtain consent and co-operation.
3	Before commencing this task the carer should ensure his/her nails are trimmed (no false nails to be worn) If possible	To prevent damage to

	<p>apply hosiery before getting out of bed.</p> <p>Ensure legs are clean and dry prior to application. If appropriate and following training, application aids may be used.</p>	<p>clients skin. To promote service users comfort and assist in easier application.</p>
4	<p>Using both hands run hands inside hosiery down to heel. Pinch heel with finger and thumb, keeping hold, turn stocking inside out.</p>	<p>To assist application.</p>
5	<p>Place hosiery over foot to cover toes up to the back of heel.</p>	<p>To assist application.</p>

	ACTION	REASON
6	Gather up remaining stocking and working in sections from the ankle take the stocking up the leg. Once the stocking is fully extended on the leg bring back to the calf. With a twisting motion, take sections of the stocking up the leg again.	To assist application. To ensure the stocking has no creases, is fitted correctly and remains in place.
8	Check that the toe section does not restrict the toes. Never fold over excess hosiery at toes, knees (if below knee) or top of leg (if full leg).	May cause restriction to normal blood flow and damage skin.
9	Ensure thigh length stockings are anchored with a minimum of two suspenders.	To ensure stockings remain securely in place.
10	To remove the hosiery at night, gently ease the stockings down taking care not to damage the skin.	To prevent trauma.
11	Record procedure and include any changes. Report any concerns to appropriate health staff.	To record procedure has taken place and to alert health staff of service users current condition.

APPENDIX 11

GTN SPRAY / TABLETS (GLYCERYL TRINITRATE)

Glyceryl Trinitrate is commonly known as GTN. The tablets/spray work by temporarily enlarging (dilating) the blood vessels of the heart, thereby increasing blood flow to the heart. This relieves the pain/discomfort of angina and they usually work quickly.

Service users make an informed decision on the need to use their GTN spray or tablet. This is usually because of an acute episode of shortness of breath and/or pain. The service user has overall responsibility for taking this medication. The carer may assist for example getting it out of the drawer or out of a handbag.

It should be noted that the dilation of blood vessels has the effect of temporarily lowering blood pressure and may cause dizziness or lightheadedness, increasing the risk of falls or faintness.

The service user has overall responsibility for taking this medication when it is needed.

AIM

To relieve the pain/discomfort of angina and they usually work quickly.

EQUIPMENT

Medication either spray or tablets- service users are aware that they need to have this medication close at hand.

Please note: Service users must be mentally able to participate with self-medication arrangements even if physically limited in what they can actually do.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	Ensure service user has adequate supplies of medication as prescribed.	To ensure service user does not run out of supplies of medication.
3	Check service user can read the labels and understands the instructions.	To ensure service user is aware of how to take the medication
4	Observe for any difficulties in self-administration of medication	Detection of changes/difficulties that may indicate prompt referral to GP.

5	Maintain service user safety if necessary, immediately following administration in relation to falls risk, dizziness etc. until this passes	To reduce risk of falls during temporary effects of lowered blood pressure.
5	Record and report procedure and any concerns and action taken in the event of any difficulties.	To record and evaluate procedure.
6	Report to the prescriber if the patient is requiring to use their GTN spray very regularly or if they never need to use it.	To prompt a review of their condition to identify any additional treatment they may need or to stop prescribing of an unnecessary item.

APPENDIX 12

GUIDELINES ON THE ADMINISTRATION OF EYE DROPS / OINTMENT

Written Assessment of needs will be completed by Health staff, following prescription of eye drops.

Care Arrangements will be written in the individual care plan.

The task of administering eye drops/ointment could be delegated to care staff following training and if they have been assessed as being competent and confident to complete them. Instruction by community nurses will be given to care staff on the individual needs of the service user.

Please note: Immediate post operative eye drops should not usually be delegated to care staff until 2 weeks following surgery. During this period the community nurse should visit daily and share the task with care staff.

MONITORING and REVIEWING will be completed by health staff according to assessed need and will be recorded by the named Health professional in the individual care plan. Health staff should be contacted to reassess if any of the following problems are noted:

- If the service user complains of discomfort in the eye.
- If the service user's vision deteriorates
- If the service user complains of double vision
- If the service user complains of headaches
- If there is a discharge from the eye (sticky eyes)
- Should there be a need for any further advice

INSTILLATION OF EYE DROPS / EYE OINTMENT

AIM

To ensure medication is safely administered and service user is comfortable.

EQUIPMENT

Eye drops/ointment – as prescribed

Gauze swab / tissue

Apron (optional)

Disposable gloves

Please Note: If applying more than one type of eye drop / eye ointment, follow the individual health profile sheet for correct order of instillation and leave a minimum of 2 minutes between drops.

If any issues or concerns contact the named health professional.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	Explain procedure to service user.	To obtain consent and co-operation.
3	Sit the service user on a chair with their head tilting back if possible, in good light, ensuring a comfortable position.	This ensures service user comfort and easy access for the carer.
4	Check the prescribed treatment carefully, which eye it is for and the expiry date. Note , eye drops / ointments should not be used over 4 weeks after opening. Always write the date medication was opened on the label. Check the expiry date & date opened at every administration.	To ensure the correct drops / ointments are instilled into the correct eye/s. To prevent damage to eye.
5	Wash hands and lay out equipment on a clean working surface. Apply disposable gloves.	To prevent cross infection and ensure a safe environment.

	Shake the eye drop bottle and remove the lid, place on clean surface. If eye ointment to be applied, discard half a centimetre of ointment onto a tissue.	
6	Ask the service user to look upwards, pull the lower lid down with gauze / tissue. Squeeze one drop into the lower eyelid, ensuring dropper does not touch the eye or eyelid. Repeat as prescribed,	This opens the eye and prevents the drop from falling into the sensitive surface of the eyeball.
7	When the drop is in place ask the service user to close their eye and encourage them to blink a few times. Gently remove excess moisture with tissue / gauze.	To ensure absorption of the eye drops and promote client comfort.
8	If eye ointment to be applied, gently apply half an inch strip of ointment inside the inner surface of the lower lid, ensuring not to touch the lid with the tube. Ask the service user to close eye for a minute and then blink several times.	To ensure absorption of the ointment.
9	Clear work-surface, remove and dispose of gloves and wash hands.	To leave safe environment and prevent contamination.
10	Record procedure and include any changes.	To record procedure has taken place.
11	Report any concerns to appropriate health staff.	To alert health staff of service users current condition.

APPENDIX 13

INSTILLATION OF EAR DROPS

AIM

To ensure medication is safely administered and service user is comfortable.

Equipment

Ear drops – as prescribed (at room temperature)

Gauze swab / tissue

Apron (optional)

Disposable gloves

Please Note:

- Care staff should only administer a course of ear-drops for chronic infections or to loosen wax in the inner ear if the medication has been prescribed and the task is delegated and reviewed by a health professional.
- If any problems or concerns contact the named health professional.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	Explain procedure to service user.	To obtain consent and co-operation.
3	Check the prescribed treatment carefully, which ear it is for and the expiry date. Always write the date medication was opened on the label. Check the expiry date & date opened at every administration.	To ensure the correct drops are instilled into the correct ear/s and they are in date.
4	Wash hands and lay out equipment on a clean working surface. Apply disposable gloves. Shake the eardrop	To prevent cross infection and ensure a safe environment.

	bottle and remove the lid, place on clean surface.	
5	Check which ear to instil the medication, refers to health profile sheet.	To safeguard the service users well being and ensure the medication is being administered correctly.
6	Draw up the medication into the dropper until half full.	Prepare for drop administration.
7	Ask the service user to tip their head to one side or lie on their side with the affected ear uppermost. Take hold of the ear lobe and carefully pull it back to create as large an opening as possible.	This opens the ear and prevents the drop from falling out.
8	Rest the end of the dropper over the ear opening and allow the drops to trickle gently into the service users ear. Wipe away any excess liquid with a gauze swab or a clean tissue.	To maintain service users comfort.
9	Ask the service user to remain with their head to one side for about five minutes.	To ensure absorption of the eardrops and promote service user comfort
10	Clear work surface and wash hands.	To leave safe environment and prevent contamination.
11	Record procedure and include any changes. Report any concerns to appropriate health staff.	To record procedure has taken place. To alert health staff of service users current condition.

