UNIVERSAL MEDICATION POLICY

FOR ADULT SERVICES IN SOCIAL CARE
The Universal Medication Policy was first published in October 2006. It has since been reviewed and revised by a joint Working Group involving NHS Hull Clinical Commissioning Group, Independent and In-House Providers, Hull Community Care Services and the NHS Yorkshire and Humber Commissioning Support Unit.

The steering Group for the Universal Medication Policy consists of representatives from all areas of the joint working group all of whom have contributed to the latest revision of the policy and continue to address issues arising. The contribution of these and other stakeholders is gratefully acknowledged.

This guidance has been updated to apply to all Care Workers in situations where they are providing medication services within Adult Social Care and is the overarching policy used within Hull City Council.

The Universal Medication Policy complies with the requirements of Care Quality Commission the organisation that inspects and regulates Service Providers.

This Policy should be read in conjunction with the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007.

The Medication Policy has also been revised taking into account “The Handling of Medicines in Social Care” by the Royal Pharmaceutical Society of Great Britain 2014 www.rpsgb at http://www.rpsgb.org/pdfs/handlingmedsocialcare.pdf
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i. INTRODUCTION

Foreword:

In any situation where care workers are responsible for looking after and administering medication to other people – the service user, it is important to follow a set of principles to ensure that this is done safely. The purpose of this policy is to provide direction of best practice for care workers in all aspects of adult social care who are involved in the handling of medicines. A care worker is defined as an unregistered and non-clinically qualified person employed by the Provider to deliver support to a Service User as detailed in the Care Plan.

It is not possible to cover every possible situation that may arise, but the principles set out in this policy outline and encourage the safe and appropriate handling of medicines and represent good practice in line with current regulation and standards.

The Current Standards and Regulations:

All transactions involving medicines are regulated by the Medicines Act 1968 and subsidiary regulations made under that Act. This policy is intended to ensure that medicines are handled appropriately and in accordance with the following legislation and guidance as relevant to the setting:

- The NHS and Community Care Act 1990,
- Care Standards Act 2000,
- The National Service Framework for Older People 2001
- The Mental Capacity Act (2005).
- The Care Quality Commission (CQC) Community Adult Social care services: Provider handbook (March 2015)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Care Act 2014
- The Misuse of Drugs Act 1971 and associated regulations and amendments
- The Medicines Act 1968 and the Human Medicines Regulations 2012
- Equality Act 2010
- Guidance from NICE and the Royal Pharmaceutical Society

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states:

‘The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.’

CQC inspects and regulates Community Adult Social Care service providers. They use five fundamental standards to assess the quality of the care services being provided including help with medication. These standards monitor the services being provided to ensure they are Safe, Effective, Caring, Responsive and Well-led. One of the mandatory key lines of enquiry by CQC reviews how service user’s medications are managed, so that they receive them safely and in line with current and relevant regulations and guidance. The fundamental standards encourage:

- Safe storage, administration, and disposal of medications, protecting service users from avoidable harm.
- A Caring environment providing dignity, respect and support.
- Effective care and treatment to promote a good quality of life and achieve good outcomes.
• Services that are provided, meet the needs of the service user.
• Services are delivered by appropriately trained care workers.

Objectives:

• To enable, and promote independent living for service users and to encourage those who are able, to self-medicate whenever possible and safe to do so.

• To give clear guidance to all staff employed by Hull City Council involved in all aspects of medication management and administration and those commissioned by them.

• To ensure unified procedures are undertaken in all Adult Social Care services with regard to medication across the Hull region.

• To meet with legislation and good practice standards prescribed by the Care Quality commission (CQC), the Royal Pharmaceutical Society (Handling Medicines in Social Care document 2014) and other relevant agencies.

• To ensure that procedures, policies and training are in place to reduce the risk of medication related errors and associated risks to the service users and employees.

• To ensure that service users who need assistance with medication are identified by standardised risk assessment and that the assistance then provided is appropriate, safe and suitably recorded and monitored.

The Scope of the Policy:

This policy applies to all providers of adult social care services, managers and care workers, responsible for delivering care packages commissioned by Hull City Council, who are involved in any aspect of medicines administration or support to vulnerable adults and the elderly. This applies to domiciliary care, Intermediate care services, residential and respite care, day care and supported living arrangements.

The policy does not apply to non-commissioned services i.e. people funding their own care or receiving personal budgets (unless these are commissioned by the Council).

This guidance replaces the earlier publication of the Universal Medications Policy and embodies a wider scope of social care environments.

Authority:

The policy that follows has been developed through joint working between health and social care organisations. This is the overarching policy for use within Hull City Council for Adult Social Care Services.

This policy has been jointly approved by Hull City Council and Hull Clinical Commissioning Group.
ii. The Key Principles of Good Practice

The following statements are introductions to the principles of good practice with regard to medication and its administration. When further detail is given in the guidance notes, there is reference to the section where this can be found at the end of the text.

- All medicines are potentially harmful if not used correctly and as intended, and care must be taken in their storage, administration and safe disposal.

- The responsibility for prescribing and management of medication rests with the service user’s GP in consultation with the patient and any other members of the Primary Health Care Team concerned with their care. **However**, everyone involved in caring for the service user is responsible for ensuring that his/her medication is well managed (See section 9 - Individual roles and responsibilities).

- The GP is responsible for ensuring that a medication review is completed for all service users in adult social care, especially those with long term conditions to reduce their risk of hospital admission. This review should take place at least annually unless a change in the service user’s circumstance would call for an earlier review. This review can be undertaken by the GP or other qualified health professional, or as part of a multidisciplinary team.

- Care providers must obtain a complete and accurate up to date list of all medication for all new service users as soon as possible to prevent any delay or loss of continuity to their treatment. Good and accurate record keeping is paramount to reducing medication related errors and improving continuity of care for the service user.

- Care providers should assume that a service user can look after and administer their medications for themselves (self-administration) unless a risk assessment had indicated otherwise. All social care environments should enable, and promote independent living for service users and encourage those who are able, to self-medicate whenever possible and safe to do so (see section 1 – Initial Assessment).

- Where a service user administers their own medication, and the care worker is concerned about the service user’s ability to continue to do this, the care worker must report their concerns to their line manager or duty manager within 24 hours. The line manager/ duty manager should take appropriate action e.g. a risk assessment or discussion with the prescriber (See Section 1.2 and Section 5.6 - Self Administration).

- Following the initial assessment of the service user to determine the level of support required, the assessment of their capacity to consent to this support is vital. It is the responsibility of the assessor to obtain authorisation from the service user, for assisted support with administration of their medication. This must be given by the service user and documented at the initial assessment stage, unless the service user lacks capacity to do so (See Section 1 – Assessment and Capacity).

- The care worker that administers medication must ensure that it is administered according to the prescriber’s (e.g. GP) written instructions and the medication label. The administration of any medicine must be recorded and signed for on each separate occasion for each individual medication (See Section 5 – Medication Administration, and section 6 - Documentation).

- Any medicine dispensed by a pharmacist becomes the property of the service user for whom it has been prescribed. It must **not** be used for the treatment of anyone else.

- Care workers can only administer medicines that have been dispensed and labelled by a pharmacist or supplied by a visiting healthcare profession e.g. an Out Of hours GP or Emergency Care Practitioner.
Medicines must be administered in a way that respects the autonomy, human rights, privacy, cultural and spiritual beliefs of the service user and takes full account, where appropriate, of the wishes of their family and carers.

Medications must be taken from the pharmacy packaging and immediately administered to the service user one at a time by the same care worker during each administration round (see section 5 Medication Administration).

Medication must never be disguised unless on the specific written instruction and guidance of the prescriber (e.g. GP) with the agreement of the care worker. This decision must be undertaken as part of a multidisciplinary team in the ‘best interest’ of the service user. Medicines must never be forcibly administered or disguised by care staff under any circumstances (See Section 1.5 - Covert Administration).

Care workers must be competent to carry out their duties. When providing support and assistance to a service user, they must be appropriately trained to the correct level required by their role and responsibilities (See Section 1.6 – Levels of Support).

Care workers must not make clinical decisions or judgements regarding the administration of medication e.g. *increase* or *decrease* of dosage, *when required* medication or when full dosage instructions have not been given. Should care staff have any doubt about the action to take, the line manager, health care professional or nominated person (e.g. next of kin) should always be consulted. A note of action taken should be made in the service users care plan (See section 3 – Dose instructions and Changes to Prescribed Medication).

A refusal by a service user to take regular prescribed medication should always be recorded and appropriate advice sought from their prescribing GP or supplying community pharmacist (See Section 7 – Refusal).

The care worker should make sure that unwanted medicines are disposed of safely. Any unused medication must be returned to the community pharmacy for disposal at the end of each cycle. A receipt should be obtained if possible and kept in the service users file (See Section 2.6 - Disposal of Medication).

Care workers must not offer advice to the service user with regard to over-the-counter medications or complementary treatments purchased by the service user. Residential care may have a homely remedies policy in place (see Section 2.8 – Homely remedies).

People who use social care services have the freedom of choice in relation to their provider of pharmaceutical care and services including dispensed medicines (See section 2.1 - Supply of Medication from a Pharmacy).

Care workers must ensure that medicines are available when the service user needs them (See section 2.2 – Ordering of Medication).

**Advice on Medicines:**

Advice on medicines can be obtained from the following sources:

- Any community pharmacist (or see service users pharmacy number on medication label)
- The service users GP
- NHS Help Line (non-emergency): 111
SECTION 1: Introduction to THE SEVEN RIGHTS

For ease of navigation and reference the policy is set out under the headings of the Seven Rights of medication administration and provides direction on good practice in line with current legislation governing the handling and administration of medication in all aspects of social care. When further guidance is required in specific care settings there are additional guidance notes within the text annotated by a purple box for Residential Care and a blue box for Home Care.

The Seven Rights of medication administration are:

1. The RIGHT service user receives…
2. The RIGHT medication...
3. At the RIGHT dose...
4. Via the RIGHT route...
5. At the RIGHT time...
6. With the RIGHT documentation...
7. The RIGHT to refuse medication...

At the end of the policy there is a glossary of terms used in this document and a reference source including guidance from other professional organisations. Also included are copies of documents and forms used in assessment and record keeping.

Right 1: The right SERVICE USER

1.1 Assessment of right Care Level for the Service User:

It should always be assumed that a service user can look after and administer their own medications to promote independent living. Providers should encourage those who are able, to self-medicate whenever possible and safe to do so unless a risk assessment has indicated otherwise. The cornerstone of this policy is a risk assessment to identify those service users who are able to self-medicate. For those who cannot, the assessment should identify the appropriate level of support required in respect to medication and care planning, and to ensure the provision of appropriate training for those care workers that will assist the service user with their medication.

After the initial assessment and implementation of the care package, a further assessment should take place 4 months after the initiation of the service, to check that the level of support being provided has been evaluated correctly. Subsequent assessments should then take place annually, unless there has been cause for concern raised e.g. deterioration in the service users’ health, in which case, re-assessment should take place sooner. This should identify the requirement for any adjustments in the original care plan where necessary and appropriate. The assessments will be carried out by a competent assessor.

A competent assessor is a nominated person e.g. a social worker and/or a care manager who arranges the care package to suit the individual needs of the service user. The care provider will need to ensure that they are able to fulfil the requirements of the care package in order to provide appropriate care to the service user.
The “Fuller’s Self Medication Risk Assessment Screening Tool” (see Appendix A and B), will be used to help identify the service users level of risk with respect to self-medication. If the service user is acknowledged to be at risk and unable to self-medicate, then further assessments may be necessary to confirm the appropriate level of care/help required. All risk assessments should be documented and placed in the service users care plan.

When making an assessment, particular care should be taken if one or more of the following risk factors apply:

- Health would deteriorate rapidly without medication
- Language problems
- Long term conditions, such as diabetes or epilepsy
- Difficulty understanding the need for or how to take medication
- Difficulty with memory
- Visual impairment
- Dexterity problems

Following the assessment, a care package will be devised for the service user which will outline the level care and support required with medications. The levels of support are defined in section 1.6.

1.2 The Service User Who Wishes and is Able to Self-Medicate:

It should be acknowledged that a service user has the right to administer their own medications and this should be encouraged whenever possible and appropriate, to promote independence, regardless of the social care environment.

It is important to consider however, that self-administration of medication is not an all or nothing situation. Some examples of this are shown below:

- A service user who may keep and use their own inhalers but not their other medication.
- A service user may be able to manage their medications provided that they have assistance to do so e.g. a person who has suffered a stroke and is unable to open containers. The carer may be requested to assist to open containers at the time the service user chooses to take/use their medication.
- A cream may be prescribed for application by the service user even though the carers assist with other prescribed medication. This could also be the case in reverse.
- A service user who may have limited understanding and awareness may be able to cope with one dose of medication left out for them to take at a later time of day. (See below Section 1.2.1 – leaving out medication).

A service user who wishes to self-medicate should be assessed by an authorised competent assessor. Assessment for self-medication should involve the service user and any relevant person / health professional involved in the service user’s care. The risk assessment and the care plan should note what aspects of self-management the service user is responsible for in regard to their medication e.g. inhalers, creams, tablets etc. This should also include how to monitor whether the service user is still able to self–administer medicines without constantly invading their privacy. This assessment should be an on-going process and monitoring should form part of the service user’s care plan. There should be a signed agreement from the service user accepting responsibility for this. If there is refusal to sign an agreement it should be recorded in the care plan.
In order to demonstrate that they have the mental capacity to self-medicate the service user should be able demonstrate that they:

- Understand and want to take responsibility for looking after and taking their medication.
- Know what medications they take, what they take them for, how and when to take them and what could happen if they don’t take them.
- Are able to identify their medications.
- Are able to make choices about their treatment and communicate them.
- Understand the importance of keeping medications safe and not accessible to others e.g. visiting children in a home care setting or another service user within residential care who may unintentionally or intentionally take them and be harmed e.g. medication carried in handbags and jacket pockets must not be left unattended.

Any changes in the service user’s capacity and/or ability to self-medicate should be reported as soon as possible to an appropriate line manager with a view to re-assess the service users care package.

1.2.1 Leaving out medication (Home Care):

This does not apply in residential care.

Within Home Care in certain circumstances, service users who are assessed as requiring level 1 or 2 assistance with medications may need doses of medication left out for them by the care workers in order to enable their independence – NOT TO SAVE ON A HOME CARE CALL. The service user should be assessed as being able to cope with one dose of medication. An example of this would be a service user who takes a sleeping tablet before bed or a service user with Parkinson’s disease who requires an early morning dose of medication prior to the time of the care call. No more than one dose should be left out.

If a service user requires medication to be left out when a care worker is not present, their capacity to remember to take the medication and any risks involved, both to the service user and other people who may visit e.g. family and friends, should be assessed and actions taken to reduce the risk documented in the service users care plan. (See section 1.1 Assessment of care level and 1.3 Assessment of capacity)

Care workers must record on the medication administration documentation (Medications Record Chart - MRC) what medication has been left out for the service user to take themselves. The actual administration cannot be recorded because the care worker will not have witnessed it. Instead they should use a designated code, for example S = Self administration.

1.2.2 Self-Medication in Residential Care:

Service users in a Residential Care have the right to choose to manage their own medicines if they want to, with appropriate support from the care home. This is particularly important for short term respite, or intermediate care, when service users may need to be able to manage their own medicines when they return home.

A residential setting should provide a secure area e.g. a lockable drawer in the service user’s own room for the safe storage of their medications. If the room is shared, there must be separate storage facilities for each service user. Any controlled drugs that the service user takes can be kept in here and do not need to be locked in the care home’s controlled drug cupboard.
The care plan must reflect the service user’s wishes and the specific arrangements for their medication. The service user may wish to order their own medications from their chosen pharmacy but any medicines ordered by the home on behalf of the service user must be properly receipted and a record made when they are handed over to the service user who self-medicates.

For the service user who self-medicates, the care plan should clearly identify what aspects of self-management the service user is responsible for in regard to their medication e.g. ordering, collection, storage and administration etc.

Some service users may need extra help to be able to manage their medicines, such as a multi-compartment compliance aid, large print labels or non-child resistant containers for example. The supplying pharmacy should be able to offer help and advice with this; pharmacy contractors have an existing and on-going responsibility to make reasonable adjustments to their services and provide help or auxiliary aids where appropriate for service users with disabilities. Please speak to the pharmacist for advice.

There is no need for staff to fill in the administration section of the Medication Administration Record or MAR chart when service users self-administer medications, but the form should indicate that they self-medicate. Some residential care providers choose to use the MAR chart to show that they have checked that the medicine has been taken, but it must be clearly indicated that this medication has not actually been given to the service user by the care worker.

Service users that self-medicate in residential care may require the occasional prompt and monitoring of a service users ability to continue to self-medicate should form part of an ongoing assessment. However if the requirement for prompting increases and becomes the necessity rather than the check, the care worker should inform their line manager. Re-assessment should identify the requirement for any adjustments in the original care plan where necessary and appropriate. (See also section 1.7- Prompting)

In a residential setting, self-administration carries the risk of another service user accidentally or intentionally taking medication that is not meant for them. A robust system of risk assessment is essential and must assess the capacity of the service user and reviewed at regular intervals. The risk to others should be taken into consideration when deciding if a service user can self-medicate.

1.3 Assessment of the Service Users Capacity:

When deciding if the service user has the capacity to make a decision about their care, it is important to understand that this is a 'time and decision specific' test. A service user may able to make some decisions but not others, or on one day but not on the next.

A service user will have the capacity to make a decision if they are able to:

- Understand the information relevant to the decision.
- Retain the information relevant to the decision being made.
- Use or assess the information while considering the decision.
- Communicate their decision e.g. verbal, visual or physical.

If there is concern that the service user may not have the capacity to give their consent this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. This act provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. There are 5 key principles to the act:
1. Individuals should be presumed to have capacity unless proved otherwise. Every adult has the right to make their own decisions.

2. Individuals have a right to be supported to make decisions e.g. given the right information in the right way.

3. Individuals have the right to make unwise or eccentric decisions. A person is not to be treated as unable to make a decision merely because they make an unwise decision.

4. Best interests – any decisions made for and on behalf of someone who lacks capacity must be in their best interests AND

5. Be the least restrictive intervention of the individual’s rights and freedom of action.

All possible steps must be taken to help the service user make the decision for themselves about their medication and care.

NOTE: It is important to clearly distinguish between those people who lack capacity and those people who have the capacity to refuse medication. It must be remembered that capacity changes and so regular reviews are needed.

1.4 Obtaining Consent from the Service user to Assistance with Administration of Prescribed Medication:

After the initial assessment of the service user with the help of the Fullers Tool, the required level of assistance with medication will be identified, the service user must communicate in their own way that they agree to this assistance.

It is the responsibility of the competent assessor to obtain the service user’s authorisation when it has been identified that they need assistance to administer their medication. The service user’s capacity to consent to this support must be assessed following the guidelines and principles of the Mental Capacity Act 2005 (see above section 1.3). Only a service user who has capacity to make this decision can give authorisation for this assistance.

The assessor must explain to the service user the type of assistance that is proposed and their consent should be recorded on a consent form and kept in their care plan. Consent may be given in writing, verbally or a physical gesture. Examples of consent include:

- The service user signing a consent form.
- The service user saying ‘yes’ to assistance offered.
- The service user nodding in agreement when assistance offered.

Care workers however, have a key role in the continued assessment of capacity. The original consent agreement cannot be used to assume the service user has given consent at the time the assistance with medication is offered. Consent must be confirmed every time assistance is given e.g. at the time of administering the medication the service user agrees to accept assistance. Consent can be assumed if:

- Medication is offered to and then taken by the service user.
- The service user agrees when asked if they are ready for their medication.
- The service user requests to take their medication.

Any change in service user’s ability consent, or their refusal of assistance with medication should warrant a review of their care as this could place the service user at risk. Possible examples of this:
• If a service user who lacks capacity but has previously complied with taking medication now refuses to take that medication, or
• If a service user who previously had capacity to agree to assistance with administration of medication now appears to lack the capacity to agree to that assistance.

In these circumstances the care worker should not proceed with administering the medication. The care worker should document the refusal and report to their line manager for further advice. The service users’ GP or appropriate professional should be contacted.

1.5 Best Interest Decisions and Covert Administration: *(Residential Care settings only)*

If the service user lacks capacity to consent to help with their medication it may still be possible to administer the medication if it is believed to be in the service user's best interest and consideration has been given to the least intrusive option.

If the service user lacks capacity and is refusing medication and or treatment, there may be certain circumstances where it could be acceptable to disguise medication e.g. when medication is essential to their care, health and wellbeing and not to give it is more harmful i.e. it is in the best interest of the service user. This is called **covert administration.** Covert administration of medication is a complex issue and involves the administration of a medication disguised in food or drink to a service user who resists it when given it openly.

In considering best interests, and covert administration further assessment should be carried out and all decisions must be made, taking into account the views of anyone caring for the service user or having an interest in their welfare. A multi-professional team plus carers and relatives of the service user must assess then approve the decision. The decision should respect any previous instructions given by the service user when they had capacity. Final responsibility for deciding best interest for the service user however, lies with the healthcare professional responsible for the service user’s treatment.

* **A Care worker cannot administer medication covertly without the written authority of the service users prescriber.**

All documentation of assessments undertaken should be recorded in the care plan with a date for review.

1.5.1 Principles of Covert Administration:

• The refusal of medicine by a resident who has capacity should be respected.
• If a service user is refusing their medicines they should be asked why they have decided to do this to establish if there are issues that can be addressed e.g. is the cause a swallowing or taste issue.
• Regular refusal of a medicine with no reason given should be discussed with the resident’s GP.
• Advice on options to support a service user in taking their medicines should be discussed with their GP or community pharmacist e.g. can the medication be split or crushed, is there an alternative?
• The decision to administer medication covertly must not be considered routine.
• Covert administration can only occur where the resident has been assessed under the Mental Capacity Act 2005 and there has been careful assessment of patient's needs.
• Written agreement of the decision, the action taken and the names of all parties concerned (including the residents GP and relatives/advocate) should be obtained and documented in the resident's care plan.

• Disguising medication in the absence of consent (covert administration) may be regarded as deception, as the person is being led to believe that they are not receiving medication when in fact they are.

• Residential homes must have a clear policy on covert administration.

On occasions there may be movement of the service user between different care settings and in an emergency where there are serious medical concerns, a decision can be made by the person in charge acting in the best interest of the service user to support with medication without their consent. **This example should be the exception and not the norm.**

1.6 The right level of support for the service user

Within a social care setting, the service user who is unable to manage their own medication is entitled to help from a care worker who is adequately trained and knowledgeable to assist with the level of support required. Only care workers who have been given the appropriate training and have demonstrated that they are competent should do this.

Support with medication can only be offered by a care provider after:

- a risk assessment has been carried out
- the level of support had been agreed
- a care plan has been developed
- the service user has consented to this assistance (See section 1.5 for exceptions)
- A service user’s care plan is accessible to the care worker.

The description for levels of support used here have been adapted from definitions used by the Care Quality Commission to apply to all social care services provided by Hull City Council. It is important that they are adhered to in respect of assisting with medication and planning of the care package for the service user. They are divided into three levels:

**Level 1 – General support or assisted self-medication**

**Level 2 – Supervised administration**

**Level 3 – Invasive techniques and nurse care**

1.6.1 Level 1; General Support or Assisted Self-Medication

During the initial assessment, the level of support that the service user requires is identified and whenever it is possible to do so, they are encouraged to retain their independence.

There are multiple ways this may be possible e.g. through the provision of easy open tops, large print labels, reminder charts and compliance aids. These simple interventions should be considered during the initial assessment and the community pharmacist will be able to help and give advice.

