Suffolk Adult and Community Services Medication Policy and Procedure

Managing the use of medication in community settings for adults receiving social care services

Owner	Louise Caesar – Principal Advisor ACS Quality Assurance and Professional Development Team
Version	1
Date	September 2018

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Changes History

Version	Date	Amended By	Summary of Changes
1.0	September 2018	Louise Caesar	First Published

Review and Approval

Role	Name	Approval Date
Policy Clearing House Suffolk County Council	Equality Impact Statement	July 2018

Authorisation

Role	Name	Approval Date
Principal Practice Lead ACS	Ioana Roberts	31/08/2018

Review Period

Date Document to be Reviewed	By whom
September 2019	Quality Assurance & Professional Development Team

Contents

The Suffolk County Council Medication Policy and Procedure was produced by a Working Group, comprising of members of Suffolk County Council including Home First Reablement Service, West Suffolk NHS Foundation Trust, Ipswich Hospital Trust, Suffolk Local Pharmaceutical committee, Ipswich & East Suffolk CCG, West Suffolk CCG

It is also important to acknowledge the input of those across the field that have provided expert feedback and tested the policy and procedure throughout the drafting process:

(AIT MEDIHELP Ltd)- Martin Bacon - Pharmacist and Medication Trainer

Anti-coagulant clinic's in Ipswich, West Suffolk and James Paget Hospitals

Homecare providers including Manorcourt Homecare, Fuchsia Homecare, One to one homecare, Westminster Homecare, Cambridge Care Company

East Suffolk Community Healthcare and various GP surgeries

The Working Group acknowledges the assistance of Surrey County Council and Norfolk County Council with the production of the original version of this document.

Comments on the policy and suggestions for future amendments should be sent to: louise.caesar@suffolk.gov.uk

1 INTRODUCTION

1.1 The administration of medicines is a regulated activity under the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This policy should be used in conjunction with CQC guidance for providers on meeting the regulations (February 2015) available from: http://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf

1.2 It is intended that this policy is a statement of best practice within Suffolk.

1.3 This policy and procedure is based on the following professional guidance/legislation and resources:

- Managing medicines for adults receiving social care in the community. NICE Guideline NG67. Published: March 2017.
- Medicines management for people receiving social care in the community NICE Quality Standard QS171 Published July 2018.
- The Handling of Medicines in Social Care. Royal Pharmaceutical Society, 2007
- The Mental Capacity Act 2005
- Medicines Act 1968
- The Misuse of Drugs Act 1971, and their associated regulations
- The Safer Management of Controlled Drugs Regulations 2006
- NMC guidelines on record keeping 2011
- Guidelines from the Nursing and Midwifery Council

1.4 This policy is not designed to be an exhaustive training guide on safe handling of medicines; it provides detail describing how medicines are managed specific to Suffolk County Council (SCC) Service Delivery. Staff members should also receive medication training as well as reading this procedure.

1.5 This policy should be read during the induction process by all staff members employed by SCC who support adults to self-medicate or who administer medication.

1.6 This policy is written and reviewed by the SCC Medication Working Group a multidisciplinary group with members from health, social care, independent providers etc

2 AIMS

2.1 Suffolk County Council (SCC) aims to encourage and support people to self-medicate and independently manage their own medication.

2.2 Medicines should be administered in a way the person using the service finds acceptable without detracting from their human rights. This policy and procedure aims to challenge discrimination based on age, gender, disability, sexuality, faith, religion, culture, ethnic or national origin, trans-gender, marital status and HIV status.

2.3 This policy applies to all home care providers who are regulated with the Care Quality Commission, providing home care to people over the age of 18. This policy applies to all providers who are regulated with CQC for provision of domiciliary care. It does not apply to day services or residential care homes.

2.4 Implementation of this policy is dependent on close collaboration between Health and Community Services in partnership with independent providers and with agreement of people using the service and informal carers or care workers.

2.5 In accepting a contract from Suffolk County Council, care providers are strongly encouraged to follow this policy. It is hoped that care providers with private clients would wish to follow this policy as an example of best practice.