APPENDIX 14

GUIDELINES FOR THE ADMINISTRATION OF NASAL DROPS

ASSESSMENT of needs will be completed by Health staff following the prescription of nasal drops. **CARE ARRANGEMENTS will be written in the individual care plan.**

The task of administering nasal drops could be delegated to care staff following training and if they have been deemed to be competent and confident to complete them.

Instruction by nurses will be given to care staff on the individual needs of the service user.

MONITORING and REVIEWING will be completed by Health staff according to assessed need and will be recorded by the named Health PROFESSIONAL in the individual care plan. Health staff should be contacted to reassess if any of the following problems are noted:

- a) If the service user complains of discomfort in the nose/nostril
- b) Should there be a need for further advice.

Nursing staff should assume overall responsibility.

ADMINISTERING NOSE DROPS & NASAL SPRAYS

AIM

To ensure medication is safely administered and the service user is comfortable.

EQUIPMENT

Nose drops/nasal spray – as prescribed

Gauze swab/tissue

Apron Disposable gloves

Please note:

Care staff should only administer a course of prescribed nose drops/nasal spray for chronic infections if the service user has capacity and is unable to administer the medication themselves.

	ACTION	REASON
1	Establish identity of service user	Safety and well being
2	Explain the procedure	To obtain consent and co-operation.
3	Check the prescribed treatment carefully from bottle and MAR chart.. Check expiry date & Always write the date medication was opened on the label. Check the expiry date & date opened at every administration.	To ensure correct drops/spray is instilled correctly.
4	Wash hands and layout equipment on a clean work surface. Apply disposable gloves.	To prevent cross infection and ensure a safe working environment.
5	Ask service user to gently blow their nose.	To clear nasal passage.
	NOSE DROPS	
6	Draw up the medication into the dropper	Prepare for administration of drops.

7	Ask service user to tilt their head back and insert the prescribed number of drops into their nose. Do not let the dropper touch the nasal membranes.	To prevent the drops from falling out and to prevent contamination of the rest of the medication.
8	Keep head tilted back for 5 – 10 seconds and sniff gently 2 or 3 times.	To enable the medication to be absorbed into nasal passageways.
	NASAL SPRAY	
9	Do not tilt the service user's head back.	
10	Insert the sprayer into the nose, try to avoid touching the nasal membranes.	To prevent contamination of the bottle contents
11	Ask service user to sniff whilst squeezing the sprayer at the same time, according to the manufacturers directions.	To enable the medication to be absorbed into the nasal passageways.
12	Do not release your grip on the sprayer until you have withdrawn it from their nose.	To prevent nasal mucus and bacteria from entering the plastic bottle and contaminating the contents.
13	Unless GP/nurse has advised otherwise, do not use nose/nasal spray for more than two or three days at a time.	Cross contamination.
14	Drops/sprays prescribed for a longer period should not be administered from the same container for more than one week. A new container should be ordered if	Cross contamination – bacteria from nose can easily enter the container and contaminate the solution.

	drops/spray are required for more than one week.	
15	Record outcome of the procedure.	Communication, safety and well being.

APPENDIX 15

GUIDELINES FOR EXTERNAL APPLICATION OF CREAMS, OINTMENTS AND GELS

ASSESSMENT of need will be completed by medical or nursing staff.

CARE ARRANGEMENTS for prescribed treatments will be defined by nursing staff and included in the individual care plan. This will include:-

- The name of the cream, ointment or gel
- The site of the application, as per body chart
- The method of application
- The frequency of application
- The indications for application

The task of applying the cream, ointment or gel may be delegated to care staff following training and they have been assessed as being competent and confident to do so.

Instruction by community nurses will be given to care staff in relation to the assessed needs of the service user. If necessary a body map indicating the application site should be provided and must be available to staff administering the cream, ointment or gel.

Please note: Care staff working in care homes, day centres and domiciliary services are **NOT** permitted to administer creams, ointments or gels with applicators/nozzles into any orifice (rectal, vaginal) as this would be considered an intrusive procedure. The exception to this may be staff working in Learning Disabilities environments who should refer to their organisational policies & procedures.

MONITORING and REVIEWING of care arrangements will be by health staff. The frequency of such monitoring will vary according to need and will be recorded in the individual care plan, which is kept with the service user.

Health staff should be contacted if any of the following problems are noted.

- A change in skin colour or texture
- A change in skin temperature
- If there is evidence of a skin 'rash'
- If a service user complains of discomfort
- If the carer has any other concerns

ASSISTANCE WITH EXTERNAL APPLICATION OF CREAMS

AIM

To manage application of creams whilst preserving service users dignity.

Creams, ointments, gels

Where topical preparations are prescribed, the provider should complete a topical application chart for use by care staff to follow, which describes the rationale, site, frequency and any other relevant information. Guidance which states 'use as or when required' is not sufficient. A body map showing the parts of the body the cream is to be applied to should accompany the chart.

All staff must be aware that some topical preparations contain potent medication and they must be applied in accordance with the instructions.

Staff for their own protection should wear disposable gloves.

The application of the medication must be recorded, at that time, on the MAR chart and on the service user's daily record sheet, noting and reporting any changes in the condition of their skin.

If creams etc are to be applied by care staff, the task should be noted on the service users care plan and monitored weekly by a senior care assistant.

Care staff may apply creams, ointments and gels following appropriate training.

Sun protection is advisable for service users and should be combined with a t-shirt, wide brimmed hat and sunglasses. It is also important to cover any exposed skin with high factor sun screen.

Sun protection can be purchased by the provider but service users should be encouraged to purchase their supply of cream/lotion and seek advice from their pharmacist or GP.

In care homes, service users should have individual bottles, to prevent cross contamination, and advice should be sought from a pharmacist by the registered person as to which is the most suitable product for the individual.

Sunscreen is an over the counter product which does not require prescribing and will not have a pharmacy label.

The sunscreen should be factor 25 or above with UVA and UVB protection.

The product should be dermatologically tested.

Wherever possible, the service user should be encouraged to apply their own sunscreen following manufacturers instructions. They should also be encouraged to sit in the shade.

Where topical preparations are self-administered, staff should support to ensure the service user is able to do this safely.

Topical Preparations and Fire Risk

Skin products containing paraffin based products such as white soft paraffin, white soft paraffin plus 50% liquid paraffin or emulsifying ointment in contact with dressings and clothing are easily ignited by a naked flame or cigarette. Keep away from fire when using these products.

Recommendations:

- Use cream preparations with the smallest paraffin content possible rather than an ointment.
- Use a Non- Paraffin based emollient for patient's using Medical oxygen therapy.

All patients and their families should be warned of the risks:

- Smoking or a naked flame could cause dressings or clothing to catch fire when being treated with paraffin-based emollient that is in contact with the dressing or clothing.
- Risk of fire is greater when using large quantities of any paraffin-based emollient/ when applied to large areas of the body.
- Bedding and clothing should be washed regularly, preferably daily, to minimise build up of impregnated paraffin. Emollients soak into fabric and become a fire hazard.
- Advise: KEEP AWAY FROM NAKED FLAMES including open and gas fires and candles.
- DO NOT SMOKE/ go near anyone smoking when using paraffin containing preparations.