General support is given when care worker helps the service user to self-medicate and take responsibility for their own medication. This level of support would be likely for a service user with a physical disability or frailty, whose mental capacity is **NOT** in doubt. The service user must have the mental capacity to direct the care worker and instruct them what to do.
The type of support that may be given by the care worker for level 1 support may include some or all of the following tasks:

- The ordering of repeat prescriptions from the service user’s GP surgery.
- The collection of medications from the service user’s community pharmacy.
- The return of unwanted medications for safe disposal to a community pharmacy.
- Help with reading labels or a patient information leaflet.
- Advise on the safe storage of medicines.
- The occasional verbal reminder / prompting to the service user to take their medications (see also Prompting section 1.7)
- The help to open a container / pop out tablets from a blister pack etc. at the request of the service user who has self-selected them.

The level of support identified should be clearly noted in the service user’s care plan.

The following is excluded from level 1 assistance:

- Administration of medication – handing a prepared dose to a service user
- Any specialist tasks, invasive or nursing procedures.

When a care worker carries out a level one task it must be recorded in the communications sheets in the service user’s documentation or care plan.

It is important for a care worker to observe and report any changes in the service user’s ability to manage their medicines e.g. a persistent need for verbal reminders or prompting could indicate that the service user no longer has the capacity to take responsibility for their own medicines and should indicate that a review of the service user’s care plan is required. If the care worker has any concerns they should contact the duty manager. (See also Prompting section 1.7)

It should be noted that care workers can only assist with general support for prescribed medications that are dispensed and labelled by a community pharmacy. A compliance aid can be used by the self-medicating service user but this must have been filled and labelled by a community pharmacy. Care workers cannot fill the aids themselves or provide assistance if the aid has been filled by the service user or their relatives.

In a Home Care environment care workers attending for assistance with personal cares can offer the occasional verbal reminder to a self-medicating service user to take their medication BUT they can in no way assist with these medications other than in accordance with a level 1 care plan. Any verbal reminders should be fully documented in the care plan and monitored. Any increase in the need for verbal reminders should necessitate a review of the care plan.

Care workers in home care must NOT administer medication from a Monitored Dosage System

If LEVEL 1: General medication support is being provided the service user retains ALL responsibility for their medications.

1.6.2 Level 2; Supervised Medication Administration

The assessment may have identified that the service user is unable to take responsibility for their own medication. There could be multiple reasons that factor into this such as impaired cognitive
awareness due to dementia or a learning disability, but could also be the result of a physical disability.

Administration at this level will involve the care worker selecting and preparing the medication for immediate administration to the service user from pharmacy labelled original medication packs or a compliance aid often known as a Monitored Dosage System or MDS (residential care only). The care worker must be deemed competent to provide Level 2 care to the service user.

The type of support that may be given by the care worker in level 2 may include some or all of the following:

As for level 1 plus:

- Popping out of tablets and capsules from original packs and offering them to the service user to take.
- Popping out of tablets and capsules from MDS and offering them to the service user to take (residential care only).
- Measuring a dose of liquid medication.
- Topical application of a cream, ointment or scalp application.
- Application of a transdermal patch.
- Application of ear / eye / or nose drops / sprays.
- Assembly / preparation of an inhaler for self-administration by the service user. (Preventer inhalers only).
- Administration of an inhaler via a spacer device for a service user who is unable to self-administer (Preventer inhalers only).

See also Section 1.6.3 below for Level 2 tasks requiring extra training.

The following is excluded from level 2 assistance:

- Invasive or nursing procedures.

In a home care environment, the service user may require a carer to select a medication for them to take for themselves at a later prescribed time of day to enable their independence. It should be left in a safe and secure place and documented in the care plan or medication chart. A risk assessment should be completed for this and also documented in the care plan (see section 1.2.1 - Leaving out medication).

If the carer is required to place the oral medication into the service user’s mouth as they are unable to do this for themselves, this must be agreed by the multidisciplinary team in a best interest meeting and detailed in the care plan.

If level 2 supervised medication administration is being provided, the care worker takes responsibility for ensuring that they have selected the right medication, for the right person, selected the right dose, to give at the right time and via the right route.

1.6.3 Specialist Tasks:

Under certain circumstances, a Level 2 care worker may also administer a medication via a specialist technique. This must be agreed with the care provider on an individual service user basis and a healthcare professional e.g. a registered nurse, must provide the required extra training to the care worker following guidance from the Nursing and Midwifery Council. A care worker may be trained under their guidance and be signed off as competent to carry out the specialist health related task. This training is both service user specific and care worker specific and re-fresher
training should take place at least annually. The healthcare professional delivering the training will not remain responsible for the competency of the care worker.

It is important that:
- The service users consents to a care worker giving this treatment (when the service user has capacity to consent)
- The care worker feels competent to carry out the specialist task and agrees to give the treatment.
- Care workers may refuse to carry out specialist tasks if they do not feel competent to do so.
- Clear roles and responsibilities are agreed by the care provider and the healthcare professional.

Specialist tasks may include:
- Simple dressings or first aid
- Prevention of pressure sores
- Changing and disposal of stoma appliance / incontinence appliances
- Assistance with prescribed hosiery
- Assistance with nebulisers and oxygen
- Use of an Epipen
- Buccal administration of midazolam

The training of a care worker to carry out a specialist task is important for situations when there is greater potential for harm to be caused to the service user if nursing or medical staff could not be present in a timely manner e.g. the buccal administration of midazolam or the use of an Epipen in an emergency.

**Stoma and Catheter appliances:**
A Carer may assist with the disposal of bags and all items used by the service user during cleansing and changing. If a service user is experiencing problems, these should be reported to the duty manager who will communicate the problem to the GP or Nurse. A Carer should not attempt to change a bag or deal with any other problems relating to the management of the stoma or catheter, unless specific training has been undertaken and the carer has been signed off as competent to do so.

### 1.6.4 Level 3 Support: Invasive Techniques and Nursing Care:

The term ‘invasive technique’ is used to describe certain medication tasks that would not be carried out by care workers. It is important to distinguish between social and personal care tasks and nursing / medical tasks that would be carried out by professionally qualified nursing and medical staff.

Administration at this level may include:

- Rectal administration e.g. a suppository (diazepam for epilepsy).
- Vaginal administration e.g. pessary.
- Insulin by injection, including blood monitoring.
- Administration through Percutaneous Endoscopic Gastrostomy (PEG).
- Administration via a Naso-Gastric or Naso-Jejunum (NG) tube.
- Catheterisation/measuring for stoma appliances.
- Catheter placement and removal.

Medications administered by the non-oral route e.g. prescribed rectal and vaginal medication such as enemas, suppositories and pessaries, may only be administered to service users by nurses. It is
good practice for two staff to be present when such medication is administered. This can be two nursing staff or, the nurse administering the medication and a care worker acting as a witness to administration and a chaperone. Both should sign the administration chart. Advice should be obtained from the Senior Clinical Nurse or the Team Leader regarding the need for same gender staff to carry out rectal or vaginal administration.

1.7 Prompting (Intermediate and Re-ablement care only)

The Department Of Health definition of Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. Intermediate Care is a halfway home.

Re-ablement is an approach that aims to help people to do things for themselves rather than having things done for them. It is the use of timely, and time limited, focused support to improve choice and quality of life, so that people maximise their independence by regaining skills and confidence.

Prompting is used by intermediate care whilst assessing the service user’s ability to manage their own medications prior to discharge. The process of medication prompting allows the service user to demonstrate their capacity to retain some independence and to identify if any assistance is required with medication administration and what to level. It will also highlight those service user’s whose medication needs are beyond the knowledge and competence of level 1 or 2 care workers and will require nursing care (level 3).

Care workers providing medication support to a service user assessed as requiring level 1 assistance with occasional prompting should be mindful to report any concerns regarding a change in the ability of a service user to manage their own medication. Any changes in the service user’s capacity and/or ability to self-medicate should be reported as soon as possible to an appropriate line manager with a view to re-assess the service users care package.

Legally, **administration** means to both personally administer **AND** to prompt the self-administration of medication. Therefore, if a care worker is prompting medication, in the eyes of the law they are essentially administering it. The same checks therefore need to be in place, the same record keeping needs to be completed and the same level of training is required to fully support the service-user.

All medications must be prepared by a pharmacy for a care worker to legally prompt or administer medication and the care worker is still responsible for ensuring that the right person gets the right dose of the right medicines by the right route at the right time.

Within residential care, the care worker may prompt medication to a service user from a compliance aid but the compliance aid **must** have been filled by the pharmacy. A care worker cannot prompt or administer medications to a service user from a compliance aid if it has been filled by anyone else e.g. family or friends.

Care workers should not prompt the taking of medication that has been removed from their original container (with the exception of monitored dosage systems or compliance aids in residential care only).

Once medication has been taken from the dispensed container by the service user it should be taken by the service user immediately.

If a label becomes detached from the container, is illegible or has been altered the medication should not be used. The care worker should inform their duty manager about this.
Right No. 2: The Right MEDICATION

The Safe and Appropriate Handling of Medicines:

2.1 Supply of Medication from a Pharmacy:

The following information relates to prescribed medication. This is medication supplied by a pharmacist from a prescription. It does not include medication that a service user has bought or obtained from someone else.

Medicines should normally be provided by a community pharmacy chosen by the service user and whenever possible, the same community pharmacy should be used to provide all prescribed medications to ensure a full and accurate record. Any advice from the pharmacist therefore, can be based on a greater knowledge of the service user’s medication. If the service user has a preferred pharmacy, this should be indicated in their care plan. With the service user’s permission, it is good practice for the community pharmacy to be informed by the service provider of the support with medicines that has been arranged e.g. a new user to the service and the level of support to be given.

In some care settings there may be one preferred pharmacy that provides services to all residents within the care environment. This has several advantages and is a common and acceptable practice unless it conflicts with the wishes of the service user. Ultimately, if the service user expresses an individual preference, this should be acknowledged.

Community pharmacists are ideally placed to offer advice and support to care workers for example: when a service user is struggling to manage their medicines. Problems such as swallowing difficulties, complex timings, unclear instructions, inability to open containers or read labels for example, can all be referred to the service user’s community pharmacist for advice.

All medications dispensed for use in home care must be supplied in the manufacturer’s original container, complete with label, patient information leaflet and a Medication Record Chart (MRC) for administration documentation.

Medications dispensed for service users in a residential care setting may be supplied in the manufacturer’s original containers or dispensed into a Monitored Dosage System (MDS). All MDS for use in residential care must be dispensed by a pharmacist. Some pharmacies may also provide printed charts for Medication Administration Record documentation (MAR charts).

Medicines dispensed and supplied by a pharmacy should not be further decanted into another container by a care worker – this is called secondary dispensing. If a medication is put out for a service user to take at a later time to enable independence in a domiciliary setting, or taken out of the care environment for a day trip – a risk assessment should be completed for each occasion and documented in the care plan. (See section 5.8 – Secondary Dispensing)

**Medicines must only be used for the named service user for whom they have been prescribed.**

**Medicines should not be separated from their label or patient information leaflet.**
2.2 Ordering of prescription medication:

It is important that medicines are available when the service user needs them. When a care provider is responsible for requesting a supply of medications they must have a system in place which outlines the ordering procedure and ensures that medications are obtained in a reasonable time frame.

The care plan should state clearly the GP responsible for the care of the service user and the community pharmacy supplier used. It should include details for obtaining a supply of medications for the service user so that everyone is aware of their responsibilities. Details should include arrangements for:

- Ordering prescriptions for regular medications
- Collecting prescriptions from the GP surgery
- Delivering prescriptions to the pharmacy
- Collection of medication from the pharmacy and taking to the service user’s place of residence.

No more than 28 days’ supply of medicines, including those on repeat prescriptions should normally be requested for an individual at any one time.

When ordering:

- Check quantities ordered are appropriate for requirement in order to avoid medication waste.
- Do not forget to check medication stored separately e.g. ‘when required’, bulk or fridge items
- If possible nominate a member of staff to be responsible for ordering with a named deputy.
- Document the date that the medications were ordered and what medications were ordered.

In a **Home Care** setting, clarification will be required to identify who will be responsible for requesting repeat medications e.g. the service user, a relative or the care worker – if this forms part of the care package. This must be clearly documented on the Medication Record Chart Request Confirmation Form (See Appendix C) and also in the service users care plan. All care workers and health professionals and even non-paid carers (the service user’s family / friends) need to be clear about their responsibilities.

Within any care setting, acute courses e.g. antibiotics may be prescribed mid-cycle. When this occurs in Home Care the original MRC chart in use must be returned to the pharmacy for the addition of the label for the newly prescribed item. Each time a new cycle of medication is supplied a new MRC chart should be supplied with these.

For creams, inhalers or **when required** medications that have the potential to vary in the quantity used within a 28 day period, the smallest quantity appropriate should be prescribed to minimise waste e.g. one inhaler or the smallest tube of cream etc. Medications should not be carried over to the new MRC chart with the exception of acute antibiotics. All dates on the labels of the medication items should confer with the dates on the MRC chart.

In **Residential Care**, request that ‘when required’ items are dispensed in original packs by the pharmacy rather than in an MDS. MDS has a reduced expiry therefore more frequent prescriptions will be necessary and more medication waste generated. Original packs of when required medication can be carried forward to the next cycle if still in date.

Bulk supplies of medicines for the use of more than one service user for example in Residential Care, must not be stored and administered by care workers unless covered by a homely remedies policy. (See section 2.8 - Homely Remedies)
2.3 Receipt of Medication:

For all social care settings medications should be checked on receipt so that any problems can be identified and rectified early and minimise any possible disruption to the service user.

Checks upon medication receipt should include:

- The name of the service user for whom it is prescribed.
- The drug name, form and strength of the medication should be checked against the labels on the original packaging and against the medication record chart.
- The labels and charts should carry clear dose or time instructions.
- The new medication record chart should be cross referenced with the previous chart to ensure that medications ordered and expected are correct.
- All medications should be checked to ensure they are in date or if there are any specific expiry instructions e.g. some liquid antibiotics
- Check and act on any specific storage instruction e.g. store in the fridge.
- Rotate stock so the earliest expiry is at the front and therefore going to be used first.
- Medication must remain in the container in which it was received – batches must not be mixed.

Labels must never be altered. In the event of any discrepancies with dose instructions, missing or discontinued medications, advice must be sought from the prescriber (GP) or supplying pharmacy.

In a Home Care setting records of receipt or collection of medications should be kept in the service users care plan and should include name of the care worker accepting the medication and the date of receipt.

In Residential Care for self-medicating service users, any medicines ordered by the care worker on behalf of the service user must record by the when they are received into the residential home and a record also made when they are handed over to the self-medicating service user.

2.4 Storage of Medication:

All medications must be safely stored against improper use or loss. Medications should also be stored so that they are not damaged by environmental factors or accessible to the wrong people. Medication can be damaged by excessive heat, light or moisture. Although their appearance may not change, they may no longer be as effective. If medications are accessible to the wrong people e.g. other service users or children they could cause harm if taken. They should be stored:

- In the original packaging that they were dispensed
- Away from light sources
- Away from extreme hot or cold temperatures – below 25°C
- Away from excessive moisture (kitchen & Bathrooms)
- Out of the reach of children
- Where they cannot be mixed up with another’s medication
- Where they cannot be stolen
- Where they do not pose a risk to anyone else.
### 2.4.1 Special storage instructions:

Some medications have special storage instructions and may need to be stored in the fridge between 2°C and 8°C e.g. insulin and some eye drops. This will be indicated both on the label and on the medications administration documentation. If in doubt ask the pharmacist.

Within the **home care** setting, medication requiring storage in the refrigerator should be stored separately from food e.g. in a sealed plastic container. If the care worker suspects that the fridge is not working correctly then advice should be sought from the supplying pharmacy.

In **residential care** medicines that require storage between 2°C and 8°C will need to be stored in a lockable refrigerator that is only used for medication storage. The minimum and maximum storage temperatures should be monitored and recorded daily. Each time the temperature is recorded the fridge thermometer must be reset following the manufacturer instructions. Should the temperature of the fridge fall outside of the recommended range the care worker must speak to a senior member of staff who should contact the Pharmacist for advice.

### 2.4.2 Fridge requirements and daily temperature recording (residential care)

- The fridge temperature should be monitored and recorded daily. It is recommended to record minimum, maximum and current temperatures, using a minimum/maximum thermometer (see example record chart).
- The fridge should be regularly cleaned and defrosted and dated records kept.
- Ensure care workers taking the thermometer readings understand how to read and reset the thermometer and why this is necessary.
• The fridge temperature must be kept between the range of 2°C and 8°C. If the fridge temperature is outside of this range action should be taken immediately.
• Avoid keeping large amounts of medicines in the fridge as this can lead to inadequate air flow and potential freezing.
• Ensure fridge contents are regularly date checked and stock rotated. Fridges can easily be overlooked when conducting regular stock audits.

2.4.3 What to do when the fridge temperature is out of range:
• Inform the duty manager immediately.
• Quarantine fridge stock while advice is sought.
• Attach a notice to the fridge clearly stating do not use.
• Estimate how many hours the fridge has been out of range (you should have the reading from the previous day’s check).
• Contact your pharmacy provider for advice or the manufacturer for individual product advice.
• If advised that the stock is no longer usable ensure that it is disposed of promptly.
• Contact the GP to order replacement prescriptions if required.
• If necessary, call out an engineer to repair the fridge.
• Remember to record the action taken on the fridge temperature record sheet.

2.5 Expired Medications:

The expiry date is the point in time when a medication is no longer within an acceptable condition to be considered effective. The medication reaches the end of its ‘shelf life’. Depending on the product, the expiry date may be set as a fixed time:
• After manufacture e.g. expires 31/01/2017
• After dispensing e.g. liquid antibiotics
• After opening of the manufacturer’s container e.g. eye drops

The shelf life of medications is determined by either the breakdown of the active drug or by risk of contamination. The expiry date of products can change once opened e.g. eye drops – the date opened should be recorded on the medicine package/label.

<table>
<thead>
<tr>
<th>In residential care, bulk and when required</th>
<th>items can be carried over to the following cycle ensuring that the items do not themselves have a limited expiry (e.g. most eye drops have 28 days from opening) and that the original directions have not changed. There should be a policy in place that will identify how long bulk items can be kept for.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In residential care ‘when required’ (PRN) medicines:</td>
<td>Can be dispensed in their original packs whenever possible, to give the longest shelf life</td>
</tr>
<tr>
<td></td>
<td>Can be carried forward each month provided they remain in date</td>
</tr>
<tr>
<td></td>
<td>Should be stock-rotated to ensure that the oldest medicines are used first</td>
</tr>
<tr>
<td></td>
<td>Must NOT be returned and re-ordered each month, as this is unnecessary and wasteful.</td>
</tr>
</tbody>
</table>

NB: Care workers should be aware of the expiry date of PRNs especially if they are not used frequently. Before a prescription is requested the current stock levels of medication should be checked. Excess quantities returned regularly should be reported. A request should be made to the GP to review if it is still needed, or to prescribe smaller quantities.
Within **home care** only 28 days’ supply of medication is required because any medication left over from the previous month should be disposed of regardless of its expiry. All medication for each new cycle must correspond with the MRC it was supplied with. Any ‘when required’ or ‘bulk’ items that are administered by the care worker e.g. creams, inhalers and liquids etc. should be re-ordered with each new cycle even if they are not empty or used. In these instances the smallest pack size that will cover requirements of a 28 day cycle should be prescribed to avoid unnecessary waste. Please ask for advice from the prescriber or pharmacy. With the consent of the service user or nearest relative, a care worker can return all unwanted or excess medications for destruction to a pharmacy. No more than 28 days’ supply of medications administered by a care worker should be kept within the home.

Prior to the administration of a medication to a service user:

- Check expiry date.
- Record the date opened and the calculated expiry on the medicine package/label where appropriate e.g. creams, eye drops. Some packaging does not allow for the pharmacy label to be placed on the product e.g. eye drops. In these instances the outer packaging will have to be endorsed with the date of opening. It is essential that the product remains in the outer packaging throughout duration of this treatment.
- Highlight any short expiry as a reminder to all staff.
- Any product whose appearance suggests it may be unfit for use should be discarded – irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.

**The table below illustrates recommended expiry dates for medications kept within Residential Care:**

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Recommended Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets and capsules packed in MDS</td>
<td>2 months</td>
</tr>
<tr>
<td>Tablets and capsules – in original blister/foil pack e.g. PRN medicines</td>
<td>Manufacturer's expiry date</td>
</tr>
<tr>
<td>Tablets and capsules - loose i.e. put into a bottle by the pharmacy</td>
<td>Six months from the dispensing date or manufacturer's recommendation where shorter</td>
</tr>
<tr>
<td>Liquids (internal)</td>
<td>Six months from date of opening or manufacturer's recommendation where shorter</td>
</tr>
<tr>
<td>Liquids (external)</td>
<td>Six months from the date of opening or manufacturer's recommendation where shorter</td>
</tr>
<tr>
<td>Ointment / creams in tubes or with a pump dispenser</td>
<td>Six months from date of opening or manufacturer's recommendation where shorter.</td>
</tr>
<tr>
<td>For unopened creams</td>
<td>Follow the manufacturer’s expiry date</td>
</tr>
<tr>
<td>Ointment / creams in tubs with a lid</td>
<td>Three months from date of opening or manufacturer's recommendation where shorter</td>
</tr>
<tr>
<td>For unopened creams</td>
<td>Follow the manufacturer’s expiry date</td>
</tr>
<tr>
<td>Medication Type</td>
<td>Storage/Disposal Recommendations</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Suppositories / pessaries / rectal tubes / patches</td>
<td>Manufacturer’s expiry date</td>
</tr>
<tr>
<td>Inhalers</td>
<td>Manufacturer’s expiry date</td>
</tr>
<tr>
<td>Ear / nose drops and sprays</td>
<td>Discard three months after opening unless manufacturer advises otherwise</td>
</tr>
<tr>
<td>Eye drops</td>
<td>Discard one month after opening unless manufacturer advises otherwise</td>
</tr>
<tr>
<td>Injections (except insulin)</td>
<td>Manufacturer’s recommendation</td>
</tr>
<tr>
<td>Insulin</td>
<td>Insulin should be stored in the fridge and can be kept unopened until the expiry date. Once opened it can be stored outside of the fridge for up to 28 days.</td>
</tr>
</tbody>
</table>

### 2.6 Disposal of Medication:

There are many reasons why a medication requires disposal. Some of these are:

- The service user’s treatment has changed and a medication has been discontinued.
- The service user has transferred care to another service.
- The service user is deceased (in residential care medications are required to be kept for seven days in case they are requested by the coroner).
- The medication has reached its expiry date e.g. short dated medication after opening e.g. some eye drops.

All care settings should have a written policy for the disposal of excess, unwanted or expired medications. They should be disposed of safely so that they cannot be taken in error, either by the service user or by someone else. The correct disposal of medications is required by law in order to protect the environment. Unwanted medications should be returned to the community pharmacy for disposal with the consent of the service user where appropriate. The pharmacy will ensure that these unwanted medications are disposed of in accordance with current waste regulations.

When the care worker is responsible for returning medications to the pharmacy for disposal, a complete record should be made. This could be within the care plan in the case of home care, or in a nominated record book in residential care.

Documentation for medication disposal should include:

- The name of the service user.
- The name of the medication to be disposed of.
- The quantity of medication e.g. no of tablets or volume of liquid.
- The reason for its disposal.
- The date of return to the pharmacy - the pharmacy may provide a signature of receipt although they are not obliged to do so.

For **home care**, with the consent of the service user or nearest relative, a care worker can return all unwanted or excess medications for destruction to a pharmacy. No more than 28 days’ supply of medications administered by a care worker should be kept within the home.
2.6.1 Reducing waste

All care workers should be mindful to help to reduce the amount of medications wasted each month. This can be helped by the care provider ensuring there is policy for the ordering for medicines.