2.6 Care workers must follow the guidance contained within the policy and accurately record all interventions. Should any problem be identified at a later date then Suffolk County Council employed care workers will be covered by the insurance policies of Suffolk County Council in respect of any claim against them arising in the course of their official duties. This is subject to their conduct not being dishonest, criminal or fraudulent, or the claim arising as a result of deliberate wrongdoing or recklessness. Employees must also act in good faith, in accordance with instructions and this policy.

2.7 It is the responsibility of each employing organisation to ensure they have appropriate liability insurance in place in respect of their employees.

2.8 There are many circumstances that arise with medication which will fall outside the scope of this policy. In any such circumstances care workers should discuss with their manager and follow any advice given. If asked, managers should investigate, act in a logical manner and document any process used until a permanent solution can be found. Advice may be obtained from the Prescriber or community pharmacist.

3 JOINT WORKING BETWEEN HEALTH AND SOCIAL CARE – OUR COMMITMENT TO SUFFOLK PEOPLE

3.1 Joint working enables people to receive integrated, person-centred support. Health professionals working in primary and secondary care have an important role in advising and supporting care workers and other social care practitioners.

3.2 People should be supported to take their medication independently wherever possible. Further support may be obtained from the person's usual pharmacy or dispensing surgery to facilitate self-administration.

3.3 Social care providers should notify a person's general practice (GP) and supplying pharmacy when starting to provide medicines support, including details of who to contact about their medicines (the person or a named contact).

When providing support for adults taking Warfarin it is best practice to call the anticoagulant clinic to advise them, this will enable effective communication of dosage changes (see section 26- Warfarin- for further details).

3.4 General practices (GP) should record details of the person's medicines support and who to contact about their medicines (the person or a named contact) in their medical record, when notified that a person is receiving medicines support from a social care provider *and a CCG commissioned provider for NHS CHC care packages.*

3.5 Social care practitioners should seek advice about medicines from people with specialist experience, such as the prescriber, a pharmacist or another health professional, when it is needed.

3.6 Health professionals should provide on-going advice and support about a person's medicines and check if any changes or extra support may be helpful, for example, by checking if:

- the person's medicines Regimen can be simplified
- information about time-sensitive medicines has been shared
- any medicines can be stopped
- the formulation of a medicine can be changed
- support can be provided for problems with medicines adherence
- a review of the person's medicines may be needed

3.7 When specific skills are needed to give a medicine, health professionals should only delegate the task of giving the medicine to a care worker when:

- there is local agreement between health and social care that this support will be provided by a care worker. This needs to be specified on the purchase order or SCC care plan (not for reablement)

- the person (or their family member or carer if they have lasting power of attorney) has given their consent
- the responsibilities of each person are agreed and recorded
- the care worker is trained and assessed as competent

3.8 Health professionals should continue to monitor and evaluate the safety and effectiveness of a person's medicines when medicines support is provided by a care worker.

3.9 Generally, Suffolk County Council Adult and Community Services does not commission medication only calls. This should only occur by exception and following discussion with a team manager. Prompting or administration of medication is only delivered as part of a wider package of social care.

4 ASSESSING AND RECORDING WHAT TYPE OF SUPPORT IS REQUIRED

4.1 Prior to commencing provision of any medicines support the care provider will assess a person's medicines support needs as part of the overall assessment of their needs and preferences for care and treatment.

4.2 Engage with the person and/or their family or carers in assessing a person's medicine support needs. Focus on how the person can be supported to manage their own medicines.