Staff should ensure residents who self-administer topical preparations are aware of and are adhering to safety advice and where this is not the case a risk management plan should be in place.



Paraffin%20containing%20emollients%20p

EQUIPMENT

Gloves

Application cream

	ACTION	REASON
1	Check care plan,risk assessment, topical administration chart, as appropriate.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	Explain procedure to service user.	Obtain services user's consent and co-operation.
3	Check the medication is clearly labelled with name, area medication is to be applied, the rational for application and frequency of applications. Check cream	To ensure medication is prescribed for the service user and is applied to correct area with correct frequency. To ensure expiry date is not exceeded.

	within expiry date (may be hand written by health staff on opening).	
4	Wash hands and put on gloves provided.	To prevent cross infection/adverse reaction to cover.
5	Ask service user to position themselves to give access to affected area in position they are most comfortable.	To ensure comfort and dignity maintained throughout.
6	Apply cream/ointment/gel medication to affected area gently using correct amount if specified e.g. liberally, sparingly. If further cream/ointment/gel is required use a clean glove.	To ensure correct amount and efficient use of cream. To prevent contamination of container and remaining cream/ointment/gel.
7	Remove gloves and dispose in household waste, ensuring remaining cream/ointment/gel is sealed and stored according to instructions.	To maintain safe and hygienic environment.
8	Record procedure. Include any changes.	To enable evaluation of procedure.
9	Report any concerns to appropriate health staff.	Alert appropriate health staff of service users current condition.

APPENDIX 16

GUIDELINES ON THE USE OF AN INHALER

Care staff should be trained and deemed competent by the community nurse or prescriber to observe if a service user is correctly carrying out the use of the inhaler. The GP/Prescriber should be informed immediately if a fault in administration is suspected.

Assessment of a service user's ability to self medicate using the inhaler should be undertaken by an appropriate health professional.

There are many different types of inhalers in use. It is vital to read the manufacturer's directions regarding storage, effective use and good hygiene.

Be aware if any spacer device is required.

Encourage the service user as much as possible to self-administer, explaining the process to them but be prepared to assist if required, i.e. it may be necessary for the worker to shake the inhaler and/or activate it following the correct directions if the service user is unable to do so.

Check medication is in date.

Administer as directed on the inhaler body or box, check that these match with what is written in the MAR chart as they can vary. The chart must be signed following administration and any issues or concerns recorded and reported to the appropriate person.

Staff should ensure that the mouth piece of the inhaler and the spacer are clean before and after each administration. These should be cleaned as per manufacturer's instructions.

AIM

To assist service user to self-administer inhaled medication.

EQUIPMENT

Prescribed inhalers

Spacer if used

Prescription

	ACTION	REASON
1.	Check that a prescription for the inhaler is in place	To ensure the medication is prescribed for the service user
2.	Check that the medication is in date and that the mouthpiece and spacer (if used) are clean	To ensure that the medication is appropriate to administer

3.	Support the service user to administer the medication as directed on the inhaler body or box	To ensure correct usage and identify any problems with administration
4.	Complete any documentation appropriate to the setting	To ensure good communication between care providers
5.	Report any issues or concerns to the appropriate person	To ensure issues and concerns are addressed
6.	To ensure the mouthpiece and spacer are cleaned after use	To maintain hygiene and reduce risk of infection

APPENDIX 17

GUIDELINES FOR USE OF A NEBULISER

A nebuliser is a device used to administer a solution of drugs in a fine mist, small enough to be inhaled easily, through a mask or mouthpiece.

ASSESSMENT of need for medication to be administered via a nebuliser will be made by a doctor in conjunction with the respiratory nurse specialist if appropriate. Equipment may be loaned to the patient via the doctor or hospital. Initial medication and administration requirements will be completed by medical and/or nursing services.

Assessment of a service user's ability to self medicate using the nebuliser is undertaken by an appropriate health professional.

ARRANGEMENTS for ordering and collecting repeat prescription medication will vary according to the service user's GP practice and local pharmacy arrangements and details should be included in the individual care plan.

Care staff are NOT permitted to administer medication when the service user or resident carer is not competent to take overall responsibility. (See Section 2 Consent).

Care staff may assist a service user to load the nebuliser with solution provided the service user is able to take overall responsibility.

Care staff may only assist a service user to load the nebuliser with a single dose solution.

Nursing and care staff may assist in plugging in and positioning the nebuliser for service users.

Nursing and care staff may wash and store mouthpieces and tubing for service users after nebuliser use.

MONITORING and REVIEWING are undertaken by Health staff according to assessed need and recorded in the individual care plan, which is kept with the service user. A reassessment should be requested if any of the following problems are noted:

- Service user becomes breathless
- Service user needs to use the nebuliser more frequently than prescribed
- Service user no longer uses nebuliser
- Service user complains of sore throat/mouth
- Sore skin/rashes are noted around the mouth
- Care arrangements break down/resident carer not competent or able to administer medication
- Any other concerns.

ASSISTANCE WITH USING A NEBULISER

AIM

To assist service user in administration of medication using a nebuliser.

EQUIPMENT

Nebuliser machine

Medication

Face mask for nebuliser

N.B. This procedure will only be carried out as part of the service users individual care plan following an assessment by a named health professional. Care staff will receive instruction in relation to the assessed needs of the service user and the particular appliance being used.

Care staff are NOT permitted to administer this type of medication when the service user is not competent to take overall responsibility. Care staff may assist a service user to load the nebuliser with solution, provided the service user is able to take overall responsibility for dose order or combining of medication in the chamber of the machine.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	Explain the procedure to the service user and establish their level of understanding and independence.	To obtain service users consent and co-operation.
3	Ensure nebuliser, tubing and chamber are clean and wash/replace as necessary. (see action 14)	To reduce risk of infection and ensure efficient function of equipment
4	Wash hands. Ensure tubing is firmly attached to nebuliser machine.	For machine to function correctly.
5	Check medication is correctly named and is within expiry date. Check dosage with service user.	To ensure the medication applies to service user and dosage is not exceeded.
6	Change filter if necessary.	To make efficient use of medication.

	ACTION	REASON
7	Plug in machine, switch on and off observing for illumination of light.	To ensure machine is working.
8	Check service user is in comfortable Position near the machine	To administer correct dose in correct order
9	Add medication to chamber as instructed by service user and in accordance with any directions on medication.	To administer correct dose in correct order.
10	Attach facemask to medication chamber and tubing.	To facilitate administration of medication.
11	Assist service user to place mask over nose and mouth, secure with elastic band around service user's head/ears. Switch on the machine.	To secure mask in place and ensure dose is delivered effectively.
12	When mist stops (medication should be administered over 10-15 minutes), switch off machine.	To discontinue procedure.
13	Assist service user to remove mask and have a drink of water available.	To rinse mouth or have a drink to prevent any reaction from medication.
14	Disconnect mask from tubing. Medication chamber and mask to be washed in warm soapy water, rinsed and dried before/after each use.	To prevent bacterial infection.
15	Record procedure including any concerns.	To facilitate evaluation of procedure.
16	Report any concerns to appropriate health staff.	To alert health staff to any change in service users condition.

APPENDIX 18

GUIDELINES FOR OXYGEN THERAPY

Assessment of needs will be completed by medical staff and oxygen prescribed as required.

Oxygen is delivered to and installed by a pharmacist, or the supplier, or the appropriate health professional.

The safety guidance on oxygen cylinders should be followed and cylinders should be stored upright safely under cover and not subject to extremes of temperatures:

- In a dry, clean, well ventilated area so they do not become dirty or rusty.
- Away from flammable liquids and other combustible materials and from sources of heat and ignition
- All rooms/areas where oxygen is in use should display the statutory warning notices.