Ways to help reduce medication waste:

- Checking quantities/stock levels of medications before placing an order. Medications supplied by a community pharmacy cannot be reused so only order what is needed.
- If the pharmacy provider orders medications as part of the contract/service, the care provider should request to check the prescriptions before they are dispensed. Copies should be made for the record, before returning the originals back to the pharmacy to dispense.
- If medications are missing, or there are medications on the prescription that are not required, inform the GP surgery and the pharmacy.
- Request that the pharmacy provider removes discontinued medications from the MAR charts and re-order documentation to prevent discontinued medications being ordered in error.
- Request that the GP surgery remove any discontinued medication from the repeat portion of the prescription form. This also helps prevent discontinued medicines being ordered in error.
- Request that the GP surgery prescribe only 28 days of regular medication.
- Order all the service users medication at the same time. This not only saves time but will prevent the risk of medicines being ordered by mistake. Medications started mid-cycle may have to be synchronised.
- Build a good relationship with your pharmacy provider and GP surgery to improve communications and ensure clarity of the ordering process.
- In Residential care, Creams and lotions can be used until the expiry date and so do not need to be reordered automatically every month.
- Ensure the service users medications are reviewed regularly by their GP or community pharmacist.

If you don’t need it don’t order it!

2.6.2 Dropped medication / Single Dose disposal and stock discrepancies.

Dropped tablets / spilled liquids can be avoided with good administration technique e.g. preparing doses over a work surface. In the event that a tablet is dropped / liquid spilled, the care worker should assess the situation and prepare another dose where appropriate. If medications are disposed of, a note should be made in the care plan daily record of what medications have been returned to the pharmacy for destruction.

Care workers should not dispose of any medication in household waste or by flushing down the toilet – even for single tablet doses. A small container or envelope may be used to return single does to the pharmacy for disposal. This should be clearly labelled ‘medications for return and destruction’.

If doses of medication are disposed of, a new prescription may be needed to replace these doses. This should be explained to the duty manager and GP surgery/Pharmacy.

In the event of a suspected discrepancy in the stock level of a service user’s medication the duty manager must be informed immediately.

In England **residential homes** can return unwanted medications to a community pharmacy for disposal but homes providing nursing care must instead use a licensed waste management company.
2.7 Controlled Drugs (Residential Care setting only):

Controlled drugs or CDs are medications that are usually prescribed to treat severe pain, induce anaesthesia or to treat drug dependence. They have additional safety precautions and requirements because they can be open to abuse if taken when there is no clinical reason to do so.

There are legal requirements for the safe storage, administration, record and disposal of CDs in residential care. These are set out in the Misuse of Drugs Act Regulations 2001 and the Safer Management of Controlled Drugs Regulations 2006. The rules do not apply to all adult social care settings and they do not apply when a service user is responsible for taking their own medication. However, since the Shipman Inquiry, all social care services are recommended to have special arrangements for CDs even though currently the law does not require it.

Within residential care, a safe storage cupboard is required when the care providers are responsible for administering CDs to the service user. This cupboard should be metal, have a double locking mechanism, be fixed to a solid wall and be solely used for the storage of CDs within the medicines room.

The care provider should keep a separate record book for the receipt, administration and disposal of CDs. It is recommended that a hard bound register is used for CD documentation. It is good practice to have a second appropriately trained member of staff to witness CD receipt, administration and record entry.

Service users who have been risk assessed as competent to administer and look after their own medications are permitted to store CDs with the rest of their medications. There is no need to keep a record in the CD register when the service user is entirely independent and orders and collects their own medications from the pharmacy. However if the care plan indicates that the care provider is responsible for ordering and collecting the CD it is good practice that records are kept.

Clear documentation should be made in the CD register and include:

- When the CD was collected from the pharmacy and by whom.
- The name and quantity of the CD.
- When they were supplied to the service user (if self-medicating and ordered by care workers)
- Any subsequent disposal of unwanted CDs and quantities.

CDs are a target for theft and misuse and through monitoring and review of self-medicating service user’s, it should be recognized that CDs should not left lying around where they could be taken by someone else either by accident or on purpose e.g. by another service user or a care worker.

In order to administer a CD all care workers should follow all the steps involved in giving any other medication to the service user but in residential settings the following also apply:

- CDs should be administered by competent care workers and this should be witnessed by another appropriate staff member.
- Administration should be recorded both on the MAR chart and in the CD book.
- These records must be kept in a bound book with numbered pages.
- There should be a separate page for each type of CD for each service user.
- There should be a running balance remaining for each medication and this should be checked against the amount in the dispensing pack or bottle at each administration.
- A stock balance should be carried out and verified on a regular basis (minimum monthly).

Unwanted CDs should be disposed of by return to a community pharmacy at the earliest opportunity for denaturing and disposal. When CDs are returned for destruction, a record of the return should be made in the CD record book and it is good practice to obtain a signature for receipt from the pharmacy.

There are legal requirements for the writing of prescriptions for CDs so extra time should be allowed for these to be written when requested. If the prescription is written incorrectly it may need to be returned to the prescriber for amendment before it can be safely and legally dispensed. If care workers are collecting the CD prescription on behalf of the service user they may be asked to provide identification.

Due to the nature of CDs being a potential target for theft and abuse it is good practice to regularly check them. The CD register should always indicate the balance that remains after administration and this should be compared with the quantity stored in the CD cupboard. A regular audit by the duty manager should ensure that entries are chronological and correct and that there are no crossings out. If a discrepancy is noted the manager should investigate. A drug reconciliation can often identify the issue e.g. a care worker has forgotten to complete the record, however if CDs are missing, this is a serious incident and should be reported to the correct authorities.

If there is an error with CD administration to a service user e.g. the wrong drug is given to the wrong service user this could have serious consequences. The care worker should contact the service users GP or call 999 if they cannot be contacted to seek advice. A safeguarding adult’s referral should also be made if appropriate.

2.7.1 Common controlled drugs and legal requirements for residential care:

<table>
<thead>
<tr>
<th>CD</th>
<th>Brand names / formulation</th>
<th>Legal requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td><strong>MST Continus tablets</strong></td>
<td>Store in a CD cupboard.</td>
</tr>
<tr>
<td></td>
<td>Sevredol tablets</td>
<td>Record in the CD register.</td>
</tr>
<tr>
<td></td>
<td>Morphgesic SR tablets</td>
<td>* Morphine Sulphate 10mg/5ml oral solution (Oramorph) is not a controlled drug. However, CD storage and CD records are a good practice recommendation</td>
</tr>
<tr>
<td></td>
<td>Oramorph Concentrated oral solution <strong>20mg/ml</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MXL capsules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Filinarine Sr tablets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zomorph MR capsules</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td><strong>OxyContin MR tablets</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OxyNorm capsules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Longtec MR tablets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shortec capsules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Targinact tablets (with Naloxone)</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>Diamorphine tablets &amp; ampoules</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>Physeptone</td>
<td></td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Ritalin tablets</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concerta XL tablets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equasym XL capsules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medikinet XL capsules</td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Durogesic DTrans patches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Matrifene patches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mezolar patches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fencino patches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actiq lozenge</td>
<td></td>
</tr>
</tbody>
</table>

**Schedule 3 CDs:**

<table>
<thead>
<tr>
<th>CD</th>
<th>Brand name / formulation</th>
<th>Legal requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>Temgesic tablets</td>
<td>Buprenorphine and temazepam must be stored in a CD cupboard.</td>
</tr>
<tr>
<td></td>
<td>Butrans patches (7 days patches)</td>
<td>Other listed schedule 3 controlled drugs do not need CD storage.</td>
</tr>
<tr>
<td></td>
<td>Transtec patches (96 hour patches)</td>
<td>None of the controlled drugs in this schedule need to be recorded in the CD register but this is a good practice recommendation.</td>
</tr>
<tr>
<td>Midazolam</td>
<td>Hypnoval ampoules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Buccolam prefilled oral syringe</td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
<td>Temazepam tablets</td>
<td></td>
</tr>
<tr>
<td>Pentazocine</td>
<td>Pentazocine capsules</td>
<td></td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>Phenobarbital tablets</td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td>Zydol (capsules / soluble tablets / MR tablets)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maxitram SR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zamadol SR</td>
<td></td>
</tr>
</tbody>
</table>

**Schedule 4 CDs:**

<table>
<thead>
<tr>
<th>CD</th>
<th>Brand name / formulation</th>
<th>Legal requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
<td>Diazepam tablets</td>
<td>No legal requirements for the care home</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>Stilnoct tablets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zolpidem tablets</td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Lorazepam tablets</td>
<td></td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>Nitrazepam tablets</td>
<td></td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Zimovane tablets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zopiclone tablets</td>
<td></td>
</tr>
</tbody>
</table>
2.8 Household or Homely remedies (residential care only)

A Homely or Household remedy is another name for a non-prescription medicine which is used in residential care for the short term management of minor, self-limiting conditions e.g. toothache, mild diarrhoea, cold symptoms, cough, headache, occasional pain, etc. The concept of a homely remedy aims to provide quick access to treatment for minor ailments as it would be for a service user living in their own home. These specific remedies are purchased by the residential home for use within the guidelines of their homely remedies policy for service users and should not be used for staff.

The practice of bulk prescribing as a way of supplying homely remedies to residential care should not be encouraged in order to obtain stock of non-prescription medicines.

Points to consider when writing a homely remedies policy:

- For each residential care home the list of homely remedies should be agreed between the residential care provider and the service user’s GP.
- Homely remedies should only be administered in accordance with the manufacturer’s directions and only to those service user’s whose GP has agreed to their use. A record of that agreement should be made in the individual service user’s care plan.
- Homely remedies should not be used for more than an agreed period, which should be stated in the policy. It is recommended that administration should not continue for more than 48 hours before consulting the service user’s GP.
- The administration of a homely remedy must be recorded in the service users care plan and include details of:
  - The homely remedy (non-prescribed medication) administered
  - Its dose
  - The time of administration
  - The care worker administering the homely remedy
  - The reason for the homely remedy administration
    E.g. Paracetamol 2 x 500mg tablets 10.00 a.m. 21/01/2015. S. Brown: for headache.
- The policy should consider how the care workers they will respond to minor ailments in service users who lack capacity and are unable to make decisions about their care.

Care workers in all aspects of adult social care MUST NOT purchase over the counter medication at the request of the service user.
Care workers MUST NOT help service users with non-prescribed medications purchased by the service user, their family or friends or by the care worker.

Care workers MUST NOT help with herbal medication or alternative therapies.

Care workers must not offer advice on non-prescribed medicines and remedies. It may be DANGEROUS TO DO SO. The Service User may be allergic to the treatment or be taking other medicine that may result in harm to the Service User

2.9 Warfarin:

Warfarin is an anticoagulant prescribed to prolong the clotting time of blood thereby protecting against thrombotic events such as stroke. To use this medication safely blood tests need to be done regularly and the dose needs to be adjusted to maintain the desired effect and reduce side effects. Under treatment can result in clot formation and over treatment can result in bleeding which can be fatal. The National Patient Safety agency recommends that care providers have written guidance and procedures for the safe administration of warfarin.
Service users on Warfarin will have regular tests to check the effect of the warfarin on their blood clotting. This is measured as an International Normalised Ratio also known as INR. The result of the test may require adjustment of the warfarin dose accordingly.

For a person not on warfarin their INR would be around 1.0. The longer the blood takes to clot the higher the INR level e.g. an INR of 2.0 means that blood takes roughly twice as long as normal to clot. The target range will vary between individuals depending on the condition they are being treated for. The aim of the warfarin treatment is keep the INR within or close to this range.

Like all medications anticoagulants have side effects. The most common side effect is bleeding. All care workers should contact their manager and the service user’s GP immediately if any of the following are present:

- Nose bleeds that last longer than 10 minutes
- Blood in vomit or sputum
- Passing of blood in urine or faeces
- Severe or spontaneous bruising
- Unusual headaches

The dose of warfarin must be carefully adjusted for each individual. It is important that all changes in warfarin dose are correctly documented to ensure that the service user is receiving the correct dose. Good communications between the care workers and providers and the anti-coagulation team nurses, the prescriber and the community pharmacist are vital for this. The overall aim is to ensure that the service user is prescribed Warfarin at the correct dose for the interval between which they have their INR’s checked.

Care workers should be aware that when dispensing a repeat prescription for warfarin, community pharmacists have to assure themselves that it is safe to provide the warfarin, that the service user is having regular INR monitoring and the service user/care worker are aware of the correct warfarin dose. It is advisable where possible, for care workers to take the yellow anticoagulation book to the pharmacy when collecting prescriptions for warfarin so that the pharmacist can see evidence of dose and regular monitoring.

2.9.1 Warfarin monitoring and administration:
The procedure for warfarin treatment and monitoring for adults in social care is clearly outlined below:

- The anticoagulation nurse visits the service user to check their INR level.
- The nurse phones through the reading to the anticoagulation team.
- The anticoagulation nurse enters the INR result and the new warfarin dose into the service users yellow anticoagulation booklet. The dose instructions should be written as milligrams (mg) and not as the number of tablets e.g. 3mg to be taken Monday to Friday and 4mg to be taken Saturday & Sunday.
- The next INR appointment is clearly stated in the yellow book.
- The anticoagulation nurse is responsible for clearly annotating the MRC or MAR if warfarin is stopped for a period of time.

Ideally, monitoring should take place as early in the day as possible. This will allow for the test to be done, the results to be clarified, the new dose to be calculated and the information to disseminate to all parties in time for the service user to take their next warfarin dose at 6pm (tea time).

The care workers should ensure that each time the service user’s INR is checked that the anticoagulation nurse has access to their yellow booklet and that a record of the test, the new dose instructions and the date of the next test is entered.
Warfarin tablets should be ordered each month at the same time as the request for all other monthly medications. The prescription should:

- Be written for Brown Warfarin 1mg tablets **ONLY**.
- Have a quantity enough to last for 28 days at the latest dosage e.g. a dose of 3mg once daily would indicate a prescription for 84 tablets should be issued.
- The dosage instructions on the prescription should be written in similar wording to: ‘**please follow dose as instructed from latest INR result in the service users yellow anticoagulation booklet**’

Care workers should always check the yellow anticoagulation book and if available the most recent letter from the anticoagulation clinic before selecting and administering a dose to the service user.

All warfarin tablets should be dispensed in their original container (not in an MDS system) as 1mg tablets and stored securely with all other medications.

Warfarin doses should be administered at the same time each day – usually around 6pm (tea time) and taken with a glass of water.

If a dose is missed the anticoagulation team should be contacted immediately the error is noticed. If the anticoagulation team are unavailable then contact the service users GP/OOH GP for advice. The anticoagulation team will advise and arrange to check the service users INR at the earliest opportunity. **DO NOT GIVE AN EXTRA DOSE.**

After each INR test the anticoagulation team are responsible for sending a letter which documents the latest result and dose for the service user and this should be sent to the service provider for information and reference should this be required. This letter should be kept with the MRC and MAR charts and later stored in the service users care plan.

The letter should contain the following information:

- The service users name and address
- The service users GP
- The date of the INR test (the letter should be produced on the same day)
- The result of the INR test
- The target range specific to the service users condition being treated
- The new warfarin dose expressed in mg e.g. 3mg Mon to Fri and 4mg Sat and Sun
- The next date for INR test

If there are any doubts as to the correct dose of warfarin for the service user, the anticoagulation team should be contacted in the first instance.

The yellow anticoagulation booklet should always be accessible and kept with the service users MRC or MAR charts. There should only be ONE yellow booklet in use at a time.

Care Providers should have a policy in place to cover service users who are on Warfarin. Each service user should have the following information about their warfarin treatment in their care plan:

- The current dose of warfarin.
- The reason they are taking warfarin.
- Therapeutic goal.
- The anticipated length of treatment.
- What to do in the event of a missed dose.
- Symptoms of under/over anticoagulation and action to take if these occur.
• Drug/drug and drug/food interactions.
• Appointment arrangements and how to obtain further warfarin supplies.
• What to do if dental treatment/surgery is required.
• What to do if a surgical procedure is required / indicated.
• Who to contact regarding any worries or concerns relating to their warfarin management.

If following an INR test the warfarin dose in increased resulting in the requirement for a mid-cycle request for a further supply, a warfarin prescription should be requested in the usual manner of ordering medication.

Any verbal dose changes should be confirmed in writing as soon as possible. (See section 3.1- Dose Changes)

2.9.2 Warfarin with other medications and diet.

Many medicines can interact with warfarin. If a service user is starting or stopping another medication the prescriber may request that a blood test is done within five to seven days of starting or stopping the new medication. This is to ensure that the INR remains within the desired range. The GP, community pharmacist or anticoagulation team can be contacted for further advice.

Foods rich in vitamin K may have an effect on an INR result. Such foods include green leafy vegetables (broccoli and spinach), chick peas, liver, egg yolks, cereals containing wheat bran and oats, mature cheese, sushi seaweed, blue cheese, avocado and olive oil. It is important for a service user to have a well-balanced diet and these foods are important and should not be discouraged but eating them in large amounts or a sudden change in diet may affect their INR result.

A moderate intake of alcohol will not affect warfarin therapy but a change in the amount or drinking large quantities (binge drinking) is dangerous.
Cranberry and grapefruit juice can also have an effect on the INR and should be avoided in large quantities.
The Anti-Coagulation team can be reached on Tel: 335509 / Fax: 335507 for advice and information.

Right 3: The Right DOSE

3.1 Dose instructions and Changes to prescribed medication:

Medications are taken to diagnose, treat or prevent illness. All medications are potentially dangerous if taken incorrectly so it is important that all medications carry full dose instructions and that they are taken accordingly. The care worker should always follow the prescriber’s instruction to administer medication to the service user in the amount and times that the instructions say.

Calculating the right dose for some medications can be very precise and affected by age, weight, kidney and liver health, other conditions or medications taken. Examples include warfarin, methotrexate and thyroid medications. These types of medication require regular monitoring and it is not unusual for dosages to be changed.
Timing is also important in medication administration. Some medications may need to be given before food or on an empty stomach; others are required to be administered after food. Some medications need to reach a consistent level in the blood stream in order to be effective, meaning that they need to be administered at the right times to keep an appropriate level in the system. High levels of a medication can build up if a dose is taken too soon, conversely if a dose is missed or the gap between doses is too long, there may not be enough medication in the system for it to work effectively. An example of medications with time specific administration are those prescribed to treat Parkinson's disease.

Having the correct dose instructions on a medication label and following the directions for administration as the prescriber intended is paramount for safe medication administration.

All medication labels and charts should include specific directions for the correct administration to the service user. If dose instructions are not clear, guidance should always be sought from the prescriber or pharmacist. Listed below are some situations when a prescribing dose may be unclear or when a prescribing dose is altered:

### 3.2 As Directed:

Directions such as ‘take as directed’ or ‘as before’ do not provide sufficient information for safe administration. In these circumstances, guidance should be obtained from the pharmacist or prescriber. Whenever possible, written confirmation of the dose should be obtained, documented and a copy stored both with the medication chart and in the care plan. Full directions should be requested on future prescriptions.

All medication that is to be administered by care workers should have full written instruction and this should be ensured at the time of ordering the medication from the prescriber. If the medication directions state ‘one to be taken daily’ or ‘one to be taken twice daily’ the care worker should seek advice from the pharmacist on the most appropriate time of day they are to be administered.

The prescribing and timing of medications in Home Care should take into consideration the time and number of care calls.

### 3.3 Acute medications:

It should be clearly noted either on the label, the medication record chart or in the care plan how long an acute course of medication has been prescribed for. This can be self-limiting e.g. the prescribing of 21 antibiotics with three times a day administration would indicate a 7 day course. However it is not always obvious when a tube of steroid cream or an eye drop preparation is prescribed. If it is unclear how long the acute medication has been prescribed for, advice should be sought from the prescriber or pharmacist and this should be clearly recorded on the medication record chart and in the care plan.

### 3.4 Mid-cycle Medication changes:

A service user’s treatment may be changed by a prescriber and will not always take place at the beginning of a new medication cycle. Doses of medications may be increased or decreased or even stopped and new medications added. This could be following a hospital admission, during a GP consultation, by Out Of Hours or by another health professional. Changes to medication may be communicated verbally or in writing by fax or email. All changes to a service users treatment should be documented in their Care Plan giving details of the medications change, reasons why if known and the prescriber who initiated the change.
### Home care
Any changes to prescribed medication must always be accompanied by the issue of a new prescription for the new medication and or new dosage instruction. The MRC chart should be returned to the pharmacy for the addition of the new label and collection of the medication. Any discontinued medication / old labels on the current MRC should be clearly annotated either by the prescriber making the changes or by the pharmacist to indicate that this medication should no longer be administered.

There may be occasions when a visiting Out Of Hours GP, Community Nurse or Emergency Care Practitioner prescribe and supply medications from their formulary in line with a Patient Group Direction (PGD) during a home visit. These medications will not have been prepared by a pharmacy so will not have a label to update the MRC chart. In these instances the visiting health professional is responsible for transcribing the medication details onto the MRC. (See section 6.3 – transcribing)

### Residential care
When a dose change is made to a currently prescribed medication, e.g. when a service user is discharged from hospital or seen by an out of hours GP, the new instruction can be recorded on the MAR chart by the GP or by a senior care worker, and a new prescription is not always necessary.

Handwritten entries or changes on a MAR chart must always be dated, clearly written and identify who has written the amendment and also reference to the prescriber who authorised the change. The entry should be written in capital letters and full directions not abbreviations should be used e.g. write ‘take one at night when required’ not ‘one PRN’. A new MAR chart from the community pharmacy is not always required for dose changes. (See also Section 6.3 - Transcribing)

If a dose is increased, or a new medication prescribed, a prescription should be provided to ensure that sufficient supplies are available until the end of the month. A new MAR chart will usually be supplied by the pharmacy with the new medication.

Amendments to MAR charts should NOT be made using dispensing labels supplied by the community pharmacy.

Verbal changes made by a prescriber to a service user’s medication can be accepted providing there is a written authorisation of the changes made at the first opportunity. Examples of accepted changes may include:

- A visiting prescriber who makes changes to a service users’ medication, should hand write the alterations on the medication chart with a date and signature (as above)
- Changes made over the phone with confirmation of alterations by fax letter.
- Verbal changes supported by written confirmation by way of a new prescription.
- Changes made over the phone by the prescriber and documented by one care worker followed by a second care worker who repeats the changes back to the prescriber for confirmation.

**VERBAL INSTRUCTIONS VIA THE TELEPHONE MUST NEVER BE GIVEN OR ACCEPTED FOR CHANGES TO CONTROLLED DRUGS.**

Although changes can be made to the MAR chart following the guidance above, there should be no alterations made to the dispensing label attached to the medication provided by the pharmacist under any circumstances. The pharmacy labels give care workers legal authority to administer the medication and these must never be altered.
When required medications:

Medication with a ‘when required’ dose (PRN) is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly.

In home care ‘when required’ medication would generally be self-administered at the time the service user needs them which may not be during the time of the care call. Examples of this are medications for pain relief or inhalers for asthma. If assistance is needed with when required medication this must be clearly documented in the service user’s care plan. The when required medication and MRC must have clear instructions and documentation must be made for every time the medication is offered and taken or refused. A risk assessment must be done to ensure that duplicate administration is not made by the service user when the carer is not present.

To ensure that the ‘when required’ medication is given as intended by the prescriber, a specific plan for administration must be recorded in the care plan and ideally kept with the MAR or MRC charts. The administration guidance should include:

- When to give the medication or indication e.g. for pain / constipation
- Quantity to be administered e.g. one tablet or 15mls of liquid
- The dose e.g. up to four times a day
- The repeat dose interval e.g. not more than every 4 – 6 hourly
- The maximum dose permitted within a 24 hour period e.g. max 8 tablets

When a ‘when required’ medication is prescribed for a psychiatric condition e.g. agitation, the prescriber must be asked to supply a clear written criteria for signs and symptoms to be observed for appropriate administration. Consideration should be given to the service user’s capacity to refuse the medication.
A record does not have to be made at each medication round to show the service user has been offered the medication and refused.