4.3 The assessment should take into account:

- All prescribed, over-the-counter and complementary medicines that the person is taking or using
- Any concerns, questions, side effects or other problems the person (and/or their family members or carers) has with their medicines
- The person's understanding of why they are taking their medicines
- How they currently manage their medicines, for example, how they order, store and take their medicines
- What they are able to do and what support is needed, for example, reading medicine labels, using inhalers or applying creams

4.4 Record the discussions and decisions about the person's medicines support needs.

4.5 If the person needs medicines support, include the following information in the provider's care plan:

- the person's needs, preferences and expectations for confidentiality
- how consent for decisions about medicines will be sought
- details of who to contact about their medicines (the person or a named contact)

- what support is needed for each medicine
- when the need for continued medicines support will be reviewed, for example, after 6 weeks.
- name and contact details of the GP and pharmacist

4.6 This support can be either:

1. 'General support tasks': Physical support that staff members provide to a person who self-medicates (e.g. occasional prompting medication, help opening medicines packs if the person can select the correct pack).
2. 'Administration by staff': This is where staff members take responsibility for ensuring the person using the service takes their medication on time (regular prompting), and / or ensures they take the right medicine in the right way, and / or they ensure the right medicine is selected.
3. 'Administration by specialist technique': This is where staff members administer items that require some form of specialist skill or technique.

4.7 Staff members training requirements and record keeping vary according to the level of support.

	Level 1 General support tasks	**Level 2 Administration by staff members**	**Level 3 Administration by specialist technique**
Medicines (MAR) chart	**Optional Must be recorded in persons care notes if not using a MAR chart. (See 9.1.3)**	**Required**	**Required**
Training	Medicines training	Medicines training	Specialist training
Competency check	By care provider	By care provider	By registered health care professional
Responsibility for administering medicine	The person using the service	The care worker	The care worker with ongoing supervision from the health professional

4.8 Staff members should report any concerns regarding the individual's ability to self-medicate to the responsible worker within the Adult Community Services Social Care team (Neighborhood team, Home First team etc).

4.9 A person's medicines support should be reviewed to check whether it continues to meet their needs and preferences. This should be carried out at the time specified in the care plan or when there are changes in the person's circumstances, such as:

- changes to their medicines Regimen
- a concern is raised
- a hospital admission
- a life event, such as a bereavement

If it is apparent at any point that the medication Regimen no longer meets the persons needs or best interests, a request should be made directly by the carer or care provider team leader to a skilled professional such as the person's GP to conduct a medication review to consider the suitability of the Regimen.

5 RESPONSIBILITIES

5.1 The care provider manager (for Home First, the registered Home First Team Leader) holds overall responsibility for the safe management of medication. They may delegate duties to certain staff members.

5.2 This manager/Team Leader is responsible for ensuring that all staff members who administer medicines (for example the Reablement Support workers from Home First) have received training and had their competence checked on a regular basis (annually as a minimum).

6 CONSENT

6.1 Written consent for staff to administer medicines must be obtained when the care plan is first set up.

6.2 For those who lack capacity to give informed consent, the prescriber(s) must indicate treatment is in their best interests. Any advance decisions regarding medication must be acted on (ref: Mental Capacity Act 2005).

6.3 **Refusal of medication in a person who has mental capacity**

Where a person with capacity refuses any medication, this should be respected. When a person declines to take a medicine, care workers should consider waiting a short while before offering it again.

- They should ask about other factors that may cause the person to decline their medicine, such as being in pain or discomfort.
- A note should be made on the medicines administration record (MAR Chart) using the appropriate code and/or within care notes.

- The local care provider manager or supervisor should be told at the earliest opportunity, they should then inform the prescriber or the person's representative.
- The time taken to inform the prescriber may vary depending on the nature of the drug and the person's illness, a pharmacist can always be asked for advice.

6.4 **Refusal of medication in a person who lacks mental capacity**

Staff members can try the following:

- Try again a few minutes later (the person may have forgotten that they refused)
- Try a different member of staff (where possible)
- Explain to the person what the medication is for
- Talk to a pharmacist to see if the timing and / or form of the medicine can be changed
- Talk to the prescriber and arrange for a medication review to take place as soon as possible

6.5 **Giving medicines to people without their knowledge (covert administration)**

Covert administration of medicines is when medicines are given in a disguised form without the knowledge or consent of the person receiving them.