‘Compressed gas oxygen. No Smoking. No naked lights’.

A service user should have an assessment for oxygen conducted by a specialist respiratory nurse. Follow the suppliers and respiratory nurse instructions for the use of oxygen concentrators. Nursing staff must be appropriately trained in the use of oxygen concentrators and this must be clearly documented. Under no circumstances should anyone attempt to alter the flow rate on the cylinder without being appropriately trained and competent.

The oxygen supplier is responsible for the transportation, delivery, installation and disposal of the oxygen. The supplier should also instruct the service user on how to use the equipment. Some cylinders are portable and have a bag or trolley so they can be transported with the patient. There is no reason why staff cannot assist with these smaller cylinders, but this must be following guidance from the respiratory nurse or oxygen supplier.

Spare consumables i.e. nasal cannulas, masks and tubing can be obtained from the oxygen supply company.

There must be no smoking, and no naked flames within 3 metres of an oxygen supply. Covered high heat sources such as gas fires with glass or electric fires/hobs must be at least 1 metre away from oxygen equipment.

If the qualified, visiting respiratory nurse carrying out the assessment deems that care staff at the home can assist a service user in administering his oxygen, she may delegate the task to the appropriately trained and thereby competent persons, in consultation with the registered person.

USING AN OXYGEN CYLINDER/CONCENTRATOR

AIM

To assist service user to self-administer oxygen.

EQUIPMENT

Oxygen cylinder OR Concentrator

Key

Face mask

Tubing

Oxygen head set

Oxygen is delivered and installed in the service user's home or residential home by a pharmacist or the supplying company or appropriate health professional. Home care staff do not transport oxygen or change cylinders.

Assessment: This procedure will only be carried out as part of the service user's personal care plan, following an assessment by an appropriate health professional. Staff will receive training by a pharmacist or appropriate health professional prior to carrying out the task.

Care staff are NOT permitted to administer oxygen when the service user is unable to take overall responsibility for administration.

Care staff are NOT permitted to administer oxygen if the prescribed level has not been pre-set by the supplier or respiratory nurse.

	ACTION	REASON
1	Check care plan & risk assessment.	Establish the needs & abilities of the service user. Takes account of health & safety.
2	There must be no smoking, and no naked flames within 3 metres of an oxygen supply. Covered high heat sources such as gas fires with glass or electric fires/hobs must be at least 1 metre away from oxygen equipment.	To prevent the risk of explosion or fire.
3	Explain the procedure to the service user. Check the care plan.	To establish understanding and obtain consent and co-operation.
4	Ensure service user is in a comfortable position near the concentrator/cylinder.	To maintain service user's comfort.

5	Whether an oxygen concentrator or cylinder is used, ensure staff have had adequate training to support the service user in its use.	To ensure health & safety of service user and others is maintained
6	Support the service user to place mask over nose and mouth securing with elastic around ears/head. Assist as necessary.	To ensure delivery of oxygen, service users comfort and to secure mask.
8	Support service user to remove mask when necessary. Assist if required. Check comfortable and relaxed.	To ensure service users comfort.
9	Wash and dry facemask after each use.	To discourage bacterial growth.
10	Record procedure in service user's care plan and report any concerns to senior care/health professionals.	To facilitate evaluation of care by health professionals and alert them of any changes.

APPENDIX 19

ADMINISTRATION OF A TOPICAL PATCH

Staff may prompt service users with capacity on the use of patches if a self administration assessment has been completed.

Reference should always be made to the MAR chart and manufacturers instructions.

AIM

To ensure the safe and effective administration of a topical patch

EQUIPMENT

Medication

Prescription/MAR sheet

Topical patch administration chart including body map

Gloves

Clinical waste bag

	ACTION	REASON
1.	Check the prescription with the patch, the expiry date and patient identifiers.	To ensure correct administration of the medication
2.	Check if the patient has any allergies that may be affected by the application of the patch.	To reduce the risk of an allergic reaction
3.	Familiarise oneself with the likely side-effects of the patch and the actions to be taken if they occur.	To ensure appropriate and prompt response to any side effects
4.	Take the MAR sheet/prescription and patch to the patient and check their identity	To ensure patches administered to the correct service user
5.	Explain the procedure/rationale to the patient if possible	To reassure service user and support compliance
6.	If this is a new drug choose an appropriate site, if a replacement,	To choose a different site to the previous patch and to reduce risk of skin reaction

	choose a different, appropriate site as per procedural guidance and with reference to the topical administration chart.	
7.	Wash hands and apply gloves	To reduce risk of cross contamination
8.	Remove the existing patch from the patient and fold it with the medicated side inwards before disposal.	To reduce cross contamination
9.	Check the site for any signs that the skin is broken or inflamed and report this as per procedural guidance.	To ensure a prompt response and any treatment can be administered
10.	Ensure the skin at the site of the new application is intact, clean and dry.	To ensure the patch adheres effectively
11.	Open the package, remove the patch and the protective film and place the patch on the patients skin, being careful not to touch the medicated side of the patch. Hold in place for a few seconds until the adhesive has been activated by the warmth of the skin.	To ensure the service user receives the full dose of medication and reduce cross contamination
12.	Dispose of any waste appropriately	To comply with infection control procedures and reduce cross contamination
13.	Record the site on the body map chart along with the patient demographics, the date, the signature of the person changing the patch and the date it is next due to be changed. If a	To ensure effective communication with other health professionals and appropriate timing of patch changes

	replacement, record also the date and time the old patch has been removed.	
14.	If a patch falls off before the next one is due, contact Community nurses or ECHSS as soon as possible for advice.	To ensure the service user receives optimum medication
15	Staff carrying out daily personal care should ensure that the patch is still in place each day. They should also identify where old patches have not been removed (i.e. the patient has 2 patches on).They should report these issues immediately to the person in charge.	To ensure the service user is receiving the correct dose of medication.

Medication Errors Reporting Process in Care Homes

1. Introduction

Medication errors in all of Warrington Borough Councils commissioned providers are usually reported as safeguarding alerts. All safeguarding alerts are risk assessed, irrespective of the circumstances, in order to determine what actions need to be taken.

Warrington Safeguarding Adults Board's recognises maintaining high quality services, including those provided by internally and externally commissioned providers, is essential to identify, respond to and minimise medication errors.

However it is also recognised that for safeguarding to be relevant and effective it also needs to be proportionate and have the capacity to respond to the more serious incidents where significant harm has occurred, or is likely to occur.

This document outlines a change in approach to the reporting and responding to medication errors within nursing and residential care homes.

2. Medication Errors and Safeguarding

A review of available literature and research identifies that there is a high frequency of medication errors, but a low impact in terms of their seriousness.

The British Medical Journals 'Care homes use of medicines' study' (2009) found that nearly 70% of residents within the study had experienced one or more errors, but with the average potential harm being low.

The General Medical Councils study 'Investigating the prevalence and causes of prescribing errors in general practice' (2012) identified prescribing or monitoring errors for one in eight individuals, with the vast majority of errors of a mild to moderate severity, with only 1 in 550 errors described as severe.

The Department of Health report 'Building a safer NHS for patients' (2004) identified a number of factors prevalent in medication errors. It identified that there may be a tendency not to report 'near misses' even though identifying near misses can promote learning as much as from actual errors. The report identifies that the more serious the error, the more likely it was to be reported and the number of incidents reported is likely to be only a small proportion of the total number of low level, or 'near miss' events.

Individual error is rarely the root cause of a medication error. Usually errors are caused by the systems and processes surrounding the prescription and administration of medication. The overall consensus of available research suggests that the vast majority of medication errors, despite being high frequency, are low impact.