The service user should be offered the medication at the times they are experiencing the symptoms either by telling the care worker or by the care worker identifying the service users need as outlined in the care plan. The exact time the medication was given and the amount given should be recorded on the MAR or MRC.

If the frequency of a PRN medication changes (by increasing or decreasing) it may be an indication of a change in the service users medical condition and necessitate a review of their current treatment by the service users GP or appropriate healthcare professional.

In **Residential Care**, ‘When required’ medication that is still in use and in date should be carried over from one month to the next and not disposed of to minimise waste. For this reason, PRN medication is best supplied in an original container and not a Monitored Dosage System.

### 3.6 Monitored Dosage Systems (residential care only)

In **Home Care** Monitored Dosage Systems (MDS) supplied by a pharmacy should only be used as an aid to compliance for the service user to **self-administer**. Any support offered by a care worker under these circumstances would be restricted to a prompt only (level 1) and therefore a Medication Administration Chart (MRC) is not required. Any prompting should be documented in the daily care notes in the care plan.

Care workers in home care who administer medications when giving level 2 support are expected to be able to individually identify each medication they administer and record it separately on the MRC. Therefore MDS is **NOT** considered appropriate and individual dispensing packs should be supplied.

Service users, who were previously managing their own medication prior to the implementation of a care plan from a care provider, may have medication including in an MDS still in their home. Care workers should be mindful of this and once the administration of medication by care workers through an MRC has been setup, old medications should be removed to avoid duplication either by a care worker or by the service user themselves. Friends or family members, where appropriate, should be encouraged to return old/unwanted medications to the pharmacy. Care workers should inform to their duty manager before removing old medications and MDS trays and must request the consent of the service user to do so.

Monitored dosage systems (MDS) are used widely in residential care homes and they have been promoted as a safe system of medication administration, they are however merely a convenient form of packaging. Safe practice is not guaranteed by the use of an MDS system alone but is promoted by only allowing staff who are trained and competent to give medicines. MDS can be used for tablets and capsules and some systems now also allow for liquids. There are exceptions to this however and the pharmacist will be able to offer advice. Some examples include:

- Medications susceptible to moisture or light e.g. effervescent tablets
- When required medications
- Irregular or changing medication doses e.g. warfarin
All MDS systems must be clearly labelled with the name of the service user and name, form, strength and quantity of medication within them. The Medication Administration Record should correlate directly with the labels on the dispensed medication e.g. service user name, medication, dose, time and date are all the same.

Some liquid medications, creams, eye/nose drops, suppositories, pessaries and inhalers must be supplied in their manufacture’s original containers. Therefore, any residential care home that uses MDS will have at least two different systems operating.

Once an MDS system has left the community pharmacy, it should not be sent back to the community pharmacy to add in additional medicines prescribed mid-cycle. Mid-cycle medications should be dispensed by the pharmacy in original packaging. In circumstances when the new medication is to be continued as regular medication, the prescriber should only prescribe enough to last to the end of the current cycle. In this way the new medication can be added, where appropriate, to the MDS system for the new cycle and thus avoiding waste.

If a medication dispensed in an MDS system is discontinued mid-cycle the MDS system should not routinely be returned to the community pharmacy to remove the discontinued item. All medications in an MDS system should be identifiable by the description given. If in doubt, ask the Pharmacist. The NHS does not fund MDS systems. Community pharmacists can be requested to supply medicines for a residential care home in a MDS but they do not have to do this and can refuse. Alternatively the residential care home may be asked to pay for the service and/or equipment.

Right 4: The Right ROUTE

Medications can be given in many different ways. Some level 2 care worker examples include:

- Oral route: swallowed by mouth e.g. a tablet, capsule or a liquid
- Sublingual route: under the tongue
- Buccal route: held inside the cheek or between gum and lip
- Topical route: applied to the skin
- Transdermal route: for absorption through the skin e.g. a patch
- Ophthalmic route: drops, gel or ointment for the eye
- Otic route: drops or sprays into the ear
- Nasal Route: sprays or drops into the nose
- Inhaled route: inhaled from a device or through a mask e.g. Ventolin inhaler

Other more invasive routes of medication administration (level 3- nursing tasks) include:

- Rectal route: suppository inserted into the rectum
- Vaginal route: pessary inserted into the vagina
- Intravenous route: injected into a vein
- Intramuscular route: injected into muscle through the skin
- Subcutaneous route: injected just under the skin
- Enteric route: delivered directly into the stomach via a tube e.g. PEG
4.1 Oral route

Medications delivered via the oral route may be in the form of liquid, sachets to be mixed with water, tablets, capsules, buccal tablets, sublingual tablets or oro-dispersible tablets.

**Liquid medications** should be administered using a liquid measure some of which will be available from the dispensing pharmacy. These include:
- Oral syringes
- Calibrated medicine pots
- Measuring spoons (do not use teaspoons)

Liquid medications should not be poured out in advance and ensure the care worker must shake the bottle before measuring the dose. The dose must be accurately measured for all liquid preparations. The care worker must not guess or use any spoon or allow the service user to drink from the bottle. When a bottle of liquid medication is first opened the date of opening must be written on the bottle label ensuring that instructions are not covered. (See also Section 2.4 – storage of medications).

**Sachets** are measured powdered dosage forms that must be prepared immediately prior to administration following the manufacturer’s specific instructions.

**Buccal tablets** should be placed between the gum and cheek and left to dissolve permitting absorption through the lining of the mouth, the oral mucosa.

**Sublingual tablets** dissolve when held beneath the tongue, permitting direct absorption of the active ingredient by the oral mucosa.

**Oro-dispersible tablets** are designed to disperse on the tongue and then swallowed.

**Tablets and capsules** are the most commonly prescribed formulation of medicine. There may be instances when this type of dosage form is unsuitable, for example in a service user with:
- Swallowing difficulties: Physical inability e.g. dysphagia or Psychological inability or refusal
- Feeding tubes e.g. Nasogastric (NG), Naso-jejunal (NJ) or Percutaneous Endoscopic Gastrostomy (PEG)
- A covert administration agreement through a best interest decision.

In these circumstances, there is a need to identify alternative ways of giving medications. Consideration must be given to:
- Can the medication be given in a different formulation e.g. dispersible/soluble tablets, liquid preparations, patches which can be applied to the skin, suppositories or injections. The pharmacist or prescriber will be able to give advice on the different formulations available.
- In some cases a different medication can be prescribed that does not need to be swallowed whole or is available as an alternative formulation.

Care should be taken with any changes in the medication or form as this may result in changes also being made to the amount of medicine or how often it is given. When an alternative form of medication is readily available this should always be the preferred option and prescribed in place of the solid dosage form to avert the need to crush or break.

Where an alternative appropriate formulation is not available, tablets may need to be crushed or capsules opened but doing this might affect the way a medication works and may even cause side effects. Consideration must be made to the potential consequences of manipulating formulations in this way and a pharmacist should always be consulted to find out if this is possible and this should be always be approved by the prescriber.
4.1.1 Splitting and crushing of solid dosage forms.

Most oral solid dosage forms are required by manufacturers to be swallowed whole. If a tablet is split or crushed contrary to the manufacturer’s instruction, administration will fall outside of the product license and the manufacturer will no longer retain responsibility for the medication.

Any medications that require splitting or crushing must be referred back to the prescriber to consider if an alternative formulation is available. If the medication is available in an alternative formulation, for example a liquid or a patch, then the alternative must be prescribed.

If there is no alternative formulation then the prescriber may wish to consider switching to a similar medication that is available in an alternative formulation. However there may be occasions when it is necessary to split or crush a solid dosage form but this MUST be the exception and not the rule.

Some tablets may be scored by the manufacturer and these tablets may be split more easily. Non-scored tablets should only be split after professional guidance has been sought. The prescriber must agree that the medication may be split or crushed and this must be clearly indicated on the prescription and dispensing label.

Care workers administering medications in this way must have appropriate training. Splitting or crushing medication must be done individually and immediately prior to administration. If half a tablet is to be administered then the remaining half must be disposed of safely. (See section 2.6.2)

Occasions when medication may need to be split or crushed:

- To make it easier for the service user to swallow when there is no other alternative formulation.
- To administer a medication covertly (see section 1.5.1 – Covert Administration)
- To administer a medication by a feeding tube
- To administer the correct dose of medication e.g. half a tablet

The splitting or crushing of a solid dosage form is ONLY acceptable when there are no alternative formulations or tablet strengths available.

It is important to recognise the implications of cutting, splitting, crushing and dissolving a medication intended to be swallowed whole. Changing the way in which a dosage form is presented can:

- alter its absorption characteristics
- result in the medication becoming unstable
- produce local irritant effects
- cause failure to reach the site of action,
- may produce occupational health and safety issues,
- result in a preparation with an unacceptable taste.

For this reason it important that prescription medications should only be taken according to the directions of a prescriber. Medicines used in a different way from what the manufacturers have stated are being used ‘off-licence’ which means the manufacturer does not accept responsibility for any harm caused by taking medicine in this way. A care worker giving crushed tablets or opened capsules to a patient without directions from the prescriber and without making the appropriate checks could be held liable for any harm caused.

Before it is decided that an oral solid medication requires crushing or splitting, an alternative dosage form must first be considered. Some medications are available in more than one dosage form examples include:
• A liquid
• Dispersible or soluble tablet
• Buccal tablets – a tablet that dissolves when placed between the upper lip and gum
• Patches
• Suppositories
• Cream or topical application

It is important that care staff have sought the professional guidance of a pharmacist who is in the best position to advise on whether a particular medication is available in an alternative dosage form of if it can be crushed or split and can be mixed with food or drink.

The splitting of tablets may be undertaken by the pharmacy during the dispensing process – ask the pharmacist for help and advice. Ideally tablets should be split or crushed by the care worker, immediately prior to administration.

Any decisions to make changes to tablets or capsules by crushing etc. must be documented in the care plan. The prescriber or GP must give written authorisation for tablets / capsules to be crushed, split or opened.

If tablets or capsules are crushed or opened for the purpose of covert administration, this can only be done following the outcome of a Best Interest Meeting (see section 3.4) and this should be fully documented.

Crushing or opening of solid dosage forms should not be routine practice and as stated above it is preferable to use a product in the way it was licensed to be used. The prescriber should take responsibility for using a medication in a manner that is outside its licence and should specify the exact directions on the prescription, e.g. "crush, mix with water and administer".

It is good practice for these instructions to be added to the dispensing label and MRC or MAR chart.

4.1.2 Crushing Medication:

A tablet splitter must always be used for splitting a tablet. For medications that are suitable for crushing the use of a tablet crusher is the preferred option.
If dispersing the medication, the smallest amount of cool water should be used. Some hard gelatine capsules can be opened and their contents mixed with water or administered with food.

Only crush, disperse or open medications ONE tablet at a time. Do not mix all the service user’s medications together. If the service user takes some but not all of their medication e.g. they spit some out or some is spilled, it would be impossible to know which of the mixed medications they had swallowed and which they had not.

Crushing, or dispersing or opening the medication should only be performed immediately prior to administration.

Some crushed medication or capsule contents may be administered with a small amount of cold soft food. Crushed tablets or capsule contents may taste very bitter and it can be helpful to mask the taste for service users e.g. in a teaspoon of yoghurt or jam. A small amount of soft food should be used to ensure the full dose is taken.

Medications should only be administered in food with the service user’s knowledge and consent. Hiding medication in food is considered ‘covert administration’ and is only accepted in certain circumstances. (See Covert Medication, Section 1.5.1).
4.2 Topical application: creams, ointments & lotions

Where possible all creams and topical applications should have specific dose instructions on the medication label and MRC or MAR. This should include how often and where to apply. The care plan should clearly indicate who is responsible for their application e.g. care workers or service user.

In a residential setting, topical applications should be clearly documented on a body map and kept with the signing sheet. These are usually kept in the service user’s room for application during personal cares. Only trained care staff can be responsible for application of creams.

4.2.1 Steroid application:

Emollients are prescribed to soothe, smooth and hydrate the skin and are indicated for all dry skin conditions. Their effects are short lived and they should be applied frequently (up to four times a day) even after improvement occurs. Emollients that are supplied in tubs should be removed with a clean spoon/spatula to reduce contamination of the emollient. Examples of emollients include Aqueous cream, Cetraben, Epaderm, Hydromol and Zerobase.

Topical steroids are used for the treatment of inflammatory conditions of the skin, in particular eczema, contact dermatitis. Steroid creams and ointments come in various potencies. They have stricter administration regimes and are usually applied thinly up to twice a day. Accurate measurement is particularly important for topical steroids and treatment should be reviewed after 7 – 10 days and referred back to the prescriber if the problem persists.

**Steroid potency table:**

<table>
<thead>
<tr>
<th>Potency</th>
<th>Steroid</th>
<th>Examples of Brand</th>
<th>With antimicrobial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Potent (up to 600 times more potent than hydrocortisone)</td>
<td>Clobetasol propionate</td>
<td>Dermovate, Etrivex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Betamethasone dipropionate</td>
<td></td>
<td>Diprosone</td>
</tr>
<tr>
<td>Potent (100-150 times as potent as hydrocortisone)</td>
<td>Mometasone furoate</td>
<td>Elocon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beclometasone dipropionate</td>
<td>Dipsone</td>
<td>Lotriderm</td>
</tr>
<tr>
<td></td>
<td>Betamethasone valerate (0.1%)</td>
<td>Betnovate, Betacap</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hydrocortisone butyrate</td>
<td>Locoid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diflucortolone valerate 0.1%</td>
<td>Neriesone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluocinolone acetonide (0.025%)</td>
<td>Synalar</td>
<td>Synalar C, Synalar N</td>
</tr>
<tr>
<td></td>
<td>Fluocinonide</td>
<td>Metosyn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluticasone</td>
<td>Cultivate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triamcinolone acetonide</td>
<td></td>
<td>Aureocort</td>
</tr>
<tr>
<td>Moderate (2-25 times as potent as hydrocortisone)</td>
<td>Clobetasone butyrate</td>
<td>Eumovate</td>
<td>Trimovate</td>
</tr>
<tr>
<td></td>
<td>Fluocinolone acetonide 0.00625%</td>
<td>Synalar 1 in 4</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Hydrocortisone 0.5 – 2.5%</td>
<td>Dioderm, Mildison</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluocinolone acetonide 0.00025%</td>
<td>Synalar 1 in 10</td>
<td>Timodine, Nysetform HC, Fucidin H, Canestan HC, Daktacort</td>
</tr>
</tbody>
</table>
The application of topical steroids should be measured in the form of Fingertip units or FTUs. An FTU is the amount of medication needed to squeeze a line of cream or ointment from the tip of an adult index finger to the first crease of the joint of the finger. One FTU should be enough to treat an area of skin double the size of the flat of your hand with your fingers together. The recommended dosage in terms of FTUs will depend on the area of the body being treated. This is because the skin is thinner in certain parts of the body and more sensitive to the effects of steroids.

For adults, the recommended FTU to be applied in one single dose are:

- 0.5 FTU for genitalia
- 1 FTU for each hand, elbow or knee
- 1.5 FTUs for each foot, including the sole
- 2.5 FTUs for the face and neck
- 3 FTUs for the scalp
- 4 FTUs for a hand and arm together, or the buttocks
- 8 FTUs for each leg and front or back of the trunk (the main section of the body, excluding the arms, legs and head)
- 40 FTUs for the entire body

Care workers should wear disposable gloves when administering creams, ointments etc. This is particularly important for steroid creams so that the cream and its active ingredients are not absorbed through the care workers skin. Ensure good hand hygiene and wash hands before and after administering the cream / ointment.

If instructions such as ‘use or apply as directed’ are on labels for topical steroid applications, advice should be sought from the prescriber for precise instruction on the application interval and site of application. This information should be recorded on the MAR and MRC and in the service users care plan. Information should be available to staff to know what the cream or ointment is for, where to apply, how much to apply and how long for.

Apply creams and ointments to clean skin, and only to the area it has been prescribed for. The administration of a topical preparation to a service user must be documented on the MRC or MAR charts.

The date of opening a topical preparation should be written on the container and unless specified by the manufacturer, an advised expiry from opening should be encouraged (see section 2.5). Discontinued or out of date preparations should be disposed of in the same way the as the disposal of unwanted medicines.

Within residential care settings opened creams and ointments should not routinely be disposed of at the end of a monthly cycle. Within home care the smallest pack size needed to cover 28 days application should be prescribed as no medications can be carried over to the next cycle.

Care should be taken not to administer the cream straight onto the service user’s skin from the fridge due to its temperature. Allow the cream to warm up in the care workers gloved hand for a few moments before applying.
4.3 Application of Patches

The most commonly prescribed type of medication patches seen in adult social care are for the treatment of chronic pain. Examples of this are Fentanyl and Buprenorphine patches, these are both controlled drugs (CDs). These patches contain a strong opioid often used in the management of severe pain. The application of a self-adhesive patch allows a standard amount of the drug to cross from the patch into the skin providing a continuous delivery over the period of application - Fentanyl patches are applied and re-placed every 3 days (72 hours), Buprenorphine patches are applied and re-placed between 72 hours – 7 days depending on the manufacturer.

Patches offer an alternative choice of formulation for service users who:

- achieve inadequate pain control from oral formulations
- Have difficulty swallowing oral medications
- Do not tolerate oral opioids well due to side effects e.g. constipation
- Have poor compliance with oral medication.

In Home care:
If creams are to be applied by the care worker, all topical application of creams and ointments should be documented on the service user’s MRC. The storage of these medications should be in line with manufacturer’s guidance. Any topical preparations requiring fridge storage should be stored within a lidded container on the top shelf of the service user’s fridge to keep them separate from other fridge items. Unlike in residential care, all topical creams and preparations should be ordered each month with regular medication and any left-over will need to be disposed of appropriately. In order to reduce waste therefore it is recommended that the smallest pack size available to last for the course duration or one cycle of application should be ordered.

Residential care setting:
All external medical preparations like creams, ointments, shampoos and bath preparations should be stored securely in a locked cupboard, separate from all internal medicines. Creams, ointments etc. can be kept in resident's rooms. Safe and secure storage must be available and the service user should be asked if they are happy for the products to be kept in their room. They should not be stored on window ledges or elsewhere where the temperature exceeds 25°C. Some creams require fridge storage and so are not suitable to be kept in a service user's room. Preparations requiring storage in a fridge should either be in a separate drugs fridge ideally in a box separate from any internal medicines.

The topical administration of a cream must be recorded. A separate MAR could be used and kept with the cream if it is stored in the service user’s room. If a separate MAR chart is used, it is good practice to document on the service user’s main MAR chart that the preparation is in the resident’s room and annotate with: “See cream chart in room” or some similar wording on the MAR chart.

Some service users are prescribed creams to use as a soap substitute. The care plan should list these products and what they are for. A record could be made in the daily care notes to record that the cream had been used to wash the service user. This would demonstrate that care workers are using the cream appropriately.

It is not necessary to dispose of creams a month after opening. However if large quantities are ordered that last for greater than 3 months, this should be discussed with the residents GP and a smaller quantity requested. It is not necessary to order creams and ointments monthly. Any remaining topical applications that are still in use should be carried over to the following cycle.
Rules for the Application and removal of patch:

- Always remove the old patch before applying the new one.
- Always change the patch at the same time of day on the change day.
- Make a note of the day, date and time the patch was applied on the MRC / MAR chart as a reminder when the patch is next needed to be changed.
- Apply the patch to clean, dry, non-inflamed, non-irradiated, hairless skin on the upper arm or trunk of body. Body hair may be clipped or cut with scissors but do not shaved (shaving irritates skin).
- Ensure the skin has been washed or cleaned with cold water and dried before application.
- Do not use soap, talc, cleansers, creams or moisturisers on area of application prior to applying the patch.
- Do not apply a patch immediately after a hot bath or shower.
- Do not take a patch out of its pouch until the application time.
- Never divide or cut the patches.
- When applying, press in place firmly with the palm of the hand for 30 seconds making sure it sticks well.
- The patch should be dated or a patch chart used to indicate the date and position of the patch on the service user so that sites can be rotated. It should also be clear on the MRC/MAR chart when a service user’s patch should be changed.
- Do not apply a patch on the same place twice in a row. Ideally allow several days (3-6 days) to pass before applying a patch to the same area of skin.
- Service users can bathe or shower (with care) whilst wearing a patch but the water should not be too hot.

Rules for Disposing of a used patch:

- Remove the old patch before applying a new one.
- After removal, fold the patch with the adhesive sides inwards so that the sticky sides stick to each other.
- Used patches will still contain the active medication. Place them in the original sachet and return to the supplying pharmacy for destruction. Wash hands thoroughly after handling.
- Ideally the underlying skin should be allowed to rest for 3-6 days before applying another patch to the same area.
- When ordering repeat prescriptions for patches it is important to ensure the service user has enough for continued therapy but it is also important not to over order the patches as the dosage of the patch may need to be changed.

Important Notes on patches:

Side effects of Fentanyl and Buprenorphine are similar to other strong opioids such as morphine and include nausea and vomiting, dizziness, drowsiness (including day time drowsiness), confusion and hallucinations, constipation, sweating. The incidence of side effects is greatest when the medication is new, then often reduces over the subsequent 48 - 72 hours.

Toxicity is more likely to occur in the elderly and in those with liver or kidney disease. Signs of toxicity include respiratory depression, excessive drowsiness/reduced level of consciousness and twitching – medical advice should be sought immediately if any of these symptoms are experienced.
Heat (e.g. hot baths, electric blankets, hot water bottles) should NEVER be applied over the top of the patch as it may enhance the absorption of fentanyl.

An increased temperature / fever may also increase absorption and the service user should be monitored for side effects and toxicity. Advice from the service user’s GP should be sought.

Site irritation, usually from the adhesive, may necessitate a change of brand and so should be discussed with the resident’s GP.

If a patch is being used for the first time there is a delay after it is applied before pain relief is achieved. Similarly after removal there is a delay before the pain killing effect stops working. Patches should therefore not be used for acute pain.

Extreme care should be taken when starting and stopping therapy with fentanyl patches because it has such a long duration of action.

More than one patch can be used at a time to obtain the correct dosage but the patches should be changed at the same time to avoid confusion. The service user’s GP will advise if this is required and it should be clearly documented in the service user’s care plan.

Fentanyl and Buprenorphine are controlled drugs and so within a residential care setting all stock must be stored in an approved controlled drug (CD) cabinet. Their use and administration must be entered into a CD register and used patches should be disposed of appropriately.

4.4 Eye drop/gel/ointment administration:

The care worker should ensure that their hands are clean and dry prior to administering eye preparations and or plastic gloves worn. The product directions should be read carefully and this guidance followed:

- The service users head should be tilted back slightly
- The lower eye lid should be pulled down and one drop allowed to fall in the pocket between the lower lid and the eye
- Two different types of eye drops should never be administered at the same time. Wait at least 5 minutes before administering the second eye drop medication.
- If more than one drop of the same eye medication is required, there should be a 1 minute interval before instilling the second drop.
- Any excess should be wiped away from the service users face
- When drops are prescribed for use in both eyes, it is good practice to have separate bottles for each marked left and right to reduce the possibility of cross contamination.
- The procedure is similar for eye ointments. Apply about half a centimetre of length of the eye ointment into the pocket between the lower lid and the eye (unless stated differently on the product literature).
- The care worker should wash their hands after administration.
- Keep eye bottles/containers closed in a cool dark place unless otherwise advised. Not all eye drops require storage in the fridge – check the individual product literature.
- Do not let the tip of the dropper touch the eye, fingers or other surface to keep it free from germs/contamination.
- Discard the bottle after the recommended time – this is usually 28 days after first opening the bottle due to the risk of infection if they are kept and used for longer than
advised. Write the date the bottle/container was opened on the label. In home care all products will need to be discarded and replaced every 28 day cycle regardless of expiry.