6.6 The covert administration of medicines (e.g. disguising medicines in food and drink) must only be considered in exceptional circumstances i.e. when deemed essential to the health and wellbeing of the person. Decisions to administer medicines covertly must not be taken by any individual in isolation.

6.7 Ensure that covert administration of medicines only takes place in accordance with the requirements of the Mental Capacity Act 2005 and good practice frameworks (Mental Capacity Act 2005: Code of Practice) to protect both the person and care workers.

6.8 The prescriber (and GP if not the prescriber) should assess whether the person has adequate mental capacity to understand if taking the medicines is in their best interests and that the medicine is essential to the person's health and wellbeing. The doctor(s) should consider the views of everyone involved in the person's care (e.g. legal advocates, family, care worker, social workers etc.) if a decision to covertly administer medication is made. All decisions must be taken in accordance with the Mental Capacity Act https://www.gov.uk/government/collections/mental-capacity-act-making-decisions

6.9 Care workers must not give, or make the decision to give, medicines by covert administration, unless there is clear authorisation and instructions to do this in the provider's care plan, in line with the Mental Capacity Act 2005.

6.10 Ensure that the process for covert administration clearly defines who should be involved in, and responsible for, decision-making, including:

- assessing a person's mental capacity to make a specific decision about their medicines
- seeking advice from the prescriber about other options, for example, whether the medicine could be stopped
- holding a 'best interests' meeting to agree whether giving medicines covertly is in the person's best interests
- recording any decisions and who was involved in decision-making
- agreeing where records of the decision are kept and who has access
- planning how medicines will be given covertly, for example, by seeking advice from a pharmacist
- providing authorisation and clear instructions for care workers in the provider's care plan
- ensuring care workers are trained and assessed as competent to give the medicine covertly (see also the section on training and competency)
- when the decision to give medicines covertly will be reviewed.
- The decision should be documented in the risk assessment and reviewed as capacity can sometimes fluctuate.

7 SHARING INFORMATION ABOUT A PERSONS MEDICINES

7.1 When social care providers have responsibilities for medicines support, they should have robust processes for communicating and sharing information about a person's medicines that take account of the person's expectations for confidentiality.

7.2 It is important when a person commences or returns home with a new care provider, that the following 'medicines data set' is sent to the new care provider on the day that they are commencing the service/ transferred to/ discharged home from hospitals.

This medicines data set should be provided electronically or as a printed document.

- Person's full name, date of birth, NHS number, address and weight (where appropriate, for example, frail older residents)
- GP's details

- Details of other relevant contacts defined by the person and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- Medicines the person is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- Changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- Other information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine (adherence support).

7.3 The care provider must establish who in their organisation is responsible for providing this medicines data set (for people they discharge) and collating this medicines data set (for people they receive). This should include who is responsible during 'out of hours periods'.

7.4 The person responsible for collating this medicines data set, should obtain it from a source, such as:

- An up to date discharge summary
- Recently dispensed medicines labels from the pharmacy
- A recent repeat slip
- Medicines administration records from their previous care service
- The dispensing pharmacist
- The prescriber
- The person using the service
- Their family/carers

7.5 There should be a formal process in place to communicate between different staff members at handover and between care calls/visits when changes occur to a person's medicines. In community settings, this must take the form of a written system.

8 CONFIDENTIALITY AND SHARING INFORMATION

8.1 Information about people using the service must be treated confidentially and respectfully.

8.2 Members of the care team should only share confidential information about a person using the service with health and social care professionals and other professional (i.e. police service, fire service, transport staff members etc.) when it is needed for the safe and effective care of an individual.

8.3 Records that contain confidential information about a person must be held securely and must be accessed only by those persons who need to have access to them.

8.4 Medication records must be kept eight years from the last date of entry. If a person using the service's care is transferred to another care provider, copies of the medication records and administration charts will be made available to the new provider for reference (on a need to know basis in line with rules governing patient confidentiality). Actual records will be retained by the service where they were created.