The Care Quality Commission's Market Report (2012) identified medication management as the greatest problem area of non-compliance within the social care sector, 20% of nursing homes and 16% of residential homes did not meet the standard on medicine management. The report acknowledged that social care services were facing increasing

challenges because of the significant growth in service users presenting with multiple health problems and requiring complex drug treatment.

In considering the local picture of medication errors reported as safeguarding alerts to Warrington Borough Council, there are broadly two groupings:

2.1. Significant Harm or the Likelihood of Significant Harm

Medication errors that result in actual harm to the service user should always follow the safeguarding route. The Care Act (2014) and Statutory Guidance replace 'No Secrets' and state that safeguarding duties apply when an adult has needs for care and support and is experiencing, or at risk of, abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Dependent on the seriousness and the circumstances of the incident, other professionals or agencies could be involved in this process, including Police and health organisations as appropriate. Within some settings, such as hospitals, it may be appropriate for their own 'significant incident' investigation to take place alongside any safeguarding process.

The 'risk of abuse and neglect' includes incidents that are 'near misses', where harm could have happened, but was prevented. There should have been a real likelihood in such situations, rather than a vague, fanciful risk of harm.

Also, incidents that do not result in harm to the service user, but may indicate a pattern or trend within a provider service which could form part of wider concerns that they are failing to meet minimum safe standards. For example, multiple errors by one or more members of staff, failures to audit correctly, delays in ordering repeat medications, or the provider being placed in default can indicate the absence of adequate training, procedures, quality assurance systems or management oversight.

These incidents are of low frequency, but high impact when they occur.

2.2. Low Level Medication Errors

Medication errors which do not result in harm to the service user, and do appear to indicate a wider trend or pattern of incidents. This circumstance is by far the most common and accounts for a high percentage of all safeguarding alerts, and can happen in any setting, even where the quality of care more than meets minimum standards.

Such incidents are of high frequency but low impact, and the way in which these incidents in care homes are reported in future will change as outlined in section 4 below.

3. Process

From the 1st May 2014, the way in which medication errors in care homes are reported has changed. This change in process has been agreed by Warrington Borough Council,

Bridgewater Community Healthcare NHS Foundation Trust and Warrington Clinical Commissioning Group (CCG).

This change in process is to:

- Enable immediate advice to be given to the care home by a clinician as to appropriate treatment or actions in response to a medication error
- Determine whether the incident should be referred as a safeguarding alert to the Access to Social Care Team
- To have all intelligence on medication errors collated and held within one database to develop a more accurate picture of frequency and trends to better inform services and improvement
- Focus the safeguarding process on those incidents where harm, or risk of harm is present

Instead of a care provider reporting medication errors to the WBC First Response (previously called ASC) as a safeguarding alert, the provider will contact Bridgewater Community Healthcare NHS Trusts Enhanced Care Home Support Service (ECHSS) – Care Home helpline (9am-5pm). Outside of these hours Single Point of Access Service (SPA) (8am-9am, 5pm-7pm) then 111 (from 7pm – 8am).

All medication errors will be reported by care homes to the ECHSS. On discussion with the ECHSS, a safeguarding alert could still need to be made by the care home to First Response, but this not likely to be a low level medication error as described in section 2.2 above. However, the individual circumstances of each incident should be considered, and it remains the responsibility of the care home to determine whether a safeguarding alert should be made to ASC.

The ECHSS is designed to advise, support and empower the care home staff to manage their residents safely within their normal place of residence. It is a multi-disciplinary team providing a coordinated approach to the most appropriate care in a timely manner. The team undertakes proactive and reactive visits to support admission avoidance as appropriate whilst liaising with the wider health and social care professionals as necessary. Their role also involves supporting the care home staff to ensure that appropriate care plans are in place (advance care plan, community care plan, individual end of life care plan) in partnership with the resident and their family / carers.

The ECHSS will make available to WBC Quality Monitoring Officers information on individual care homes prior to a monitoring visit to enable all medication errors to be considered, including those referred to First Response as a safeguarding alert, and those deemed as dealt with only by ECHSS

Wider intelligence and trends will also be shared by Bridgewater Community Healthcare NHS Trust at the monthly Safeguarding and Quality Intelligence Meeting, chaired by the Warrington Borough Councils Assistant Director for Quality Assurance.

4. Pathway

See section 5 for process flowchart.

In the event of a medication incident in a care home

ECHSS is available Monday to Friday 09.00 - 17.00 hrs via fax number **01925 867922** or if a more urgent response is required (i.e. within 20 minutes) via telephone number **01925 867737**.

SPA is available Monday to Friday, 8am-9am & 17:00 to 19:00 via fax number **01925 867953** or if a more urgent response is required (i.e. within 20 minutes) via telephone number **01925 454814**.

Outside of these hours the 111 Service and Warrington's GP Out of Hours Service is available via Tel No: **111**.

The contact details of First Response Care Team is telephone number **01925 443322**, if urgent contact Out of Hours Service on **01925 444400**.

4.1. Urgent/Emergency Treatment Required

1. Call 999

2. Transfer service user/patient with records and information of incident to A+E

- Where appropriate inform next of kin of transfer to hospital and incident
- Document service user/patients records appropriately
- Action appropriate incident reporting procedures for care home

3. Fax information of incident to Enhanced Care Home Support Service (ECHSS) 01925 867922 (8am – 5pm)

- ECHSS-will return a call to provide onward support and advice as appropriate to need and best practice, where available pathways and guidelines are used to enhance support, i.e. NICE, Map of Medicine
- ECHSS will collate statistical information of medication errors for vulnerable adults in Warrington
- Promoting and developing best practice guidelines and benchmarking to support and prevent incidents
- The service users GP's is advised of the medication incident in a timely manner dependent on priority (information transferred no later than 08.00 hrs the next working day)
- Where harm has occurred ECHSS will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, ECHSS will report the incident of harm to safeguarding

4.2. Non Urgent Medication Incident

Less urgent priority including incidents of possible harm or incidents with no harm (e.g. missed medication, medication audit issues where medications have not been signed for). No emergency transfer to hospital is required and care or advice can be given in the community.

4.2.1. In Hours Pathway (09:00 – 17:00 hrs, Mon – Fri)

1. Fax or Telephone ECHSS as to care priority

2. ECHSS nurse will contact care home to provide best practice advice and support including triage guidance based on the following information:

- Service users current presenting complaint, including incident, current signs and symptoms, recorded vital signs observations TPR, BP, Oxygen saturation percentage
- Service users medical history, inclusive of medications and allergies

3. Document service users records appropriately and action incident reporting procedures

4. Where appropriate inform the service user and where relevant advise their family

6. ECHSS nurses will further utilise guidelines from BNF/Mims/Patient Information Leaflets and where necessary via the additional support of a Pharmacist, GP or The National Poison Safety Centre to ensure the correct care treatment and support is offered

7. Patients may require onward referral to hospital, GP assessment or other community services

8. ECHSS will collate statistical information of medication errors for vulnerable adults in Warrington to promote and develop best practice to support and prevent incidents

9. The patients GP's is advised of the medication incident in a timely manner dependent on priority (Information will be transferred by 08.00 hrs next working day)

10. Where harm has occurred ECHSS will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, ECHSS will report the incident of harm to safeguarding.

4.2.2. Out of Hours Pathway

1. Telephone 111

2. The Out of Hours Service will provide best practice advice and support including triage guidance based on the following information:

- Service users current presenting complaint, including incident, current signs and symptoms, recorded vital signs observations TPR, BP, Oxygen saturation percentage
- Service users medical history, inclusive of medications and allergies

Triage Nurses will further utilise guidelines from BNF/Mims/Patient Information Leaflets and where necessary via the additional support of a Pharmacist, GP or The National Poison Safety Centre to ensure the correct care treatment and support is offered. The service user may require onward referral to hospital, GP assessment or other community services

3. Fax ECHSS to advise of the incident

4. Document service users records appropriately and action incident reporting procedures
5. Where appropriate inform the service user and where relevant advise their family
6. The next working day the ECHSS nurse will return a call to the care home to coordinate any outstanding care issues
7. The service users GP's will be advised of the medication incident in a timely manner dependent on priority (Information will be transferred by 08.00 hrs next working day).