- Eye drops may cause a taste in the mouth or a feeling that drops are running down the back of the throat. To help prevent this the service user may be advised to gently press on the tear duct for a minute after application.
- Eye drops should only be used in the eyes and must not to be taken by mouth

4.5 Ear drop/spray administration:

The care worker should ensure that their hands are clean and dry prior to administering ear preparations and or plastic gloves worn.
The product directions should be read carefully and this guidance followed:

- The service users head should be tilted to one side or if more comfortable they should lie on their side.
- Gently pull the ear lobe down away from the neck and administered the required number of drops or sprays. This can be done all in one go and not separated unlike eye drop administration.
- The service user should keep their head tilted for a further 5 minutes after the administration of the ear drops / spray.
- Any excess should be wiped from the service users face.
- Repeat this procedure to the other ear if required.
- The care worker should wash their hands after administration.
- Keep ear drops/containers closed in a cool dark place unless otherwise advised – check the individual product literature.
- Discard the bottle after the recommended time – this is usually 28 days after first opening the bottle due to the risk of infection if they are kept and used for longer than advised. Write the date the bottle/container was opened on the label. In home care all products will need to be discarded and replaced every 28 day cycle regardless of expiry.
- Ear drops should only be used in the ears and must not to be taken by mouth

4.6 Nose drops/spray administration:

The care worker should ensure that their hands are clean and dry prior to administering ear preparations and or plastic gloves worn.
The product directions should be read carefully and this guidance followed:

- The service users head should be tilted well back and the correct number of drops or sprays allowed to flow down to the nose
- The service user should be encouraged to keep their head tilted for a few minutes to allow the drops/spray to be absorbed.
- Any excess should be wiped from the service users face.
- The care worker should wash their hands after administration.
- Nose drops should only be used in the nose and must not to be taken by mouth
4.7 Inhaler Administration:

Inhalers are prescribed for people with asthma or chronic obstructive pulmonary disease (COPD). There are many different types of inhaler devices available, containing a range of different medications for the control of airway symptoms such as wheezing, breathlessness and coughing.

Inhaler devices contain the medication in either a dry powder form or in an aerosol mist. Within these inhaler devices there are different types of inhaled medication to control symptoms of airways disease. These can be classified as follows:

- **Short acting relievers**: e.g. Salbutamol, Terbutaline. These are often called ‘relievers’ and are usually blue. They work by relaxing the muscles, opening the airways to quickly ease the symptoms of breathlessness, wheeze or a tight chest. These inhalers should be used when required to relieve symptoms.

- **Long acting relievers**: e.g. Salmeterol, Formoterol, Tiotropium. These work in similar ways to relievers but have a slower onset of action and work for 12 – 24 hours after taking each dose. These inhalers should be used regularly.

- **Corticosteroid inhalers**: e.g. Beclometasone, Fluticasone, Budesonide. These are often called ‘preventers’ and reduce inflammation in the airways preventing airway narrowing and causing symptoms of wheeze and cough. These should be used regularly, usually twice a day.

Inhalers come in a range of different colours. Short acting relievers are usually blue and long acting relievers are green. Preventers (steroid inhalers) are usually brown, but some can be orange. There are also combination inhalers available which contain a steroid and a reliever. Below is a general guide to the different types of devices,

**'Press and breathe' Metered Dose Inhalers (MDIs)**. An MDI inhaler uses a small canister with a mixture of medication and a gas or liquid that turns the medication into a very fine spray upon pressing the canister. This is usually termed ‘a puff’. They require well timed coordination of actuating the device and breathing in at exactly the same time. MDIs work better with a spacer, especially for children and the elderly. Spacers make these inhalers easier to use and more effective. Spacers collect the medication inside the chamber, so eliminate the need to coordinate pressing the inhaler and breathing in at the same time. Correct use of this inhaler device requires inhalation to be deep and slow. This inhaler should be shaken well before each puff to mix the medication well before use. Examples of these devices include: Ventolin Evohaler, Seretide Evohaler, Fostair, Clenil & Qvar.

**'Breathe in normally' Breath Actuated MDIs** are usually given to people who have difficulty using a press and breathe inhaler (as above). These inhalers are activated by breathing in normally through the mouth piece and the medication is automatically released in a fine spray form. With this inhaler there is no requirement to push the canister to release the dose. This is known as a breath-actuated device and examples include Autohaler and Easi-breathe. This inhaler should be shaken well before each puff to mix the medication well before use.

**'Breathe in hard' Dry Powder Inhaler (DPIs)** release medicine in very fine powder form instead of a spray by breathing in through the mouthpiece. Correct use of this inhaler type requires a steady, strong, deep inhalation by the user. Examples of DPIs include Accuhalers, Clickhalers, Easyhalers, Novolizers, Turbohalers, Diskhalers and Twisthalers.
Whenever possible, self-administration of inhalers should be encouraged. This is important especially for reliever inhalers, because it allows the service user to use their inhalers at the time that they need them.

Inhaler technique is very important for good medication delivery to the airways. Good technique can be demonstrated by the pharmacist for each of the inhaler types as listed above, and reference can also be made to the individual product information leaflets.

In some instances, care workers may be required to assist a service user with their inhaler. This assistance may include:

- Assembly of a new inhaler ready for use e.g. loading the canister into the inhaler device e.g. a respinmat inhaler.
- Preparing the inhaler for the current dose e.g. loading a capsule (Spiriva Handihaler) or twisting a turbo-inhaler (Symbicort or Bricanyl).

This type of assistance would prepare the inhaler ready for the service user to self-administer and the dose is released when the service user inhales from the device.

For those who struggle to use their inhalers it is worth asking the pharmacist or prescribing GP for advice on alternative devices that the service user may find easier to manage. Technique can also be improved by the use of an ‘aero-chamber’ or ‘spacer device’ which is attached to the inhaler prior to its use. These devices can only be used with a MDI device. The spacer device slows down the process of administration and thus improves coordination and encourages deeper inhalation by the user. If a care worker is helping the service user with administration of a ‘press and breathe’ MDI, correct technique and drug delivery can only be possible with the aid of an aero-chamber device and this should be encouraged.

Examples of incorrect technique:
- Not shaking the device before use
- Not breathing out first
- Lying down during use
- Inhaling too fast or too slow
- Inhaling too early or too late with an MDI device – poor coordination
- Breathing out too quickly after inhaling, not holding breath
- Inhaling through the nose and not the mouth

Service users should always be sitting upright or standing when using their inhaler devices allowing better air entry deep into the lungs.

Using a spacer device with MDI inhalers will help with coordination and drug delivery.

After using corticosteroid inhalers service users should be encouraged to rinse their mouth out with some water to reduce deposits on the back of the throat and the risk of hoarseness or oral thrush.

Always replace the inhaler cap/lid after use to keep the inhaler clean and free from dust.

### 4.8 Administering Medications via Feeding Tubes:

Administration of medications via feeding tubes in residential care or home care must be carried out by healthcare professionals trained to skill level 3 – invasive techniques and nursing care (See Section 1.6.4 – Level 3).
The choice of drug and/or formulation to be administered via a feeding tube requires specialist knowledge and advice must be sought from local medicines information departments to ensure suitability, compatibility with the feed and to establish an appropriate enteral tube flushing regiment.

Right 5 – the right TIME

Medication Administration

5.1 Safe Medication Administration

The Medicines Act 1968 states that medications can be given by a third party, e.g. a suitably-trained care worker, to the service user that they were intended for when this is strictly in accordance with the directions that the prescriber has given.

In all care settings all medications must be administered to the service user (except if self-medicating) by designated and appropriately trained care workers from the container dispensed and labelled by a pharmacist.

All medication for administration by a care worker should be labelled complete with:

- The service users name
- The date of dispensing
- The name, formulations and strength of the medication
- The quantity of medication in the container
- The dosage instructions
- Any special instructions e.g. before or after food.

All of this information should be replicated on the MRC or MAR.

In all care settings the administration process must always include:

- Checking the identity of the service user.
- Checking for known sensitivities or allergies.
- Checking medication on the MRC or MAR charts.
Checking that the medication has not already been administered.
Selecting the correct medication for the correct time of day.
Checking the selected medication against the record.
Measuring the dose if required.
Rechecking that the measured dose is correct.
Administering the dose to the service user.
Checking that the dose has been taken.
Recording, at that time, the administration, or the reason for omission or refusal as per codes on the chart.
The chart codes should be clear with further annotation on the reverse or documented within the care plan when needed.
The care provider should keep up to date copies of care workers signatures for identification.

Do not rely on memory – There may have medication changes since the care worker last administered medications to that particular service user!

5.2 Medication Administration in Residential Care

Medications should be given to one service user at a time. They should be prepared according to the prescribers directions and taken directly to the service user and given immediately. Other care staff and managers should ensure that the care worker administering medications is able to do so without interruption, that it is a protected activity.

It is not acceptable for one care worker to prepare the medication and give this to another care worker to administer to the service user. If the second care worker does not have the original container with the label they cannot be sure that the right service user receiving the right medication or the right dose as prescribed.

Service users living in residential care who have a physical or mental disability should not have their medicines automatically given by care workers. The community pharmacist may be able to offer advice or to adjust the way that their medications are packed or labelled for individual service users in order to promote self-administration e.g. large print labels if eye sight is poor or containers with easy open tops when child resistant caps cannot be opened. Some service users choose not to keep their own medicines for self-administration even when they have capacity to do so, preferring instead to allow the care workers to take the responsibility for them. When this happens the care workers should document this decision in the service users care plan.

Whenever possible, medication should be administered direct to the resident from the container in which it was supplied. Another container, for example a medicine pot, may be used to aid the administration of the dose, but this must not be prepared in advance of the administration time.

It is good practice for medications held in a residential care setting to be audited at regular intervals to ensure that the records tally with the actual amounts held. Any discrepancies must be reported to the line manager at the time that they are discovered.
5.3 Good Practice for Safe Administration:

- The service user should be in an upright or sitting upright before help with medication is given. If this is not possible then the carer must report this to their line manager who can ask advice from the service users’ GP or Community Pharmacist.

- If it is a new medication for the service user, care workers should ensure that they have the right information for safe administration. This information should be from the pharmacist, GP or hospital.

- Some medication may have variable doses which may need to be checked with separate charts or booklets e.g. warfarin (See Section 2.9 - Warfarin). On these occasions the correct dose should be cross referenced prior to administration and the dose administered should be clearly entered onto the MAR or MRC chart.

- There may be occasions when it is necessary to split a tablet in half to comply with the prescribed amount when there is no liquid alternative. This must be carried out under written instruction by the prescriber (See Section 4.1.1 - Splitting and Crushing). This must be checked with the pharmacist and recorded. If a service user has difficulty swallowing, this problem could be discussed with the pharmacist or prescriber to enquire if a suitable liquid or alternative is available.

- When administering medications, the service user should be offered a drink and/or food to help them swallow it. If the service user consents, medication can be added to food as an aid to swallowing, but it should never be hidden in food without their knowledge and consent, unless the procedure for covert administration had been followed. (See section 1.5, Covert Administration)

- Where medication administration is provided, medications should be handled as little as possible. Oral medication should be removed from a bottle or pushed out of a foil (blister) strip into a small pot or onto a small plate etc. for the service user to access. Once administered, all lids and packaging should be re-placed and medications should be re-stored.

- Medication administration should be supported by the service users care plan which should identify any specific needs of the service user e.g. if the service user prefers to have medications given to them by a member of the same sex or if they observe religious festivals which may affect medication administration times.

- Care workers should have the correct level of training before administering any medication to the service user.

- Service providers should have written procedures for the safe administration of medications, which are reviewed to ensure that care workers follow safe practice.

- Medications must only be administered to the person for whom it is prescribed. It is illegal to administer medications prescribed for one service user, to another.

- Medication administration should be an uninterrupted procedure and given full attention by the care worker. It is essential that the medication administration process is a protected activity which should not be interrupted by any other activity.
• The administration of medication must be exactly in accordance with the directions of the prescriber, whether these be written or verbal. If any directions to administer are at all unclear then administration must not take place until clarification has been received from the prescriber, another medical practitioner, or the community pharmacist (See Section 3 Changes to directions).

• Liquid medication should always be shaken before it is measured or administered. Measurement of the dose should always be with a medicine spoon, oral syringe, or calibrated dropper. Although medicine pots may be used to aid administration, they are not accurate enough to be used for the measurement of doses. Teaspoons should not be used and the service user should not be encouraged to drink from the bottle. Liquid medications should not be poured out in advance of the administration time and the date of opening any new bottles should be written on the dispensing label.

• Medications should not be handled. They should be prepared by a ‘clean technique’ e.g. pushing a tablet or capsule out of the blister directly into the administration pot and the use of plastic gloves must be encouraged. Some medications may be harmful to care workers if they have direct contact with them e.g. cytotoxic medications such as Methotrexate & Finasteride.

5.4 Stages of Medication Administration

Follow the ‘seven right’ checks prior to administering any medication.

1. The **RIGHT** service user receives…
2. The **RIGHT** medication...
3. At the **RIGHT** dose...
4. Via the **RIGHT** route...
5. At the **RIGHT** time...
6. With the **RIGHT** documentation...
7. The **RIGHT** to refuse medication…

Following the steps outlined below will ensure good practice for medication administration in all care settings.

**Step 1: ASK:** Before help with medication is given and where appropriate, the care worker should ask the service user if they are ready to take their medication. This is important prior to all medication administration but is especially important for medications that are only to be taken when the service user requires them e.g. pain relief and the instructions state ‘one or two to be taken when required up to four times a day’. The care worker should enquire whether the service user has any pain before the medication is selected and prepared. Other examples of occasional medications are treatments for constipation or indigestion. If the service user is not ready to receive their medication, the care worker should ask again at a later time e.g. at the end of the medication round (residential care) or later during the care call (home care).

**Step 2: CHECK:** The MRC or MAR chart should be checked. The care worker must check the service users name and DOB on the charts and verify this with the service user. They must also check the name, strength and dose of the medication on the chart against the medication selected for administration. Checking the chart will also confirm that the dose has not already been administered, if there are any recent changes or special instructions e.g. before or after food, chew or dissolve in water etc. and what time the medication is due – some medications may be only taken once weekly.
Step 2: PREPARE: The care worker should then wash and thoroughly dry their hands and any utensil that may be required e.g. medication spoon, measure, and glass. Care workers should use gloves provided to handle medication. Ensure that there is a fresh glass of water and/or food to help swallow the medication. This should be prepared for each service user. A hot drink is not advised because many medications are affected by heat.

Step 3: SELECT: The MRC or MAR chart will indicate the medications to be administered for that time of day for the service user. There may be medications in the fridge or liquid medication in bottles. It is important NOT to rely on memory; medications may have changed since the care worker was last on duty. Note any special instructions e.g. before / after food, to be chewed / dissolved in water. The pharmacist label on the medication container should correspond with the instructions on the MRC or MAR chart and instructions should be clear and concise.

Step 4: Administer: The medication should be selected from the pharmacy dispensed container and the correct dose emptied into a suitable vessel and handed to the service user to take with the glass of water. Encourage the service user to sit upright. It is very difficult to swallow tablets or capsules when lying down. If the tablet or capsule gets stuck it could cause choking or damage to the lining of the gullet.

Step 5: DOCUMENT: Assistance given with all medication must be recorded on to the MRC or MAR chart. The care worker providing assistance should initial in the appropriate box on the MRC or MAR chart to document that the medication has been given. This should only be recorded immediately after the medication has been administered and not before. Any when required medication or variable doses should be fully documented to indicate, the time of administration and the quantity given. If medication administration has been unsuccessful this must be documented with annotated notes if required e.g. refusal, not required etc.

Step 6: STORE: Safely return the service users medication packs and containers to their place of storage e.g. medicine trolley, box or fridge etc. ready for the next administration. Do not leave medications lying around. Any prepared medication that are refused during administration should be stored separately for destruction at a later time in a clearly marked container in a secure area away from the rest of the medication. This should be returned to the pharmacy for destruction at the earliest convenience. (See section 2.6 Disposal of medications)

Remember:

**RED:** Ask the service user, Check the administration chart and prepare.

**Amber:** Select the correct medication and administer the medication as per the prescriber’s instructions and care plan. Adhere to any specific requirements

**Green:** Record and store safely – follow up or report on any concerns that needed addressing.

5.5 Administration by non-paid carers

When family or friends of the service user administer some doses of medication e.g. a home care service user or a residential care service user on a day outing, it should be documented in the care plan, who is responsible for administering which doses. Care providers may wish to show the family or friends how to complete the MRC or MAR chart to ensure doses are not omitted or duplicated.
The chart should be clearly marked to indicate the medication has been administered by someone not employed by the care provider. (See also section 8.7.1)

5.6 Safe Self-administration

The service user who wishes to self-medicate will have been assessed for their ability to do so and risk assessment will have been completed. Ongoing assessment of the ability of a service user to self-medicate should include a periodic check list of the following:

- Is the Service User able to read the information on the container?
- Can the Service User open the container?
- Does the Service User understand what the medicine is for?
- Is the Service User able to understand any special instructions to be followed?
- Does the Service User understand the dose to be taken?
- Does the Service User remember to take their medication on time?

If the care worker has any doubt or notices any changes in the service users ability to self-administer their medications, this concern must be reported to the duty manager and a further risk assessment be carried out. Examples of this are: the service user becoming more forgetful and missing doses or a deterioration in eye sight so they are not able to clearly read a pharmacy label.

5.7 Training:

In all social care services and settings, administration of medication should be designated to appropriately trained and competent care staff. It is the responsibility of the employer to ensure that the care workers have been trained and judged competent, appropriate to the work that they are to perform for the service user within their care. Care workers responsible for the administration of medications to a service user should be trained to level 2, having been mentored by a senior worker and assessed as competent and confident to administer. If a care working has not had training or does not feel confident, they should not be administering medication.

All care providers are responsible for ensuring their care workers are competent to carry out the level of care required by a service user. Any new members of staff, those returning from a period of absence, or those moving from another employer must be assessed as competent and credentials checked before they can start to administer medication.

It is recommended that refresher training and competency checks for care workers should take place annually. The review should assess the care workers knowledge, skills and competencies relating to managing and administering medicines. Care providers should identify any other training needed by care home staff responsible for managing and administering medicines. If there is a medicines-related safety incident, this review may need to be more frequent to identify support, learning and development needs.

A record of any training undertaken by a care worker should be retained for inspection and updates. The Care Service provider is responsible for the developing and monitoring of their medication policies and for the provision of training to their staff.
The essential elements of training to skill level 2 should include:

- How to prepare the correct dose of medication.
- How to administer different forms of medication, including tablets, capsules and liquid medicines given by mouth; ear, eye and nasal drops; inhalers; and external applications.
- Understanding the responsibility of the care worker for ensuring that medications are only administered to the service user, for whom they were prescribed, giving the right (prescribed) dose, at the right time by the right method/route.
- Checking that the medication ‘use by’ date has not expired.
- Checking that the service user has not already been given the medication by anyone else, including a relative or care worker from another agency.
- Recognising and reporting possible side effects.
- Reporting refusals and medication errors.
- How a Care Worker should administer medications prescribed on an ‘as required’ basis, for example, pain killers, laxatives.
- What Care Workers should do when service users request non-prescribed medications.
- Understanding the service provider’s policy for record keeping.

Further training will be required for specialist tasks on an individual service user basis (see Section 1.6.3)

5.8 Secondary Dispensing:

Secondary dispensing is when medications are removed from the original dispensed containers and put into pots or compliance aids in advance of the time of administration. This is NOT considered good practice as this process has removed a vital safety-net to check the medicine, strength and dose with the prescription, MAR chart and label on the medicine and the identity of the service user.

Medicines should always be administered from containers dispensed and labelled by the pharmacy (for the exception see section 3.4 – Out Of Hours visiting health professionals). Care workers should always be able to identify and record each individual medicine they administer.

It is recognised that occasionally service users may need to take a dose of their medication whilst away from their usual place of residence or in the absence of a care provider. Examples include:

- Attending a hospital appointment
- An short outing with friends
- A visit to a day care centre
- A weekend stay with family
- Medication put out for self-administration at a later time e.g. sleeping tablet.

In these circumstances it is not acceptable to re-pack medications for the service user to take with them. This is secondary dispensing and care workers are not qualified to dispense medication. Medications issued in this way are not labelled properly or legally and the medication is not identifiable. It does not provide proper a dose, warning or storage instructions. A care worker who gives medication to a service user to use in this way will take full responsibility if something goes wrong.

Problems with secondary dispensing:

- How will the care worker know that the service user receives the right dose of the right medication at the right time as prescribed
• Other prescribed medications may have been missed that are held in original containers e.g. inhalers eye drops or when required medications.
• The medication documentation may be inaccurate

The acceptable alternatives to secondary dispensing are:

1. Supply the service user with medication in the original pack already supplied by the pharmacy, be that in boxes or bottles or MDS.
2. For planned periods of absence, speak with the prescriber and the pharmacy in advance to arrange to have the doses needed for the period of absence dispensed into separate containers that the service user can take with them.
3. Obtain a separate prescription to cover for the period of absence with medications packed and labelled by a pharmacy in individual containers.

There are exceptional circumstances when the practice of secondary dispensing may be acceptable in social care:
• Absence at very short notice
• In Home care, if it has been agreed with the service user and it is in the care plan, doses can be left out for that individual to take at a later time, e.g. a sleeping tablet. (see also section 1.2.1)

Exceptional cases such as these need a robust risk assessment and written procedure. Details should include, which staff are permitted to do this, what containers the medicines are to be put in, how the containers are to be labelled and what other information is to be given.

A clear record should be kept of all staff involved in each stage of the procedure and the actions taken. This can only be deemed acceptable if the practice places neither service users nor care staff members at risk. Whenever possible, secondary dispensing procedures should be witnessed and checked by a second member of staff (See also Section 8: Transfer of medication between care settings).

Right 6 – The right DOCUMENTATION

Administration Recording and Documentation

6.1 Record Keeping

Record keeping and documentation is a legal requirement for all providers of care supporting medication administration. Records must be maintained of the following:

• Requests for supplies of medication. (Record of medication on order)
• Receipt of medication from all sources
• The medication prescribed for each service user
• The medication administered to each service user (incl. “homely remedies”)
• The disposal of medication
6.2 Medication Documentation

It is important to document when medication has been administered to a service user. The use of charts is an essential element in determining whether the service user has been given the medication when the prescriber has instructed. If medication has not been given or refused this must also be clearly documented on the chart using appropriate codes with further explanation given where needed.

All documentation on the charts should be in ink – NEVER use pencil. Within a residential care setting the charts are referred to as Medication Administration Records or MAR and in home care they Medication Record Charts or MRC. Both MRC and MAR charts are prepared by the pharmacy at the time of dispensing a prescription.

All charts must detail:

- The name of the service user
- The details of the prescriber e.g. GP and surgery
- Each medication prescribed for the service user
- When each medication must be given e.g. at tea time
- What the dose is e.g. one or two
- Any special instructions to be followed e.g. with or after food.
- The start date for the medication cycle
- The administration dates
- The quantities of each medication supplied.
- For medication prescribed in variable dosage e.g. warfarin, Senna or lactulose, the record must include the actual quantity given on each occasion

**The medication administration chart must be kept up to date at all times.**

The legal direction to administer medication is as per the dispensing label. The MRC and MAR chart is a record of medication to be given and medication taken. Both the dispensing label and the MRC/MAR chart should be an exact match. If this is not the case, the medication should not be administered and the care worker should contact their duty manager for clarification.

After each time a medication is administered the charts should be immediately initialled. It is also important to keep a record when a prescribed medication has not been given and often letter ‘codes’ are used to record this and the reason why. The chart must clearly explain what the codes mean and these must not be the same as the care worker’s signatures or initials.

The care provider should keep an up to date record of all care workers signatures or initials with which they sign the MRC/MAR to document administration.