ECHSS will collate statistical information of medication errors for vulnerable adults in Warrington to promote and develop best practice to support and prevent incidents

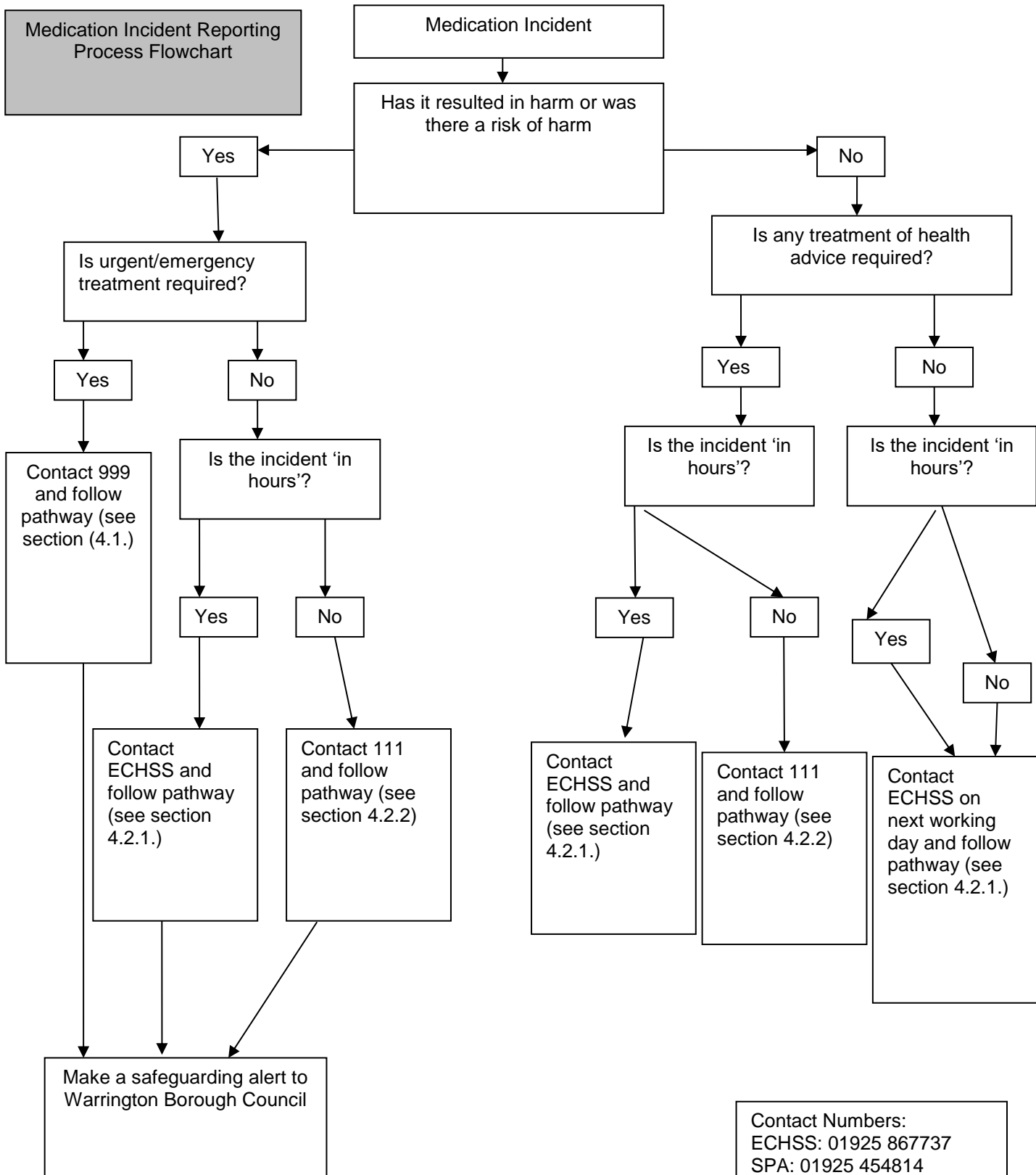
8. Where harm has occurred ECHSS will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, ECHSS will report the incident of harm to safeguarding.

A process flowchart is included in section 5 below and if you require any further advice or information please contact:

- Safeguarding Strategy Managers
- Tel No. 01925 444078/444070/443855
- Email: AdultSafeguardingManagers@warrington.gov.uk

Section 5; **Process Flowchart**

Medication Incident Reporting Process Flowchart



Contact Numbers:
 ECHSS: 01925 867737
 SPA: 01925 454814
 WBC: 01925 443322
 01925 444400
 (Out of Hours)

APPENDIX 21

COVERT ADMINISTRATION OF MEDICINES POLICY & GUIDELINES

INTRODUCTION

Covert administration of medication occurs when medication has been deliberately disguised, usually in food or drink, in order that the person does not realise that they are taking it. There is therefore an element of deception in this act, which would be considered unethical and possibly unlawful in most cases. It is therefore only be used only in extreme circumstances, as a last resort, and once certain legal requirements have been satisfied.

Covert medication can refer to medication given to treat either mental or physical health problems. Covert medication, giving medication without the person's knowledge (and perhaps their consent), should not be confused with forcible medication, where it is given with their full knowledge, but not their consent.

The Nursing and Midwifery Council (NMC) recognises that there may be exceptional circumstances in which covert administration may be considered to prevent a service user from missing out on essential treatment. This policy provides guidance for staff regarding the covert administration of medicines and explains when this can be done within the law.

SCOPE

This policy is intended for use by all health & social care professionals working in nursing or residential care settings, who may be planning the use of covert medication, or who may be administering it as part of a treatment plan. It is important that the protocol within this policy is followed every time covert medication is used, or whenever it is being considered.

THIS POLICY SHOULD BE READ IN CONJUNCTION WITH:

Human Rights Act (1998)
Medicines Management Policy (2016)
Mental Capacity Act 2005 and updates
Nursing & Midwifery Council (2007), (2008)
NICE guidelines for medicines management in care homes (2014)
Mental Health Act (1983)

MEDICATION NON-CONCORDANCE

Many people, with or without a mental illness do not wish to take medication and often fail to follow the treatment regime recommended by health professionals. Data available from the World Health Organisation shows that in the developed world only 50% of people take their medication as prescribed. This includes approximately 51% of people who take hypertensive medication, 40-70% who take antidepressants, and between 30-70% for asthma (WHO, 2003.)

Studies have shown that this non-concordance with medication can be for a variety of reasons including:

- Inadequate information about why a drug is being prescribed / administered
- Because the person feels the symptoms of their illness are mild and do not require treatment
- Because treatment is preventative and the person does not feel it is essential
- Because the medication has unpleasant side-effects
- The reputation of certain drugs
- Concerns about long-term dependence/addiction
- Beliefs about the value or efficacy of medication
- Beliefs about medicines in general
- Relationship with the person prescribing or administering the medication
- Not remembering how to take the medication

The reluctance of a person to take prescribed medication should therefore not be automatically seen as part of a mental illness, or sign of a lack of mental capacity. The World Health Organisation has highlighted the need therefore for professionals to understand and support people who do not wish to take their medication, rather than imposing their own values, or blaming the person for not following advice (WHO, 2003)

OPTIMISING MEDICATION CONCORDANCE

Research has shown that concordance with medication can often be improved by considering why the person does not wish to take the medication, and taking simple steps to support them:

- Involve the person as much as possible in the process of prescribing and consult them about their views
- Find out why the person does not wish to take their medication and offer information/advice/support where needed
- Offer choice where possible in order to give the person a heightened sense of control
- Regularly discuss medication with the person, including any side-effects that they might be experiencing
- Provide information about medication and address any concerns that the person may have
- Offer alternative preparations (e.g. liquids, creams, patches) if available, if the person finds swallowing tablets difficult
- Build trust with the person

LEGAL AND ETHICAL CONTEXT

Covert medication is a complex issue which involves the fundamental principles of patient/client autonomy and consent to treatment, which are set in common law and statute and underpinned by the Human Rights Act 1998. All qualified staff should be aware of the law, and of their professional duties around treatment and medication.