Any persistent refusal of a service user to take regular prescribed medication should be reported to the duty manager and prescriber.

Any missed entries or gaps with regular prescribed medication should be reported and investigated immediately.

There must be sufficient information in the directions to administer ‘when required’ medications safely and documentation on the chart should include what time the dose was given and the quantity of medication e.g. ‘two’ administered at ‘9am’.
Care Workers must NOT:

- Sign for medicines administered by other care workers or unpaid carers.
- Change an existing administration entry on a MAR/MRC chart when a service users medication is altered or an error has been made.
- Use correction fluid.
- Use a pencil to sign the MAR charts.
- Sign for medication administration retrospectively.

Written mistakes should be corrected by drawing a single line through the mistake followed by the correction and a signature, date and time.

6.2.1 Home Care Medication Record Charts (MRC):

All medications for service users at home should be dispensed in their original containers. The pre-printed MRC charts will be completed using duplicate labels that have been over signed by the pharmacist to make them tamper evident. The pharmacist should sign in pen the letter MRC over the left edge of each label on the MRC to reduce the risk of altering the labels and highlight evidence of tampering.

The labels must be attached to the MRC at the time of dispensing and only ONE MRC should be in use in any one medication cycle (See also section 8.4 - Hospital discharge). If there is more than one MRC in use, the care worker must ensure that they are using the most up to date MRC containing the correct medications and doses that correspond to the current medication being administered. If necessary this may be clarified by the prescribing GP surgery or supplying pharmacy.

The only exception to the rule of one MRC, would be if a service user was prescribed ‘Just-in-Case’ medications e.g. antibiotics and steroids prescribed for an exacerbation of COPD. In this instance, the just-in-case medications would be dispensed and a separate MRC chart would be supplied to go with these. Please ensure that the pharmacy is informed of this at the time of dispensing. The ‘just-in-case’ medications and chart must be stored safely together within the home of the service user until needed. Once in use, the ‘just-in-case’ medications and MRC chart should be put with the regular medications and MRC and both charts should be clearly annotated to indicate that 2 charts are currently in use for the duration of the just-in-case medications only.

Each new month, the previous cycle MRC must be removed from use and stored securely by the care provider for 3 years.

The Removal or alteration of the medication labels on the MRC is not permitted by care workers (see also section 6.3 - Transcribing Charts) Charts should be clearly annotated by a health professional e.g. prescriber or pharmacist when a medication has been discontinued or a dose has been changed mid cycle to avoid administration errors or duplications. More detailed notes can be made on the chart in the space provided with the date and health professional initials.

Loose labels must not be supplied by the pharmacy for the care worker to add to the MRC.

The labels on the MRC should correlate directly with the labels on the dispensed medications e.g. service user name, medication, dose, and date are all the same. The only exception to this is the date. An example of when the dates may differ on the medication label and the label on the MRC is when:

- A pharmacy has either forgotten to issue and MRC or was not aware that an MRC was needed at the time of dispensing the medication. The pharmacy may then issue the MRC the following day or a couple of days after dispensing the medication.
If following collection or delivery of the new MRC with medications the MRC is misplaced, the pharmacy may produce another MRC clearly indicating that it is a Duplicate.

In order for a replacement MRC to be issued the pharmacist needs to assure themselves that there have been no changes to the medication before they can prepare an MRC. The date on the labels will be the day the MRC was issued and not the date of dispensing the medication. They must make this known to the care workers.

For mid-cycle requests or acute courses the MRC must be returned to the community pharmacy for the addition of the label when the new item is collected. The pharmacy MUST NOT provide a loose label to be applied by the care worker. If medication is supplied by a visiting health professional and not dispensed by a pharmacy there will be no second label to attach to the MRC. The visiting health professional must transcribe the medication details onto the MRC (See Section 3.3 Medication Changes and 6.3 – Transcribing).

For mid cycle requests that may follow into the next cycle e.g. a seven day course of antibiotics prescribed on day 26, the pharmacy should print two extra labels at the time of dispensing – one to attach to the current MRC and the other to add to the new cycle MRC. This will ensure where possible that only one MRC chart is in use for each medication cycle.

Each time a medication is administered the charts should be appropriately signed by the care worker, any special notes or documentation should be clearly written on the chart in the space provided with date and carer worker initials.

If there are any unpaid carers involved in the administration of medication to a service user in home care they should be encouraged to complete the MRC to enable a complete record of medications taken to be made.

The completed MRC is a 4 week record of medication administration and should be returned to the Home Care Office and stored in the service user’s file. To meet insurance purposes, these forms must be kept for a minimum of 3 years.

Care workers must follow the guidance contained within this policy and accurately record all assistance provided. Removal or alteration of labels from the MRC is NOT permitted under any circumstances. If labels are tampered with staff will be subject to disciplinary proceedings by their employers.

Level 1: general support tasks do not need to be recorded on an MRC chart. A record of any level one task should be made in the care plan. If the service user has a MRC chart for level 2 administration for other prescribed items, the care worker should write ‘self-medicating’ next to any level 1 items.

6.2.2 Residential Care Medication Administration Records (MAR)

The responsibility for providing MAR charts rests with the residential care home; the community pharmacy is not responsible for providing these. However in a residential care setting, MAR charts are usually prepared by the community pharmacy at the time of dispensing a medication from a prescription.

Ideally the MAR chart should be printed. Poor records are a potential cause of preventable medication errors. Printed MAR charts are not essential but they are recommended as they are better than handwritten charts as there is less risk of error due to incorrectly transcribing the details from another document and poor handwriting that is difficult to read and can be misunderstood.
If a handwritten MAR chart is the only option, there must be a robust system to ensure it is correct before it is used. See Transcribed Charts below.

Care workers are not required to fill in MAR charts for service users who are self-medicating however the MAR charts should be clearly annotated to show that the service user has been given responsibility for their medication for self-administration. The charts may be used to show that a care worker has checked that a medication has been taken as part of ongoing assessment, but it must be clear that the medication was NOT actually administered by the care worker. Where creams have been dispensed and are stored in the service users own room for administration and documentation on a separate administration chart, this also should be annotated on the original MAR chart.

The MAR chart must be kept up-to-date and any changes to a service user’s medication should be clearly annotated on the MAR chart. Any care workers with appropriate training can amend the MAR chart, in line with a prescriber’s recommendation, but the residential care home should have a system to check the source and accuracy of the changes. A cross reference to the daily notes in the care plan is recommended. When a service user’s medication is altered, care workers are responsible for amending the MAR unless the prescriber or other health professional is present. The following should be documented:

- cancel the original direction
- write the new directions legibly and in ink on a new line of the MAR
- write the name of the doctor or other prescriber who gave the new instructions
- date the entry, print your name and sign that you have written on the MAR chart
- where possible, get a second appropriately trained member of staff to print their name and sign that they have checked the entry
- ensure that handwriting is clear and can be read easily
- take extra care when writing strengths and doses to make sure they cannot be misunderstood.

When writing on a MAR chart, care workers, wherever possible should ensure they do this where they won’t be interrupted to minimise the risk of errors.

A GP does not have to sign any documents produced by a residential care home or community pharmacy for medication administration. However it is appropriate and good practice to ask the GP to sign the MAR chart, for example when the doctor visits and changes the dose of a prescribed medicine.

The dosage ‘as directed’ is not appropriate and should be clarified with the GP or pharmacist.

There may be more than one MAR chart in use for the same service user. They should all be kept together in the medication administration folder used in medication rounds.

Administration of controlled drugs should be recorded on the MAR chart as well as the record in the controlled drug (CD) register. (See Section 2.7.1 - Controlled Drugs)

Medications that are prescribed for ‘when 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 ‘when required’ medicines previously supplied for that service user. The MAR chart should be supplemented by information that clearly describes the circumstances when ‘when required’ medicine may safely be given. (See section 3.5 - When Required Medication)
The MAR chart may include a medication that has not been supplied. The care home must check whether the prescriber has stopped the medicine and if so cross it off the chart, date and sign it. If the treatment is to continue, the residential care home must check why there is no supply. The MAR can be a very useful tool for the residential care home to use to keep track of medicines that are not ordered every month but only taken occasionally. The residential care home may use the MAR to record tablets carried over onto a new chart e.g. PRN medications.

A record should also be kept of medications administered by visiting health professionals on the service users MAR chart e.g. Vit B 12 injections.

6.3 Transcribing charts

A Temporary MAR chart may be produced by a care worker for a service user for reasons including a new mid-cycle medication, a change in dose or hospital discharge. The temporary MAR can be handwritten – this is called transcribing. Secondary labels should not be requested from the service users pharmacy or labels removed from dispensed medication to add to the MAR chart.

When transcribing new medication:
- Complete all of the service users personal details at the top of the chart for each chart in use
- Copy the information EXACTLY as it appears on the pharmacy label. This should include:
  - the name
  - the form
  - the route
  - the strength of the medicine
  - FULL directions for use

When transcribing an amendment to an existing medication:
- Cancel the original direction and clearly indicate that a new dose has been prescribed.
- Write the new dosage instructions on a new line of the MAR chart.
- Write the name of the Prescriber who gave the new instructions and date the entry.
- The care worker should print and sign their name to indicate that they have amended the MAR chart.
- Where possible the amendment should be checked and witnessed by a second care worker who should print their name and sign that they have checked the entry.

Care providers should ensure that the care worker who is transcribing a MAR chart is competent to do so and there should be a system in place to check the source and accuracy of the changes. All transcribing should be printed and legible and in ink. Transcribing should be an uninterrupted task.

Transcribing medication on MRC charts in Home Care should be a rare occurrence. There may be however circumstances when this must occur in order to minimise interruption to the care of the service user. Transcribing onto the MRC chart in home care is ONLY acceptable when the medication prescribed has been not been supplied by a pharmacy and to do so would cause a delay in treatment. Transcribing in home care would be acceptable when:

- An Out Of Hours GP / nurse prescriber / visiting health professional prescribes and supplies the service user with an over-labelled medication (this will not be dispensed at a community pharmacy) e.g. antibiotics or medication required immediately for pain relief.

In these circumstances the visiting health professional must transcribe the medication information onto the MRC chart – It is NOT the responsibility of the care worker to do this.
6.4 Medication administration and documentation errors

The National Patient Safety Agency defines a medication error as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice. Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents.

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

The following are examples of errors in the administration of medication:

- An omissions – a dose not given
- The wrong dose administered e.g. too much or too little
- An extra dose given
- The wrong person – the administration to a service user of any medicine not prescribed for them (this is a criminal act if deliberately done)
- The wrong dose interval
- The wrong administration route – administration of a medicine by a different route or in a different form, from that prescribed
- The administration of a drug to which the service user has a known allergy
- The administration of a drug past it’s expiry date

The administration of medication has been demonstrated to encompass many areas for potential error and as such the procedure for medication administration requires uninterrupted concentration and care. The three most frequently occurring types of medication error in order are:

1. wrong dose/strength/ frequency of medicine
2. omitted medication
3. wrong medication

Care workers must report errors in the administering of medication and related tasks to their duty manager; this may result in appropriate further training and competence testing. It is important that all errors are recorded and the cause investigated to learn from the incident and prevent a similar error happening in future. Failure to follow these guidelines could result in a safeguarding alert being raised.

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

1. Notify the duty manager. If unable to contact the manager, the care worker should not delay seeking medical advice.
2. Seek advice from the service users GP, appropriate Healthcare Professional e.g. pharmacist or A&E. Some errors may appear trivial, e.g. omitting a dose of paracetamol or antibiotics; however, since it is not appropriate for a care worker to gauge the seriousness of an error, advice from a professional must be sought. Medication errors must not be treated as trivial and ALL must be reported.
3. Enter details of the error on the MAR/MRC or in the care plan including a note of any changes or deterioration in the service user’s health or behaviour.
All medication errors, incidents and near misses should be reported to the duty manager to inform them what has happened and also what action has been taken to rectify the immediate situation and what has been done to prevent it happening again. The service user and their relatives should be notified of any medication errors or incidents. (See appendix F for an error reporting form)

6.4.1 The statutory requirements for reporting medication errors

From 1 October 2010, all adult social care services must notify the Care Quality Commission (CQC) under the Health and Social Care Act 2008 about specific incidents and errors. The law requires these notifications to be submitted within certain timescales. Further guidance is available via the CQC guidance on Statutory Notifications: Regulation 20 – ‘Duty of Candour’. This covers any event which adversely affects the well-being or safety of any service user. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment. The notification must be made in writing and the CQC provide template forms to simplify the notification process.

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

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

- Notify the Care Quality Commission of the error in writing. The timescale for reporting is ‘Without delay’ for Care Homes and ‘Within 24 hours of becoming aware’ for others.
- Consider raising a Safeguards alert following the procedures of the organisation.
- Inform the Service User’s GP if not already done so.
- Investigate the cause of the incident.

As part of the CQC inspection and regulation, social care providers are required to have written procedures for the reporting of adverse events, adverse drug reactions, incidents, errors and near misses. These should encourage reporting, learning and promoting an open and fair culture of safety. Providers must keep a record of the written notification, along with any enquiries and investigations and the outcome or results of the enquiries or investigations.

If a service user is unwell as a result of the medication error or incident, medical assistance should be sought straight away.

If serious negligence or an attempt to cover up an error is discovered, this should be treated as a disciplinary offence and the safeguards alert process should be followed, including informing the Police. This may result in legal action against the care worker, their employer or both.

All notifiable incidents should be reported to the CQC. However, social care providers should not ignore other errors, incidents or near misses but should encourage a culture that allows their care workers to report incidents without the fear of an unjustifiable level of recrimination. It is clear that the more evidence that is reported the more information is available about what could possibly go wrong. Care workers should be trained in how to deal with medication errors, incidents and near misses and be clear as to the definition of a medication error, incident and ‘near miss’.

No Error should be ignored. The care provider should have a clear process for error reporting and reviewing, including the requirement for:

- A written report describing:
  - what has happened,
  - what was done to rectify the immediate situation and
what has been done to prevent it happening again.

- A regular schedule for investigating and reviewing medication errors, incidents and near misses by a designated member of staff.
- The results of these regular investigations should be recorded including any actions taken such as offering training to individuals or reviewing existing procedures in order to prevent a similar error happening in the future.
- Regular meetings should be held with all care workers involved with the handling of medications to review the outcomes and investigations of errors/incidents/near misses share learnings and prevent reoccurrence of similar errors, incidents or near misses.
- The care provider should also log any incidents that occur as a result of errors made as part of the prescribing or dispensing process, for example, by GPs or community pharmacists. Such errors should be discussed with the GP or community pharmacist.

To help reduce administration errors, the ‘Care Home Use of Medicines Study’ (CHUMS) recommends a robust system for constant review of accuracy of medication administration records. This could be in form of a regular audit or review. It could focus on, for example, reasons for omitted doses, coding of refusals, and administration of when required medicines.

Poor practice can result in harm when risks are not identified and no action is taken to prevent further incidents occurring or the concern escalating. Incident logs should always be checked for patterns. If the same or similar incident occurs that relates to the same or another service user, it would suggest that the risk assessment/care plan or other elements of prevention in place are not effective. Recurring incidents may not appear to have any visible impact on the service user or others, however raising a safeguarding alert should be considered, to prevent harm being experienced in the long-term.

Whenever it becomes apparent that a notifiable incident has occurred or the care provider must notify the Care Quality Commission (CQC) (Regulation 20). There is also a positive obligation on the part of all care workers and care providers to consider whether a safeguarding alert should be triggered. In reaching a decision, reference and guidance should be sought from the Hull Safeguarding Vulnerable Adults team and reference made to the ‘Risk Assessment and Thresholds of Harm Matrix’.

6.5 Reporting Adverse Drug Reactions:

If a new medication is prescribed for a service user and they become unwell, this could be as a result of the new medication. NICE guidance recommends that care workers should report all suspected adverse reactions that a service user has had from the use of prescribed medications to the health professional who prescribed the medication or another health professional as soon as possible. Care workers should record the details in the service users care plan and tell the supplying pharmacy (if the service user agrees that this information can be shared).

Doctors, nurses and pharmacists can report adverse drug reactions to the Medicine and Healthcare products Regulatory Agency. There are some occasions when it is appropriate for a service user or their carer to make this report. You can get further information from their website www.mhra.gov.uk.
Right No. 7 – The right to REFUSE

7.0 Refused medications

It is an individual’s choice to refuse medication. Administration cannot be forced but some degree of encouragement can be given.

Medications can be refused or not taken for different reasons. For medications being administered, the service user may:
- Not be ready for them
- Does not like the taste of their medication
- Find solid oral dosage forms difficult to swallow
- Does not understand what the medication is for and why you are administering them

For the service user who self-administers they may:
- Not be able to open the packaging
- Not be able to read the labels
- May be experience deterioration in health and memory.

If a care worker is administering medications, it is advised that they should ask the service user if they want their medication before taking them out of the dispensing packaging. If the service user refuses medication when asked it is good advice to wait a while and offer them a while later. If the service user continues to refuse they should never be forced to take medication against their wishes and the care worker must never hide the medication in food or drink.

If a service user refuses a dose of medication then the care worker must record the refusal on the MRC or MAR chart and also record details of the circumstances of the refusal in the care plan. The duty manager must be informed, and advice sought from the prescriber when medications are regularly refused.

When a service user continues to refuse their medication it is important to try and understand why. There may be simple solution to help. For example if the service user finds solid oral dosage forms difficult to swallow or foul tasting there may be alternatives available that the service user may find easier and more palatable. Ask the pharmacist for advice.

If a service user is self-administering their medication and is refusing this should warrant the need for further assessment to review their care plan.

Guidance for care workers should be included in the care plans of service users who regularly refuse medication. This should detail the actions required of the care worker in the event of poor compliance and instructions on when the prescriber should be contacted.
Section 8:
Transfer of Medication between care settings

8.1 Hospital Admissions

A service user may be admitted to hospital either as a planned or unplanned admission: A planned admission is when a service user has a planned date for admission to hospital e.g. for a planned operation or procedure. An unplanned admission is when a service user is transferred to hospital unexpectedly i.e. with no planned date for admission e.g. suspected heart attack or a severe fall.

Whilst there is less time within an unplanned admission it is important that information accompanies the service user wherever possible to assist hospital staff. However, in an emergency situation, transfer to hospital should never be delayed in order to collect all the necessary information.

8.2 Reducing unnecessary hospital admissions

Care workers have a key role in helping to avoid unplanned hospital admissions by their service users. Their actions may have a direct impact on the maintenance of their service user’s health and quality of life. In some instances for example in Home Care the care worker may be the service user’s only point of outside contact. Promoting a good diet and where possible appropriate exercise to a service user, are fundamental to achieving this aim. In addition, care workers have a duty of care to report any notable changes in the service user’s health or any health problems, enabling timely intervention with a potential to reduce the need for hospital care e.g. ensuring adherence to medication such as drugs for the prevention of osteoporosis, can prevent fracture following a fall.

Care workers can help to avoid unnecessary hospital admissions through their awareness and understanding of their service user’s behaviours and non-verbal communication, and ensuring early intervention by appropriate health care professionals where necessary.

8.3 Hospital Admissions Procedure

Care providers should have a procedure for the admission of a service user to hospital. This should include planned admissions, unplanned admissions and out-patient appointments.

For a planned admission the procedure should include details on:
- What medication and information are to go with the service user into hospital. Be sure to consider all medications including those that are packed in an MDS or original packs, as well as all other medications such as inhalers, eye drops, insulin, GTN sprays etc.
- If any medications are to be omitted prior to any procedure as confirmed by the hospital or prescriber e.g. anticoagulants: warfarin and aspirin.
- How the service user will get to hospital and if required, who if anyone, will accompany them.
- Where the service user admission information is documented, and who is responsible for documenting this.

8.4 Information Required by the Hospital:

The following information where possible, should be included with a service user when they are admitted to hospital. This information is important for hospital staff to ensure the best care for the service user.
Complete resident details:
- full name
- date of birth
- GP & Practice
- NHS number
- Next of Kin details
- Date and reason for admission

Care provider details including a contact name and number

Current medication details – see further individual setting details below.

Name and contact number of the community pharmacy provider who usually supplies the service users medications

Details of all other illnesses / medical history

Any other information that will improve the care of the service user while they are in hospital. This might include any mobility issues, including equipment they use and whether this has been sent with the service user e.g. wheelchair or Zimmer frame.

Details around cognition, i.e. whether the service user has dementia (ensure any behaviour management strategies are clearly communicated)

Information around continence issues; in this section you could include whether the service user uses incontinence pads or has a catheter and when for example the catheter is due to be changed

if the service user needs any extra support with eating and drinking e.g. has swallowing difficulties or is on nutritional supplements (please also include a recent weight if possible)

Any tissue viability issues, including details of any wounds or sores.

Any support that the service user might need with communication, sight or hearing.

For an emergency or unplanned admission DO NOT delay admission to hospital to collect information. Whist the information is extremely helpful to hospital staff the service users wellbeing must be the first priority. The most important information for hospital staff in an emergency situation is the service user’s name, date of birth and a contact number for the service provider. This information must be sent with the service user.

All care workers should be aware of their admissions procedure and comply with it when an admission of a service user is required.

It is important the information is clear, unambiguous and legible. It is also essential that the information is correct at the time of admission and not out of date. Incorrect information can cause as many problems on Admission as no information and can lead to inappropriate care. Remember it is unlikely the hospital staff will know the service user and so providing the above information will help them ensure the best care for them.

When a service user is admitted to hospital and is receiving district nursing care, it is important to notify the district nursing team as soon as possible, to inform them of the admission. When a service user is discharged from hospital, ward staff may not be aware that district nurse teams are involved in care and would need to know when the resident will be back in the care home. It would therefore be beneficial if items administered by district nurse e.g. insulin, could be annotated on the MRC/MAR charts so the hospital is aware that district nursing teams need to be notified of the service users discharge. It is also recommended that once the care provider is notified a service user is to be discharged from hospital, they also contact the district nursing team if the district nurses are required to administer medicines, change dressings etc.
### In Residential Care:
- Where possible the service users MRC and medications should accompany them to the hospital during an admission. If this is not possible then a complete list of medications (ideally this should be the current up to date MRC chart) and any additional information should go with them. Any medications the service user no longer takes should have been clearly crossed out and annotated by the healthcare professional.
- If it is not possible to take the MRC chart, then list all current medications:
  - Drug name, strength and formulation (i.e. tablets, capsules, liquid, cream etc.)
  - Complete dosage instructions for each drug as it appears on the MRC chart
  - When the service user took their last dose
- Ensure any medications that are being taken short term are also included e.g. antibiotics and where known include the reason for taking.
- Ensure medication that are self-administered are included e.g. inhalers or creams
- If the service user is taking warfarin, take the yellow anticoagulation booklet or list the current dose and most INR recent test with date and result.
- Ensure any medications taken on a periodical frequency such as Vitamin B12 injections, weekly Alendronic acid or Fentanyl patches for example, are also included with the frequency and date of last dose given.
- If a District Nurse administers any of the service user’s medications, state which ones.
- Any known allergies, including medication allergies/medications the service user hasn’t tolerated (for example due to side effects).
- Resuscitation status/documentation i.e. “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) document if one exists.

### In Home Care:
- Where possible the service users MRC and medications should accompany them to the hospital during an admission. If this is not possible then a complete list of medications (ideally this should be the current up to date MRC chart) and any additional information should go with them. Any medications the service user no longer takes should have been clearly crossed out and annotated by the healthcare professional.
- If it is not possible to take the MRC chart, then list all current medications:
  - Drug name, strength and formulation (i.e. tablets, capsules, liquid, cream etc.)
  - Complete dosage instructions for each drug as it appears on the MRC chart
  - When the service user took their last dose
- Ensure any medications that are being taken short term are also included e.g. antibiotics and where known include the reason for taking.
- Ensure medication that are self-administered are included e.g. inhalers or creams
- If the service user is taking warfarin, take the yellow anticoagulation booklet or list the current dose and most INR recent test with date and result.
- Ensure any medications taken on a periodical frequency such as Vitamin B12 injections, weekly Alendronic acid or Fentanyl patches for example, are also included with the frequency and date of last dose given.
- If a District Nurse administers any of the service user’s medications, state which ones.
- Any known allergies, including medication allergies/medications the service user hasn’t tolerated (for example due to side effects).
- Resuscitation status/documentation i.e. “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) document if one exists.

For further information on the Health Action Plan and Hospital Passport contact the Community Learning Disability Teams.
8.5 Hospital discharge:

When a service user is ready to be discharged from hospital, the ward nurse or pharmacist have a duty of care to contact the care provider to discuss the discharge and the current supply of medicines and to inform the service users GP. If the hospital has contact details for the pharmacy provider, it would be advisable to contact the pharmacy especially for service users with an MRC returning to home care.

Upon discharge, the service user should also have complete documentation listing all of their medication at the time of discharge and details of their admission on an Immediate Discharge Summary (IDS). The IDS should detail:

- Any changes in care needs,
- Any changes in the service users conditions / new diagnosis;
- Any changes, additions or stopping of medications.

The failure to transfer appropriate information effectively can lead to misinformation, confusion, and the potential for medication errors.

Care workers must ensure that they are aware of any changes in the service user’s medication or treatment which may have changed from the medication that was taken into hospital. If a supply of medicine has not been sent but is required, it is essential to contact the ward or the hospital pharmacy immediately for a further supply to ensure required doses are not missed.

The HEY hospitals are contracted to provide a minimum of 14 days (usually 28 days) supply of any previous medicine and supply of newly initiated prescriptions on discharge unless this is clinically not appropriate. This includes supplies of dressings and appliances where appropriate. The hospital may therefore contact the care provider to see if they need further supplies of medications which will be dispensed in bottles and boxes. Medicines supplied in bottles/boxes from the hospital cannot be re-packaged into MDS by a community pharmacist. If they are not used, they must be disposed of.

Medication documentation, the care plan and risk assessments should be updated according to any changes detailed in the IDS or through contact with the service users GP. Medications may have been discontinued or adjusted by the hospital and the care worker must ensure they are working to the most current instructions to administer the correct medications.

Any discontinued medications may remain on the premises but should be disposed of at the earliest opportunity. (See section 2.6 - Disposal) Any new or adjusted medications must be considered when re-ordering the new monthly cycle.

Following discharge from hospital the care worker should:

- Let the supplying pharmacy know of any changes to the service user’s medication as soon as possible.
- Dispose of any unwanted or discontinued medication by returning it to a pharmacy.
- Ensure the service user has enough medication and organise for new prescriptions as appropriate, taking into consideration any medication changes.
- In Residential Care: Prepare a new MAR chart. (See section 6.3 - Transcribing)
- In Home Care: Ensure service users are discharged with an MRC chart. If there are changes to their medication a new MRC with 28 days of all medications must be issued by the hospital pharmacy. If there are no changes in medication, this should be the original MRC chart taken into hospital with the service user. Carers must ensure that the MRC chart is checked against discharge medications and dispensing labels.
8.5.1 What to do if Information is not sent with the service user:

**Discharge Letter Missing:**

If on arrival back to the care provider the service user does not have IDS, the care provider should contact the ward the service user has been discharged from and ask one of the ward nurses to send this information. The care provider needs to ensure that when receiving such information they conform to Information Governance and Data Protection requirements.

**Medication / Appliances Missing:**

If a supply of medication has not been sent but is required, it is essential to contact the ward or the hospital pharmacy immediately for a supply to ensure required doses are not missed. The discharging ward should then complete an incident form which will ensure that incidents are logged and reviewed.

In an emergency, if medications are not received and you are unable to contact the relevant ward, please contact the service users GP or Out Of Hours to ensure that the service user is not without medication.

**Administration chart Missing:**

In Home Care if a service user is discharged with a supply of new medication from the hospital but without an MRC, the care worker must contact the hospital pharmacy to arrange for a new MRC immediately to ensure that any medication doses are not missed. The usual community pharmacy will **NOT** be able to supply an MRC against hospital dispensed medications.

If the service user is discharged with the same medication but without the MRC that they took in with them, in the first instance the care worker should contact the hospital pharmacy to locate and provide the original MRC.

If this has not been possible, the care worker can contact the usual supplying community pharmacy and request a new MRC. The pharmacy can agree to supply a replacement MRC but **ONLY** if they can assure themselves that there have been **NO** alterations to the service user's medication during the hospital admission i.e., The supplying pharmacy must confirm that there are no medication changes prior to issuing a duplicate MRC by contacting the service users GP or with a copy of the IDS. The community pharmacy may then issue a replacement MRC to go with the medications that they had previously dispensed. Please note that the date on the medication label and the date of the MRC labels will not match in this instance.

If the community pharmacy cannot confirm that there have been no changes to the service user's medication during a hospital admission, then a replacement MRC must not be provided. The care worker must then request for new prescriptions for all medications.

If service users are discharged with a short course of medication e.g. antibiotics, and the course will run past the end of the 28 days of the MRC currently in use, the hospital should supply the short course medication on a second MRC. In this instance both the MRCs should be clearly annotated to show that two charts are in use until the short course in complete.

Service users in Residential Care will not be discharged with a MAR chart. All changes or new medication should be carefully transcribed onto a new MAR from the IDS and medication label (See Section 6.3 – Transcribing). Care should be exercised during transcribing and should be checked and verified by a second staff member. Any discontinued medications on existing MAR charts should be clearly annotated.
8.5.2 The discharge Process

Adult Social Care providers should have a procedure for the discharge of a service user from hospital into their care. This should include new and existing service users.

The discharge procedure should include:

- Who will review the discharge letter and ensure any necessary changes are implemented.
- If there are changes to the service user’s care / condition / medication who will contact the GP to discuss this, where they will document that the conversation has been had with the GP and any outcomes from the conversation.
- Who will contact the Community Pharmacist to inform them the service user has been discharged, discuss any medicines changes and where this will be documented. Currently Community Pharmacists do not receive information on service users when they are discharged from hospital and so they need to be made aware of a service user’s discharge as soon as possible to ensure a correct and regular medicine supply continues.
- If any medicines are administered or care is received via the district nursing service who will contact the District Nursing Team to ensure they are aware of the service users discharge. This should be done as soon as possible after the residents return to the care home to ensure doses of the medication are not missed.
- If the service user receives care from the Palliative Support Team or Macmillan Nurse ensure the residents named lead is informed of their discharge.
- What to do if the discharge letter is missing (see section below) and who is responsible for sorting this.
- When the care provider is contacted by the hospital about the service users medication it is important to document the conversation including what was agreed regarding the supply of further medicines.
- If the service user’s medications are not discharged with them (see below) who is responsible for ensuring a supply is received.
- If the service user is at the end of their life and if they are on an Integrated Care Pathway, that anticipatory drugs have been organised with the GP and Out of Hours notified of the patient’s condition.
- For service users with learning disabilities please contact the Community Learning Disability Teams for further advice and support if required.

All care staff should be aware of the procedure and comply with it when a service user is discharged from hospital.

It is also advised that a list of useful and up-to-date telephone numbers are included with the care homes discharge procedure that include the GP practice, OOH, Community Pharmacy etc.

8.6 Intermediate Care

Service users who have been assessed as requiring support with medication during a hospital admission may be discharged from hospital to an intermediate care bed. Here further assessments will identify the ability of a service user to self-medicate or the level of support required, and if the service user is to return to their home or enter into permanent residential or nursing care (See section 1.6 – Levels of support).

Service users who were previously independent who transfer from their own homes into intermediate/residential care either for respite care or to identify what help may be required with medications through assessment, will bring their medications with them. Medications brought in, in this way could be presented in their original containers, in MDS trays or even in strips or bottles. It is
important that care workers check the medication brought in from the service users home. All medications must:

- Be Identifiable - in original packaging or an MDS system which is fully labelled. Medications presented as blisters or strips or in brown bottles are not safely identifiable.
- Have a medication label. – Do NOT use medications without a label.
- Have the name of the service user on the label to correctly identify the service user they were prescribed for.
- Have full dose instructions on the label.
- Be in date – all original packs should have an expiry date printed clearly on the packaging.
- Be current – Check the date on the label to ensure it has been dispensed recently. Medication older than one month may not be current.

If the service user was administering their own medication via compliance aid e.g. an MDS tray, in order for correct identification, the tray MUST have been dispensed by a pharmacy and not filled by friends or relatives. An MDS tray filled by a pharmacy will come with a backing sheet that contains information about the medication in the tray including: the medication name and form, the full dose instructions, a dispensing date and the name of the service user they were prescribed for. This information will not be available if an MDS tray is filled by family or friends.

If the medications brought in are not identifiable, then the service users GP should be contacted to obtain a new prescription for all medication as soon as possible. If the GP’s surgery is closed then Out Of Hours should be contacted by calling 111. Unidentifiable medication must NOT be administered.

If the medication is identifiable following the instructions above, the care workers may transcribe a MAR chart to allow for medication administration or prompting without delaying treatment for the service user. However their GP must be contacted at the earliest opportunity to confirm the correct current medication and obtain new prescriptions.

8.7 Transferring of medication between social care settings

If the service user has a planned trip where medication will need to be sent with the service user to enable administration, e.g. a regular day centre attendance or an outing etc. the original packets with the dispensing label attached should go with the service user in order that the care workers can still administer the medication. If it is not practical to send the whole box, the dispensing pharmacy can be requested at the original point of dispensing to supply a smaller quantity that the service user may take. This is easier when a trip is planned in advance.

The MRC chart (home care) should go with the medication and the service user. A photocopy of the MAR (residential care) should go with the medication for documentation of administration and then attached to the original upon return.

Transfers between care settings may include:
- Hospital admission
- Respite care in a social care setting
- Attendance at a day care or educational centre
- Permanent move to a residential care home or nursing home.

When a Service User transfers to another care setting, to ensure continuity of care it is essential that a summary of the service user’s care plan and all their necessary documentation along with their medication goes with them. A record of what was sent with the service user should be documented in their care plan and also be provided to the receiving care provider. It should include the following information:

- Name, date of birth and place of residence of the service user
- Date of transfer
- Name and strength of medication
- Quantity of medication
- Signature of the member of staff who arranged the transfer of the medication.

If a service user regularly leaves their place of residence then discussion with their Healthcare Professional should take place to see whether the time the medication is taken could be adjusted to suit the service user’s way of life. Transporting medication should be kept to a minimum and safe alternatives discussed with the appropriate professionals.

When care workers carry medication on their person or in a vehicle they should ensure a risk assessment is carried out by their line manager and that their insurance cover is appropriate.

8.7.1 Transferring of medication to a non-paid carer

These procedures do not apply to a service user in Home care as all medications are the property of the service user and are not required to be ‘checked’ in or out. However, care providers are encouraged to have good communication with relatives and friends for activities that would necessitate medication administration to the service user by them and not the care worker. Documentation of administration on the MRC by the relative/friend administering the medication should be encouraged and annotated in the notes (See section 5.5 – Administration by a non-paid carer)

In Residential care when a service user leaves their place of residence, for example to go on holiday, or a day out with their family or friends, it is essential that the medication required during the time they will be away is taken with them. It may be necessary to arrange alternative packaging of the medication in which case a separate prescription to cover this period will be needed.

If this cannot be arranged at short notice, all necessary medication in their original containers must be sent with the service user, this may include the MDS tray. Medication must not routinely be repackaged (see section 5.7 – secondary dispensing). Risk must be assessed by the care provider as part of the care plan.

A copy of the MAR charts should be provided and the family/friend should continue to record the prompting, assisting or administration of the service user’s medication using the appropriate recording practice and codes.

Upon return to residential care all medication and MAR record sheets should be returned to the care provider. All medications sent with the service user should be documented in the care plan both when taken out and upon return. Details should include the names, strengths and quantities of medication, the time of going out and return and the details of the family/friend responsible for administration whilst away from the care provider.
GLOSSARY

ROLES & RESPONSIBILITIES:

The care package for help with medication will be planned and tailored according to the individual needs of the service user. The following describes the roles and responsibilities of all parties potentially involved within the adult social care service.

9.1 Responsibility of the Service User

The level of responsibility assumed by an individual service user will depend on their ability to control this aspect of their lives. Those who are able to assume a greater amount of control and independence will require less assistance than people with reduced physical or cognitive abilities.

The fullers Self Medications risk Assessment Tool (Appendix A) will help to identify the level of assistance required to support independent living. If assistance with medication is required then the service user must allow the care providers access to their prescription medications and any other relevant information to enable them to carry out the duties identified in the care plan safely.

If the service user has the capacity to consent to receiving assistance with medication administration, this consent must be given and documented during the initial assessment and then prior to each offer of assistance from the care worker. Consent from a service user can be verbal or non-verbal and examples include:

- The care worker asking the service user if they are ready for their medication and obtaining a verbal response.
- The care worker offering the prepared medication and the service user accepting it.

Service users have the right to expect that any assistance offered be carried out in a professional manner by appropriately trained and competent care workers.

9.2 Responsibilities of the Unpaid Carer e.g. family / friends (Home care only)

An unpaid carer could be a family member or neighbour / friend that provides assistance with medication required by a service user. This could be full time or at specifically identified times e.g. evenings or weekends only or during an outing or holiday.

There may be times when an unpaid carer takes a break and a paid Care Provider assumes responsibility for the duration of absence. During this absence the unpaid carer must provide the Care Provider with access to all prescription medications and any other information to enable them to carry out the duties identified within the care plan. A prepared Medication Record Chart (MRC) should be obtained from the pharmacy and all prescription medications must be provided and contained within the original pharmacy produced labelled packaging. This medication must be administered in line with this policy and recorded on the MRC.

When responsibility for medication administration is shared between an unpaid carer and a care provider the name(s) of the unpaid carer(s) should be recorded in the care plan. The care plan should include details of shared duties / responsibilities and a risk assessment.

Each time the unpaid carer administers medication to the service user they have a responsibility to clearly document this appropriately on the MRC so that duplicate administration to the service user is avoided.
9.3 Responsibilities of the Care Workers

Following a needs and risk assessment, the level of assistance required by individual service users will be defined within the Care Plan. Carers should follow the instructions documented in the Care Plan.

Care workers in Home Care may only use and document administration on MRC charts provided by a community pharmacy. Residential Care workers must document medication administration on a MAR chart. These may be provided by the supplying pharmacy or transcribed. Documentation of administration on photocopies of the MAR charts is ONLY acceptable when the service user has a transfer of care for day trip etc. (see section 8.7).

It is the responsibility of the care worker to follow the Care Plan and to report any concerns to their duty manager.

Care workers should only carry out assistance with medication to the level appropriate to their training and competence.

Care workers should not carry out task for which they are not trained or deemed competent including any invasive, clinical or nursing procedures. They are not expected to make judgements on medications e.g. take as directed.

A Care worker must:

- work within their areas of training and competence
- Must not place themselves or the client at risk
- Must contact their Line Manager if they have any concerns
- Must not undertake any duties which fall within the responsibility of a GP or nursing staff
- Must ensure that medication is presented in clearly labelled appropriate containers with a pharmacist’s label, and return to the pharmacist if this is not the case.
- Accurately complete Medicines Administration Record (MAR) sheets
- Concentrate on the important task of administering medication (where authorised to do so), to the exclusion of all other duties and distractions
- Report any instance of a medication error immediately to the duty manager and seek medical advice via the service user’s GP or 111.
- Complete an accident / incident report form if required and send to Departmental Health and Safety

A care worker should not give medication to a service user when:

- **Service User unwell**: When the service user appears to be or complains of not feeling well, the care worker should contact their duty manager. If the service user is able to take their medication and wants to, assistance should be given. If the service user is unable to take their usual medication guidance must be sought from the prescriber.
- **No clear directions on medication labels or charts**: Refer to the duty manager who will refer to the supplying pharmacy.
- **No date on opened medication with limited expiry**: Examples include eye drops and some liquids or creams. Confirm the shelf life of the medication from opening e.g. for eye drops this will be 28 days. Look at the pharmacy label on the container to confirm the date of supply and if the date of opening cannot be established it should be assumed to be the day of dispensing.
- **Refusal to take medication**: It is the service user's choice to take or not to take their medication. The service user cannot be forced to take their medication, however some degree of encouragement can be given. If the service user regularly refuses help with
medication this must be recorded on the MRC or MAR chart and reported to the line manager and the prescriber. Medications must not be disguised or hidden in food in order to force a service user to take them against their wishes. (See section 1.51 - covert administration)

- **Missed Doses:** If a dose of medication was missed or omitted during the previous visit a double dose MUST NOT be given. A record on the MRC or MAR chart that a dose has been missed must be documented and the incident reported to the duty manager. Consult the supplying pharmacy for advice if necessary.

- **Service User consuming alcohol or using illicit drugs:** It is a service user's own decision to drink alcohol or use an illicit substance. If a service user appears to be intoxicated care workers should seek advice from the prescriber or community pharmacist as to whether to administer medication. Full documentation of the events and outcome should be made in the service users care plan.

Service Users who are known Alcoholics or illicit substance users may still need to take their medication whilst under the influence. The Service User's medication needs should be risk assessed by a health professional with regard to their use of alcohol or illicit substances. Once a risk assessment has taken place the Service User's medication needs should be noted in the care plan and regularly reviewed.

- **Possible side effects:** Service users will react differently to medications, so it is not possible or helpful to list anticipated side effects. However, should concern arise, the care worker should note whether any new medication or a change of dose to existing medication has occurred during the last few days. The duty manager should be informed who will discuss with the prescriber or pharmacist as appropriate.

- **Infection contamination:** The risk assessment should have identified possible sources of infection or contamination e.g. clinical waste from blood testing or injections. Cases of suspected infections such as head lice or scabies must be reported to the duty manager who will seek expert advice. The duty manager must ensure that appropriate infection control precautions are undertaken. If a service user self-injects medication e.g. insulin, the care worker should not handle the used equipment. If this is necessary due to the risk to the service user or others, protective barrier gloves must be worn. Contact with or handling of any needles must be avoided. These must be discarded directly into sharps boxes and NOT into household waste. Sharps boxes are available on prescription and collection of full boxes can be arranged with the council – Do not return to the pharmacy.

### 9.4 Adult Social Care Providers:

The responsibility of the Providers of adult social care is based on the individual service user's needs assessment and is to ensure that they can provide the appropriate care on a day to day basis by trained and competent staff.

The appropriate care will be determined through the risk assessment process. (See section 1.1 - Assessment) A copy of the “Medication Risk Assessment” form must be available and clearly documented in the service users care plan.

The Provider is responsible for ensuring that all care workers involved in the administration of medication have had the appropriate level of training and are competent to do so.

The Provider is responsible for ensuring that all care workers that are trained to handle medication receive refresher training at least annually.

The Provider must adhere to the legal requirements under the Management of Health and Safety at Work Regulations 1999 and the Health and Safety at Work Act 1974. These are also the requirements of the Care Standards Act 2000 and Domiciliary Care National Minimum Standards.
These standards impose a general duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare of employees and others which includes service users and any others who may be affected by what is done. This duty extends to all aspects of the provision of care, including the ordering, collection, administration, storage and disposal of medications.

In addition to having sufficient numbers of suitably trained care workers, Care providers will need to demonstrate they have in place appropriate quality assurance systems to record and monitor the effectiveness of their medication arrangements. These will include:

- Lists of care workers who received training.
- Records of the initials of the care workers who will record on MRC and MAR charts including relief/agency staff for identification purposes.
- A central system for recording medication incidents, including referrals to safeguarding.
- Regular auditing of MRC and MAR charts.
- Records of care worker supervision and competency assessments and training records.

It is the responsibility of the Care Provider to inform the service users GP and supplying pharmacy of their involvement in the provision of care and assistance with medication administration to their patient. For Home Care an MRC request confirmation (Appendix C) should be completed and sent/faxed to the supplying pharmacy for their information.

Care providers may need to liaise with a service user’s GP’s to ensure that assistance with medication via an MRC is appropriate to the current medication dosages and the number of care calls in place to support this.

Care providers must:
- Ensure that all staff receive appropriate medication training at least every 18 months to 2 years.
- Ensure that competency assessments are carried out on an annual basis or sooner especially if there is an error/issue.
- Provide a supportive environment for the staff when undertaking medication duties to ensure distractions are minimised.
- To ensure that where medicines are stored and prepared for administration this is in an area with restricted access. A risk assessment may support this.
- Ensure that medicines procedures and forms are audited regularly (as good practice this should not exceed three months) and that processes and systems reviewed for trends or practices that might contribute to errors.
- Maintain an awareness of the quantities of medication in stock and to ensure that excess is not kept in stock and ensure that service users have regular medication reviews.
- Ensure that employees who report errors are supported immediately.
- Ensure that safeguarding referral will be made when harm has occurred as a result of a medication error.

9.5 Care Management Teams and Reablement teams

Within the Care Management Team and Reablement Team, the competent assessor has the responsibility to evaluate the service user’s need for assistance with medication. This assessment is a fundamental aspect of promoting independent living. The Fullers Risk Assessment Tool (Appendix A & B) will be used as part of the assessment process.

The assessor will be responsible for identifying the appropriate level of support required by the service user and ensuring that this area of need is included in the Care Plan, with an appropriate
completed Medication Risk Assessment. They will also assess a service user’s capacity to consent to the agreed level of assistance with the administration of their medication.

Following the assessment, if the service user is discharged back to their own home and requires support from a care provider with medications they are responsible for completing the Medication Record Chart Request form (Appendix C), liaising with the service users preferred community pharmacy to organise an MRC chart and informing the service users GP of the social care package to be provided.

All service users will continue to be monitored for 90 days after the start of the initiation of a care package to confirm that the right level of care has been put in place.

It is the responsibility of the Care Management Team to ensure that all providers of adult social care e.g. Day Care, Respite, residential and Home Care, are aware of individual service user’s needs.

9.6 Home Care Commissioning - Hull City Council Social Service Team

Reviewing Officers hold responsibility for ensuring that an Annual FACS review is completed. Whenever there is a change in a service user’s circumstances an unscheduled review should be undertaken by the Care Coordinator. Where there is no change reviews must take place at least annually.
Whenever there is a change in a service user’s health or circumstance, an unscheduled review should be undertaken by the Care Coordinator.

9.7 GPs & Prescribers

Prescribers have a responsibility of care for all of their listed patients to provide general health and medical care, or refer for specialist health care or social care. In looking after an individual service user’s health and well-being, the GP or Prescriber (e.g. Nurse, Pharmacist) will prescribe medication to their patient to prevent, treat or relieve medical conditions. (It should be noted that individual service users might also receive medication prescribed by specialists, and which might have been supplied to them in hospital).

Prescribers should ensure full dose instructions are written on all prescriptions so that they are administered as by the care worker as the prescriber intended. Care workers cannot administer any medication that is labeled ‘as directed’. Pharmacists and care workers are encouraged to refer prescriptions back to the GP practice to obtain full dose instructions. Dose instructions should be full and clear for ALL prescribed items.

GPs and health professionals visiting OOH who prescribe and supply over-labelled medication through a PGD must update the patient’s medication chart accordingly. It is the responsibility of the visiting prescriber to ensure that the new medication or amendments are recorded on the MAR (care homes) or MRC (Home care) chart including the medication name, quantity supplied and full dose instructions, the date, name and initial of the GP/Health professional.

All prescription for Warfarin should be written for ‘Warfarin 1mg Tablets’ only with dose instructions similar in wording to: ‘Please follow dose as instructed from latest INR result in the yellow anticoagulation booklet’. Enough tablets should be prescribed to last 28 days at that dose and not until the next INR test to avoid running out.

When prescribing remotely (telephone), prescribers should ensure that written confirmation is provided to the care provider as soon as possible in the form of fax confirmation or new prescription.
When prescribing ‘variable doses’ and ‘when required’ medication, prescribers should ensure the care worker understands how the decision to administer should be made i.e. how many, when, how often and for how long.