Any mentally competent adult has the right to give or refuse consent to treatment or nursing intervention. The ethical principle underpinning this free choice is respect for autonomy, and the nurse's professional duty to respect the decision of the patient is

enshrined within the Nursing & Midwifery Code of Conduct (NMC, 2008). To administer medication covertly to a competent adult could therefore be seen as unlawful (an assault) and unethical (overriding autonomy).

If the person lacks capacity under the Mental Capacity Act (2005) however or is detained under the Mental Health Act (1983) then in certain circumstances covert medication could be justified and might be seen as both legal and ethical.

PROTOCOL FOR USE OF COVERT MEDICATION

As already discussed, the use of covert medication should be a last resort, not be a routine measure, or a contingency plan should the person not agree to take their medication. However, there are certain circumstances in which covert medication could be both legally and ethically justified, providing certain requirements have been met. The following protocol incorporates these requirements and should be followed by all healthcare practitioners before covert medication is commenced.

Consent

Establishing consent should be done via a discussion directly with the person about their medication. If the person consents to follow medical guidance in relation to their medication, then covert medication should not be used. If the person consents, but there is doubt about their capacity then the principles of the MCA (2005) should be followed, and medication should not be given covertly. It should be noted that no-one can consent on behalf of someone else when the person concerned is an adult.

Establish the reason why the person does not wish to take the medication.

If a person with established capacity to make this decision, does not consent, consideration should be given as to;

whether this reflects a long-held belief about medication

whether an advance directive regarding refusal of medication exists

whether it amounts to a religious or cultural belief

OR this is an 'eccentric/unwise' decision.

All are valid reasons for declining medication and must be respected. The person's reasons should be recorded in their single clinical record

Ensure that alternatives have been explored.

If necessary, alternative preparations should be offered, and flexibility (where possible) given. Research shows that medication concordance is improved when the person has been involved in the decision-making process and has been enabled to have some control over what is prescribed.

Establish that the medication is essential.

The medication that the person is declining must be deemed to be essential for the person's health and wellbeing, or for the safety of themselves or others, and this must be documented in the person's clinical records.

Establish that the person lacks the mental capacity to make the decision themselves.

The principles of the Mental Capacity Act (2005) should be followed. A capacity assessment should take place directly with the person where a conversation should be had about their medication. It should be determined that the person is unable to:

- Understand information relevant to the decision (e.g. the risks from not taking it)
- Retain this information (if only briefly)
- Weigh up the information / risks involved
- Make and communicate their decision

As detailed in the MCA (2005) all reasonable efforts must be made to help the person understand. It should be recognised that many people's capacity fluctuates during the day and so an optimal time of day should be chosen. In some cases, several attempts may be required. A record should be made of methods used to help overcome any communication issues including use of an interpreter.

If the person successfully passes these four tests, then they should be assumed to possess the mental capacity to make the decision themselves, even if their decision appears unwise. In these circumstances the decision must be respected, and covert medication cannot be given. It is important that this process is followed as presumptions about a person mental capacity cannot be based solely on a person's diagnosis (MCA, 2005.)

Discussion about best interests.

The NMC states: "As a general principle, by disguising medication in food or drink, the patient or client is being led to believe they are not receiving medication, when in fact they are. The NMC would not consider this to be good practice. The registrant would need to be sure what they are doing is in the best interests of the patient" (NMC, 2007.) Having established that the person lacks capacity a decision about whether covert medication is in the person's best interests should therefore be had in an open and inclusive way, ensuring that holistic factors are considered. All staff involved in the decision-making process should be aware that covert medication is often not always appropriate or in line with what the individual would have wanted. What is suitable for one person may not be for another. The decision to give medication covertly should therefore only be made following a detailed examination of the individual's circumstances. Appendix 1 contains a best interest's decision-making tool which may help to inform discussion.

The views of people involved in the person's care should be sought, as it is important that the decision to administer covert medication is not an isolated one. Members of the multi-disciplinary team, the person's family (unless it is clear that the person would not wish for them to be involved) people closest to them, and (if applicable) their GP, care home manager, advocate, or IMCA should all be invited to express a view. It is crucial that a decision is reached which is based on what the person would have wanted, not necessarily what is best for their physical or mental health. If an advance directive exists, the person's wishes stated within it must be respected as they are legally binding. Where consensus cannot be reached, or there is concern about restriction of liberty a DoLS (Deprivation of Liberty Safeguard) application and/or a second opinion may be useful.

Involvement of the pharmacist.

Advice must be sought from the pharmacist when mixing any medication with food or drink. This is to ensure that the medications the person takes are safe to be given in this way and recommendations can be made about use of alternative formulations or medications as necessary. Any changes to the person's medication after a plan for covert medication is put in place should be discussed with the pharmacy supplier

Documentation.

In order to be transparent and to provide a clear audit trail, all people receiving covert medication should have a care plan which contains information about why the person is not concordant with their medication, the necessity for covert medication, ways in which concordance could be improved, and how often this will be reviewed. The decision to use covert administration should be recorded in the service users notes. If covert medication is being used in a community setting, or is felt to be necessary on discharge from hospital, then arrangements should be made to communicate clearly the covert medication plan to the family/care home manager, and the need for this plan to be regularly reviewed.

Review.

Ongoing attempts to encourage compliance are essential. As far as possible, a reason for refusal must be sought and documented within an appropriate care plan. Once taken, the decision to administer covert medication must be reviewed in respect of each patient on a regular basis, preferably weekly. It should be understood by the team that covert medication is not a long-term solution.

EXCEPTIONS TO PROTOCOL

Extreme Situations

The NMC (2007, 2008) recognises that there may be "certain exceptional circumstances" in which the administration of covert medication may ensure the patient is not deprived of essential treatment. In extreme situations (such as when the person is putting themselves or others at risk due to their behaviour) a person who lacks mental capacity and who is not compliant with medication may have an immediate need for a specifically prescribed medication. When circumstances prevent the privilege of an impromptu multi-disciplinary meeting with carer input, the nurse may, after discussions with the immediate team, administer the initial dose under section 6.35 of the Mental Capacity Act Code of Practice* where the patient is incapable of consenting. This situation would then be reviewed within the following 24 hours with a view to seeking compliance or following the protocol in the previous paragraphs.

*Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay.

One exception to this is when the healthcare staff giving treatment are satisfied that an advance decision to refuse treatment exists.

Patients Detained Under The Mental Health Act (1983)

For patients detained under the Mental Health Act, the principles of 'consent' continue to apply to any medication for conditions not related to the mental disorder for which they had been detained. The assessment of their capacity to consent or refuse such medication therefore remains important. However, in relation to medication for the mental disorder for which the patient has been detained, medication can be given against a patient's wishes during the first 3 months of a treatment order or afterwards if sanctioned by a Second Opinion Approved Doctor (SOAD).