When medications are required to be split or crushed to enable treatment, the prescriber should first consider if an alternative formulation or medication is available to avert the need to alter a solid dosage form. If there are no alternatives, the prescriber must consider the risks and assume responsibility for any medications that are prescribed with directions to split or crush. Clear direction to split or crush the medication must be included in the dosage instructions e.g. ‘Half a tablet each morning. Please half immediately prior to administration and safely discard the remainder’. When a dose of ‘half a tablet’ is to be administered, enough medication must be prescribed for the duration of treatment to allow for disposal of the remaining half e.g. 28 tablets for 28 days. Half tablets cannot be stored safely.

Medications administered via a feeding tube should where possible, be prescribed in a liquid formulation. If a liquid formulation is not available the prescriber must consider the risks and assume responsibility for any solid oral medications that are prescribed with directions to split or crush. Dose instructions should be full and clear: ‘One tablet to be taken in the morning. This medication should be crushed and dispersed in water immediately prior to administration. For PEG administration’

Covert administration of medication can only be decided following a ‘best interest’ meeting in the interest of a patient without capacity. This must be fully documented. Liquid formulations should be the product of choice where available (see point 6). Dose instructions should be full and clear: ‘One tablet to be taken in the morning. Tablet should be crushed and dispersed in water immediately prior to COVERT administration’ or ‘One capsule to be taken in the morning. Open capsule and empty contents into liquid or soft food immediately prior to COVERT administration.

The service users GP is responsible for ensuring that a medication review is completed for all service users in adult social care especially those with long term conditions to reduce their risk of hospital admission. This review should take place at least annually unless a change in the service user’s circumstance would call for an earlier review. This review can be undertaken by the GP or other qualified health professional, or as part of a multidisciplinary team.

9.8 Pharmacists

Community Pharmacists have a professional responsibility to supply medication prescribed by GPs and other recognised prescribers. The medication must be of a suitable quality and comply with legal and ethical requirements for the packaging and labelling. Additionally, Pharmacists have a responsibility to ensure that a service user or care worker receives appropriate information and advice to support them in gaining best effect from any medications supplied.

This includes ensuring that the care workers know what dose and how to administer a service user’s medication. Prescriptions received with dose instructions stating ‘as directed’ will not provide the care workers with the information they will require to administer the medication safely and in accordance with the prescribers intention. It is the responsibility of the supplying pharmacy to confirm the correct dose with the prescriber for all prescriptions received with medication doses that are incomplete or ambiguous, prior to dispensing. All medications must be dispensed with full dose instructions for the carer to safely administer to the service user.

Pharmacists have a duty of care to provide medications for use as the manufacture intended and ensure that they are administered as the prescriber intended. If a medication is prescribed with directions to half a tablet or crush a solid dosage form, in the first instance the pharmacist must refer
back to the GP to consider an alternative formulation or product to avoid splitting or crushing. There may be instances when there is no alternative and prescribed medication may need to be split or crushed in order to administer a service user’s treatment. The pharmacist can advise of and re-enforce the need to split or crush a tablet immediately prior to administration and dispose of the remainder safely.

9.8.1 Pharmacy services to Home Care

Once a supplying pharmacy has been informed via an MRC Confirmation Form (See Appendix C) that a service user will receive help with medication administration from a care provider, they have a responsibility to provide an MRC every 28 days with monthly prescription requests in line with the Service Level Agreement. The Confirmation form will clearly indicate the responsibilities of all parties involved in the care of the service user regarding ordering and collection of medications. All mid-cycle requests must be dispensed with two identical labels, one for the dispensed medication and the other to add to the MRC in current use. All labels on the MRC must be overwritten on one side with the letters ‘MRC’ in ink by the pharmacy to ensure they are tamper evident. All labels on the dispensed medication and the MRC must be identical. (See Section 8.5.1 for the exception to this rule).

For mid cycle requests that may follow into the next cycle e.g. a seven day course of antibiotics prescribed on day 26, the pharmacy should print two extra labels at the time of dispensing – one to attach to the current MRC and the other to add to the new cycle MRC. This will continue to ensure, where practically possible, that only one MRC chart is in use for each medication cycle.

When ‘Just-in-Case’ medications are prescribed for administration by carers e.g. antibiotics and steroids prescribed for an exacerbation of COPD, they should be dispensed separately with a separate MRC chart supplied to go with these for use when needed.

9.8.2 Pharmacy services to Residential Care:

Pharmacists will enter into a contract to provide Residential Care homes with medications for their service users. These agreements are between the pharmacy organisation and the residential care home and will clearly define each of their roles and responsibilities during the provision of the service.

9.9 Nursing Personnel

Nurses will provide nursing and clinical care to individual service users, e.g. caring for wounds, pressure sores and the change of dressings and catheters or with invasive procedures such as injections and bladder irrigations and matters relating to feeding tubes (see section 1.6.4 - level 3 Support). During such provision they will also monitor the health status of the individual and report any changes in circumstance to the GP.

It should be noted that certain qualified nurses are now able to prescribe from a list of items, to treat wounds and other minor injuries or symptoms.

Specialist Nursing, for example stoma nurses or palliative care nurses will similarly provide nursing and clinical care to individual service users and support to their families. These specialist nurses will support and educate the service user in coping with their particular condition and assist them in dealing with equipment or the drug treatments or therapy necessary to the condition. They can also assist with training of care workers to carry out specialist tasks (See section 1.6.3)
Useful Links:

Further information on managing medicines in social care is available from the following documents:

The Nursing and Midwifery Council (NMC) provides guidance and advice on a number of topics which is available on their website; www.nmc-uk.org The National Patient Safety Agency also contains safety alerts related to medicines; http://npsa.nhs.uk/ Information on dosage

The Care Quality Commission (CQC) guidance: ‘Medicine administration records in care homes and domiciliary care’ provides further detailed information.


Nice Quality Standards: Medicines Management in care Homes: Quality standards published March 2015 available at nice.org.uk/guidance/qs85

The Handling of Medicines in Social Care published by the Royal Pharmaceutical Society of Great Britain this can be downloaded from their web-site at http://www.rpharms.com

North Yorkshire and Humber Commissioning and Support Unit: Good practice guidance documents for care homes and domiciliary care.

Useful Contacts:
Advice on medicines can be obtained from:
- Any community pharmacist
- The service user’s GP
- NHS emergency and urgent care services : Tel 111

Common Terms:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administer</strong> <em>medication</em></td>
<td>To select, measure and give medication to a Service User as specified in the care plan.</td>
</tr>
<tr>
<td><strong>Approved person</strong></td>
<td>The person with responsibility for assessing competency in relation to medication and related tasks.</td>
</tr>
<tr>
<td><strong>Assist</strong> <em>with medication</em></td>
<td>To physically help a Service User who has mental capacity and ability to instruct a Care Worker on what they require, for example, opening a medication container or removing tablets from a blister pack.</td>
</tr>
<tr>
<td><strong>Container</strong></td>
<td>A blister pack, bottle or any other container that the pharmacist deems suitable. A pharmacist must supply medications in childproof containers unless requested not to do so by the service user / care provider.</td>
</tr>
<tr>
<td><strong>Care worker</strong></td>
<td>An unregistered and non-clinically trained person employed by the Provider to support a Service User as detailed in the Care Plan. This includes health care assistants.</td>
</tr>
<tr>
<td><strong>Care Manager</strong></td>
<td>Professional responsible for the Care Plan Summary and Risk Assessment.</td>
</tr>
<tr>
<td><strong>Care Provider</strong></td>
<td>A registered body that provides care to meet identified needs of the service user and is regulated by the Care Quality Commission.</td>
</tr>
<tr>
<td><strong>Care Setting</strong></td>
<td>The place of residence where the service user receives support.</td>
</tr>
<tr>
<td><strong>Care Quality Commission (CQC)</strong></td>
<td>The national body that regulates social care provision for adults, including residential care homes and domiciliary support services. CQC has a legal duty to inspect provisions and services to ensure that standards are upheld.</td>
</tr>
<tr>
<td><strong>Commissioner</strong></td>
<td>The person who arranges for support to be put in place. This may be the Practitioner or Facilitator completing the assessment or review. For personal assistants being employed by the Service User using their personal budget, the Service User is the Commissioner.</td>
</tr>
<tr>
<td><strong>Commissioning</strong></td>
<td>The process of making arrangements for the support to be put in place, including instructing, informing, purchasing or contracting providers and Care Workers/Personal Assistants to deliver the support. The Commissioner is responsible for assessing, co-ordinating and reviewing the Support Plan and completing Risk Assessments.</td>
</tr>
<tr>
<td><strong>Commissioning Assessor</strong></td>
<td>The Practitioner or Facilitator completing the assessment or review and commissioning the support for the Service User.</td>
</tr>
<tr>
<td><strong>Drug</strong></td>
<td>The terms 'drug', and 'medication' are used interchangeably.</td>
</tr>
<tr>
<td><strong>Duty Manager</strong></td>
<td>The person with overall responsibility within the Care Provider for the services that are provided to the service user. The Duty Manager may delegate some authority or responsibilities to other staff members but will retain overall accountability.</td>
</tr>
<tr>
<td><strong>Healthcare professional</strong></td>
<td>Examples include – a GP, Nurse, Pharmacist, Occupational Therapist, Physiotherapist and Dentist.</td>
</tr>
<tr>
<td><strong>Invasive procedure</strong></td>
<td>Any clinical procedure which punctures the skin surface (e.g. injections) or which requires administration onto or into some areas of the body (e.g. rectum or vagina).</td>
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<tr>
<td>------------------------</td>
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<tr>
<td><strong>Medication</strong></td>
<td>The terms ‘drug’, and ‘medication’ are used interchangeably.</td>
</tr>
<tr>
<td><strong>MDS</strong></td>
<td>Monitored Dosage System (sometimes known as compliance aids or multi compartments aids. Brands include: Nomad or Dossette).</td>
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<tr>
<td><strong>MAR</strong></td>
<td>Medicine Administration Record.</td>
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<td><strong>MRC</strong></td>
<td>Medication Record Chart.</td>
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<tr>
<td><strong>Paid Carer</strong></td>
<td>A person under the employment of Local Authority Social Services or a private Independent Sector Company, who is engaged to provide care services to one or more service users.</td>
</tr>
<tr>
<td><strong>Professionally filled (MDS)</strong></td>
<td>Filled in a pharmacy and checked by a pharmacist.</td>
</tr>
<tr>
<td><strong>Service User</strong></td>
<td>The person/customer/patient receiving the package of care and support.</td>
</tr>
<tr>
<td><strong>Unpaid Carer</strong></td>
<td>An individual who provides care for someone on an informal basis and is not paid to do so, usually a relative, friend or neighbour.</td>
</tr>
</tbody>
</table>
### Appendix A: Fuller’s Self Medication Risk Assessment Screening Tool (validated and refined April 2004)

<table>
<thead>
<tr>
<th>Enter Score Below:</th>
<th>Number of prescribed medications</th>
<th>Mental State</th>
<th>Vision</th>
<th>Social Circumstances</th>
<th>Physical condition</th>
<th>Attitude and knowledge about medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Drug</td>
<td>1 Drug</td>
<td>4</td>
<td>1</td>
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<td>1 Drug</td>
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<td></td>
<td>Alert and orientated</td>
<td>Orientated but sometimes forgetful</td>
<td>Confused, muddled/disoriented/very forgetful</td>
<td>Very confused</td>
<td>Can see to read with no aids</td>
<td>Needs glasses/aids to read print</td>
</tr>
<tr>
<td></td>
<td>Living with others who can fully support medication needs</td>
<td>Living with others who usually / sometimes support medication administration</td>
<td>Living alone with some from paid carers or family/friend</td>
<td>Living alone with no one</td>
<td>Can manage to open bottles/packets independently</td>
<td>Weakness of hand/poor coordination, but can manage to open bottles/packets with difficulty</td>
</tr>
<tr>
<td></td>
<td>Interested about prescribed medications and knows all about them, believes they are important</td>
<td>Fairly interested about prescribed medications and knows enough about them to administer them safely/believes they are important</td>
<td>Not very interested about prescribed medications. Does not believe they are important/unable to recall medication regime</td>
<td>Disinterested and or unwilling to take prescribed medication</td>
<td><strong>TOTAL SCORE</strong></td>
<td><strong>Minimum Score: 6</strong></td>
</tr>
</tbody>
</table>

Total your score and please see guidance for Risk Management

6 - 13 Low risk  
14 – 16 Medium  
17 – 22 High Risk  
23 – 42 Very high risk

*Please see advice overleaf for Risk Assessment Guidance: Appendix B*
Appendix B:

Minimum Score: 6  Maximum Score: 42

Appendix B

RISK ASSESSMENT GUIDANCE

LOW RISK
1. Give full explanation / information to patient about prescribed medications before discharge (or in the Patient’s own home if hospital admission is not required)
2. If carer/family will be given medication, give full information about the drug regime
3. Patient or carer may benefit from a personal medication chart with written information and advice about medication regime.

MEDIUM RISK
As above plus:
1. May need support or need someone else to administer medication safely
2. Inform local pharmacist and patients GP of concerns and needs including memory aids, easy open bottles, large print labels
3. Keep medication regime simple
4. Consider referral to pharmacist/doctor for more in-depth medications review.

HIGH RISK
As above plus:
1. Activate a system of to administer medications
2. Refer back to prescribing doctor and dispensing pharmacist if this is not possible.
3. Recommend regular medication management reviews by the patients pharmacist or doctor
4. Keep prescribing to a minimum

VERY HIGH
As above plus:

The strongest elements that contribute to risk are those related to mental state, the individual’s attitude and beliefs about their medications and visual impairment.
The risk is further increased for individuals with more than one of the three strongest risk elements, especially if living alone.
### Appendix C: Medication Record Chart Request Confirmation

<table>
<thead>
<tr>
<th>Service Users Name</th>
<th>Address</th>
<th>D.O.B.</th>
<th>Telephone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GP Surgery Address</th>
<th>Initial Contact details</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Contact Name</th>
<th>Home Care Provider Contact Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Initial Contact details</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact name</td>
<td>Address</td>
</tr>
</tbody>
</table>

Following the Fullers Self Medication Risk Assessment. Please indicate the level of risk.

<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hull Community Care Services Care Management team Address</th>
</tr>
</thead>
</table>

If a Pharmaceutical Assessment is required refer to Hull Teaching PCT Medicines Management Team on 01482 344901

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Date Pharmacy contacted to arrange supply of MRC</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Date Pharmacy contacted to arrange supply of MRC</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Approximate start date for supply of MRC</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

Who is named as responsible in the care plan for ordering monthly prescriptions? (Please tick)

<table>
<thead>
<tr>
<th>Service User</th>
<th>Family</th>
<th>Carer</th>
<th>Other (Please state)</th>
</tr>
</thead>
</table>

Has their agreement been confirmed? Y/N

Who is named as responsible in the care plan for collection of monthly prescriptions from surgery?

<table>
<thead>
<tr>
<th>Service User</th>
<th>Family</th>
<th>Carer</th>
<th>Pharmacy</th>
</tr>
</thead>
</table>

Has their agreement been confirmed? Y/N

Who is named as responsible in the care plan for collection of the MRC and monthly repeat prescription items from the pharmacy?

<table>
<thead>
<tr>
<th>Service User</th>
<th>Family</th>
<th>Carer</th>
<th>Pharmacy</th>
</tr>
</thead>
</table>

Has their agreement been confirmed? Y/N

Arrangements for storage (please state)

Other important medication issues (e.g. Warfarin, or over the counter medications)

Has Patient consented to receive the service and understands that their MRC may be shared with others (i.e. the pharmacy) Y/N

Completed by........................................................................................................Date.............
Position....................................................................................................Telephone..........................

Community Pharmacy: This document is the written request for a Medication Record Chart for the service user and a copy **must** be provided to the Community Pharmacy prior to MRC’s being produced.

Hospital Discharge: When a service user is in hospital a copy of this document **must** be sent to the ward to facilitate their discharge with an MRC.

Anticoagulation Clinic: If the service user is currently taking Warfarin a copy of this document **must** be faxed to the Anticoagulation clinic on 335507.
Appendix D

Example Letter informing GP of Social Service Input

Date

Dear Doctor

Please be advised that ___Service Provider___ care service will be Assisting / administering* medication for the following Service User.
*(Delete as appropriate)

**Insert Service User details: Name, date of birth, address**

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

Yours sincerely

Care Manager

Care provider details

____________________________________________________________________

I have been advised by that the care staff are Assisting / administering* medication for Service User’s name whose details are attached.
*(Delete as appropriate)

Print Name

____________________________________________________________________

Signature .................................................................

Date .................................................................

Practice Stamp


Appendix E

Signature Record Sheet

To be completed by all care workers and staff who administer medication or is involved with the completion of a MAR sheet.

<table>
<thead>
<tr>
<th>DATE</th>
<th>NAME</th>
<th>SIGN NAME</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
APPENDIX F

Example Incident Report Form

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

### About the Incident:

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did the incident occur?</td>
</tr>
<tr>
<td>When was the incident discovered?</td>
</tr>
<tr>
<td>Who was involved?</td>
</tr>
<tr>
<td>Has the service user / next of kin been informed?</td>
</tr>
</tbody>
</table>

### What was the error?

<table>
<thead>
<tr>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong person</td>
</tr>
<tr>
<td>Wrong medicine</td>
</tr>
<tr>
<td>Wrong amount given</td>
</tr>
<tr>
<td>Wrong strength</td>
</tr>
<tr>
<td>Wrong form</td>
</tr>
<tr>
<td>Medicine not given</td>
</tr>
<tr>
<td>Medicine out of date</td>
</tr>
<tr>
<td>Recording error</td>
</tr>
<tr>
<td>Wrong Time</td>
</tr>
<tr>
<td>Prescription error</td>
</tr>
<tr>
<td>Pharmacy error</td>
</tr>
<tr>
<td>Other, please state</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Circumstance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interruption by another member of staff</td>
</tr>
<tr>
<td>Medicine poorly labelled</td>
</tr>
<tr>
<td>Administration of medicine not recorded by previous carer</td>
</tr>
<tr>
<td>interruption by the service user</td>
</tr>
<tr>
<td>interruption by another service user</td>
</tr>
<tr>
<td>phone ringing</td>
</tr>
<tr>
<td>Other, please state</td>
</tr>
</tbody>
</table>

### Who did you contact?

<table>
<thead>
<tr>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you contact the GP / Pharmacist / NHS Direct / Out of Hours GP Service?</td>
</tr>
<tr>
<td>Did you contact your line manager?</td>
</tr>
<tr>
<td>When did you contact the above for advice?</td>
</tr>
<tr>
<td>What advice was given?</td>
</tr>
<tr>
<td>Did you act on the advice given?</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Was any medical treatment necessary?</td>
</tr>
<tr>
<td>Did you / service manager inform the patient?</td>
</tr>
<tr>
<td>Did you contact a relative if the service user lacks capacity?</td>
</tr>
<tr>
<td>Does the service user / relative wish to take the matter further?</td>
</tr>
</tbody>
</table>

**Action taken to prevent the reoccurrence:**

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of systems / procedures</td>
<td></td>
</tr>
<tr>
<td>Employee training</td>
<td></td>
</tr>
<tr>
<td>Medication review</td>
<td></td>
</tr>
<tr>
<td>Separating the products</td>
<td></td>
</tr>
<tr>
<td>Photos of service users</td>
<td></td>
</tr>
<tr>
<td>Adjustment of staffing levels to meet the needs of the service user</td>
<td></td>
</tr>
<tr>
<td>Two members of staff to administer medicines especially if complicated</td>
<td></td>
</tr>
<tr>
<td>regimen.</td>
<td></td>
</tr>
<tr>
<td>Other, please state.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Homely Remedies Policy

The table below contains a suggested list of homely remedies to be considered and a proposed template for agreeing which homely remedies are suitable for administration to a service user in Residential Care. This may be copied or amended as required, but should be used as part of a homely remedies policy.

Resident ......................................................................................................................

Authorisation to administer homely remedies for **a maximum of 48 hours** for the treatment of the conditions listed below. After this period, if symptoms persist the GP will be contacted. (GP to delete item(s) from this list, if they are not appropriate for this resident)

GP................................................................. signature..............................................................

List agreed (date) .................................

<table>
<thead>
<tr>
<th>Minor illness requiring treatment</th>
<th>Drug/Medicine</th>
<th>Maximum dose to be taken at one time</th>
<th>How often it can it be given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Simple Linctus</td>
<td>Two 5ml spoonful</td>
<td>Repeat after 4 hours</td>
</tr>
<tr>
<td>Indigestion</td>
<td>Peptac or Gaviscon liquid</td>
<td>Two to four 5ml spoonful</td>
<td>Up to four times a day and at night</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Rehydration sachets</td>
<td>One sachet</td>
<td>Repeat regularly as Required</td>
</tr>
<tr>
<td>Constipation</td>
<td>Senna tablets or syrup</td>
<td>Two to four tablets or two to four 5ml spoonfuls of syrup</td>
<td>Once a day - usually at bedtime</td>
</tr>
<tr>
<td>Headache, toothache or Muscular aches e.g. backache</td>
<td>Paracetamol</td>
<td>One or two 500mg tablets</td>
<td>Doses NOT closer than 4 hours apart NOT more than 8 tablets in 24 hours. N.B. Care must be taken that other medicines containing paracetamol are not being used.</td>
</tr>
</tbody>
</table>
APPENDIX H

HOMELY REMEDIES RECORD FORM

To be administered for a maximum of 48 Hours before Contacting the Service user’s G.P.

<table>
<thead>
<tr>
<th>Residents Name:</th>
<th>D.O.B</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP:</td>
<td>Allergies:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Medication</th>
<th>Dose</th>
<th>Reason</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Appendix I

Hull Community Care Adult Services
CONTACT DETAILS updated 22/09/09

**CARE MANAGEMENT TEAMS**

<table>
<thead>
<tr>
<th>West Hull Long Term Support Team (WLTST)</th>
<th>East Hull Long Term Support Team (ELTST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Marsden – Operational Manager</td>
<td>Cheryl Giles – Operational Manager</td>
</tr>
</tbody>
</table>

**HOME CARE PROVIDERS**

<table>
<thead>
<tr>
<th>Reablement Teams</th>
<th>Homecare:</th>
<th>Day care:</th>
<th>Learning disability / Housing support:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Adult Services in-house providers)</td>
<td>Debbie Stephenson &amp; Petra Bengtson – 01482 331014</td>
<td>Barbara Wright – 01482 32088</td>
<td>Phil Stewart Netherhall – 01482 318269</td>
</tr>
</tbody>
</table>

**Highfield Resource**
Wawne Road
Hull
Tel: 589518
Heather Woods – Highfield

**Central Hull**
Baylea Homecare
Helen Lauterbach / Karine Richards / Sally Carey
27 Bourne Street
Hull
HU2 8AE
Tel: 348286
sallyc@springfieldhealthcaregroup.com

**North Hull**
HICA Homecare
Branch Manager - Robbie Wright
Geneva Court
Geneva Way
Leads Road
Hull
HU7 0DG
Tel: 01482 782929
Manager.hull@hica-homecare.co.uk

**West Hull**
DH Home Care
Gill Varley
Iridium Court
Owen Avenue
Saxon Way
Hessle
HU13 9PF
01482 641950
Gill.varley@dhhomecare.co.uk

**East Hull**
Allied Healthcare
Unit 5
Marfleet Environmental Technology Park
Westgate Way
Hedon Road
Hull
HU9 5LW
Tel: 01482 798669
Alison Baysal
hull@alliedhealthcare.com

Anticoagulation Service:
Westbourne NHS Centre, 81 Westbourne Avenue, Hull, HU5 3HP
Tel: 01482 335509
Fax: 01482 335507