GENERAL PRINCIPLES OF COVERT MEDICATION

Where covert medication is used the following principles should be seen as good practice:

- Last resort; covert medication should only be used when all other options have been tried
- Time limited; it should be used for as short a time as possible
- Regularly reviewed; the necessity of covert medication plan should be regularly reviewed
- Transparent; the decision-making process should be easy to follow and clearly documented
- Inclusive; the decision should be a team one, and should not be taken by one person in isolation. People closest to the person should also be involved in the decision
- Best interests; all decisions should be made in the person's best interests, having undertaken a holistic assessment of the impact of covert medication on the person

It should be remembered that covert medication is entirely different to medication given under restraint. Covert medication is medication given without the person's consent or knowledge, whereas the latter is given with their full knowledge but not consent. This would need to be formally authorised under DoLS or the Mental Health Act. Similar authorisation should be sought if any medication given covertly is likely to sedate the person or otherwise cause them to be deprived of their liberty.

Best Interest Meeting

Mental Capacity Act (2005)

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his/her best interests-Principle 4 of the MCA

Meeting held on:		Venue:	
Name:		Male / Female	Ethnicity
Address:			
Postcode:			
Chair of meeting		Decision Maker	
Name of participants		Designation / Location	invited
			present

Confirmation of 'lack of capacity'

Mental Capacity Record assessment attached and completed

AND

Those present / invited agree that the person 'lacks capacity' to make the decision (In the event of anybody challenging the assessment result, and the disagreement cannot be resolved, then a second opinion or a ruling from the Court of Protection may be required. This will depend on the urgency of the decision to be made)

Comments:

Regaining of Capacity (Is it likely that the person may regain capacity, can the decision wait until that time, if not why not?)

Is this the least restrictive option? (If not, why not?)

Justification for proposed care / treatment:

Risks relating to proposed care / treatment:

Risks related to not carrying out the proposed care / treatment:

What are the persons past and present wishes and feeling (These may have been expressed verbally, in writing or through behaviour or habits)

Are there any beliefs and or values that would be likely to influence the decision had the capacity? (e.g. religious, cultural, moral or political)

What are the views of the other relevant people in the person's life?

What are the views of the Mental Capacity Advocate (IMCA)? (If involved)

Is there a dispute about best interests?

Outcome of discussions; reasonable belief as to best interests-

Where the court is not involved, carers (unpaid), relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances.

The undersigned believe this to be a fair and accurate representation of the that took place. Those in attendance have reasonable grounds for believing are doing or deciding is in the best interests of the person concerned at this

Name: Designation: Signature:	Name: Designation: Signature:
Name: Designation: Signature:	Name: Designation: Signature:
Name: Designation: Signature:	Name: Designation: Signature:

REFERENCES

Department of Health (2008) The Mental health Act 1983; code of practice. The stationary Office, London.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf

Mental Capacity Act (2005) Code of practice. The Stationary Office

<http://webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

NMC (2007) Advice; covert administration of medicines: disguising medicine in food and drink <http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/>

NMC (2008) <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/Covert-administration-of-medicines/>

Acknowledgements:

East London NHS Foundation Trust
Northamptonshire Healthcare NHS Trust

APPENDIX 22

ADRENALINE AUTO-INJECTORS (EPIPENS)IN CARE HOMES

1. It may be identified that a service user has an allergy or medical condition for which an adrenaline autoinjector (AAI) is required. In this case there must be sufficient adequately trained staff (at least one on every shift, day and night) to administer the medication and assist in an emergency.
2. A risk assessment and care plan should be in place for this procedure. The care plan should include information on storage, disposal after use, necessary checks etc (see point 4)
3. The prescriber has a responsibility that any prescribed medicine/ device is used appropriately, so in the case of an AAI, the prescriber may complete a patient specific direction/care plan or support the care provider to complete one, on the appropriate use.
4. Guidance for the risk assessments and management of AAI's:
 - Ensure two AAIs are available in the care home for each resident at all times.
 - Check the expiry date on your AAI as this can vary considerably depending on product.
 - Ensure that a new AAI is ordered before the existing ones expire. Out-of-date AAI may not work.
 - Make sure residents and/or carers prescribed AAIs are trained to use the brand prescribed, as injection techniques and administration vary between brands e.g. EpiPen®, Jext® and Emerade®.
 - The supplying pharmacist can refer or provide individual Summary of Product Characteristics (SPC) and Patient Information Leaflet (PIL) for each product when counselling the user and offer general advice e.g. on storage, disposal of used, miss-fired or expired stock.
 - Checking of AAI's should be included and documented in medication audits i.e. expiry dates, signs of damage etc.
5. It is expected that all care home staff will have undergone annual mandatory training including basic life support. Some basic life support training will also include anaphylaxis. If managing anaphylaxis is not covered, it is the providers responsibility to ensure that adequate training is provided to each duty first-aider in managing anaphylactic reactions. Candidates who successfully complete Warrington Borough Council 3 day first aid at work or 2 day paediatric first aid course are deemed competent to assist in the administration of the residents own AAI. First Aid certificates are valid for 3 years and then requalification is a legal requirement.
6. Evidence of all staff completing this training must be kept by the provider and recorded on the staff training matrix. Where competencies are required by the course, recorded evidence of up to date successful completion of these must also be kept by the provider
7. Following the use of an AAI, the necessary actions must be taken to replace the used equipment immediately (the same day or the next morning) to ensure adequate provision at all times.

8. Following the use of an AAI, there must be contemporaneous record keeping documenting full details of the event and any reviews or updates to risk assessments or care plans completed and documented. Records should be arranged to allow trends to be viewed and not just in daily notes.
9. Where trained staff give notice to leave the role or the organisation, succession planning must take place to ensure that trained staff continue to be available on every shift.
10. Following the use of an AAI in an emergency situation it is good practice to undertake a significant event analysis to ensure any lessons are learned for future situations.
11. If homes keep adrenaline as a stock item, they must have their own policy regarding its use, ensuring it is regularly checked and in date and staff have the appropriate, in date training.

Thickening Products

1. Thickening products are designed for use by patients with swallowing disorders (dysphagia), to assist patients to manage the intake of food and fluids as safely as possible. They are a prescribed product and should not be used without guidance from the relevant, appropriately qualified professional i.e. speech and language therapist, GP etc.
2. Thickening products are designed for the dietary management of dysphagia by modifying the texture of both food and fluids. They can also be used in cooking.

Guidelines for use;

3. As a prescribed preparation, thickeners must be stored safely in a locked area, as with any other medicines.
4. Different products have varying product guidelines so it is important to read and follow the instructions provided with the product prescribed.
5. The use of thickening agents, the rationale, dose details and review criteria must be recorded in a care plan.
6. Ensure the correct international dysphagia diet standardised thickener guidelines are being used (last updated April 2018).
7. Ensure the correct size scoop as provided with the product, is used at all times, as this may alter the dose the patient receives.
8. Do not use products prescribed for one patient for another patient.
9. Ensure the prescribed dose is recorded clearly in the patients care plan and on any other relevant documentation i.e. fluid intake chart.

10. Ensure there is a process to record every time thickener is administered and that it is signed, timed and dated by the person administering.
11. Always measure the liquid required, e.g. 200ml.
12. For best results, thickeners can be mixed using a fork, whisk or shaker. It is recommended to first place the powder all at once in the glass/cup/shaker and then add the liquid, but it is also possible to first place the liquid in the glass/cup/shaker and add the powder second. To avoid lumps start stirring or shaking as soon as possible. Leave to stand for one minute. Stir gently for five seconds, then serve.
13. Milk based drinks can take longer to thicken so allow more time for this to happen and do not add more thickener than is prescribed.
14. More information on the international dysphagia diet standardisation initiative (IDDSI) can be found here;
https://www.nutriciahcp.com/adult/Studies/Dysphagia_Learning_Module/

REFERENCES