8.5 When records are then destroyed, they must be shredded or destroyed in a way that preserves confidentiality.

9 SUPPORTING PEOPLE TO TAKE THEIR MEDICINES

9.1 General support tasks (self-administration)

9.1.0 Each person using the service will be supported to self-medicate as far as possible. Obviously, this depends on their mental capacity and ability to communicate. Self-medication will not be seen as an 'all or nothing' affair. Some people may be able to self-medicate with items such as inhalers, GTN sprays, or creams (for example) whilst staff members administer other medicines.

9.1.1 Staff members can provide physical assistance (we call this 'general support') to people who self-medicate as long as the person using the service can give staff members clear directions telling them what to do on each occasion. The person using the service must remain responsible for selecting the right medication and ensuring that it is used in the right way and taken on time. Staff members are simply providing physical assistance, with the person using the service being 'in charge'.

9.1.2 To self-medicate, a person MUST be assessed as able to:

- Tell you which medicine(s) they self-medicate with (so they must know if an item was missing)
- Identify their medicines correctly
- Tell you when they take the medicine, what time of day, if regular or for what symptom as required

- Tell you how they'd take each item (i.e. before food or dispersed in water etc).

9.1.3 There is no requirement for staff members to record general support tasks on a medicines administration record. This is because staff members are enabling a person who uses the service to remain independent and self-medicate rather than taking responsibility for administration. For example, a Reablement service may be assessing a person's continued ability to self-medicate on returning home from hospital, however, it is expected within the NICE guidelines for adults receiving social care in the community that "Care workers must record the medicines support given to a person for each individual medicine on every occasion (Para 1.5.2 NICE guidance)"

Therefore, clear details of the support supplied must be recorded in normal care record notes. If the support is through occasional prompting it must be recorded which medication was prompted on each occasion and the person's response in the daily care notes. If the person who uses the service has a medicines administration record (because other items are being administered by staff members) then staff members must write 'self-medicating' next to those items that the person self-medicates with. It should also be documented in the assessment and care plan and kept under review.

9.1.4 Staff members can give the very occasional prompt (reminder) to a person who is self-medicating. However, if the person needs a regular prompt i.e. they become reliant on these prompts, or the prompts are so regular that they have to be included in a care plan, then staff members should watch to see that the medication is used / taken correctly and record this on a medicines administration record (MAR Chart). Hence regular prompts are considered the same as 'staff administering medication'.

9.1.5 If staff members receive medicines that a person self-medicates with, they must record the quantity that they then hand over to that person. This can be recorded on a medicines administration record (if one is being used) or on any form that the service wishes to use.

9.1.6 When a person self-medicates, staff members must have a method of checking that the person is coping. Such methods may include:

- Counting any doses that remain (as long as the person using the service agrees to this)
- Keeping an eye out for any tablets, capsules etc. left lying around untaken
- Asking the person using the service if they are taking their medicines without problems
- Keeping a general eye on the person using the service and noting if any of their treated conditions worsen

9.1.7 Staff members who provide general support tasks to people who self-medicate must have received medication training even though they are not 'administering' medication to the person using the service. This is because the person using the service who self-medicates may deteriorate and require staff

members to administer medicines for them. It's also unlikely that staff members will only be supporting clients who self-medicate. They will more likely be supporting a number of people, some of whom will need their medicines administered by staff members.

9.1.8 When family or friends of the person using the service administer some doses of medication, it should be clearly documented in the care plan who is responsible for administering which doses and that a discussion has been held to agree responsibility should there be any medication errors. Agencies may wish to show the family or friends how to complete the MAR chart to ensure doses are not omitted or duplicated. The MAR chart should be clearly marked to indicate the medication has been administered by someone not employed by the agency.

9.2 Administration by staff members

9.2.1 Care workers should only provide the medicines support that has been agreed and documented in the provider's care plan. The care plan should be clear and unambiguous about the level of support being provided.

9.2.2 Appropriate hand hygiene should always be undertaken before administering any medication. Gloves should be worn to administer all medication (If latex gloves any possibility of allergies need to be considered).

9.2.3 A medicines administration record (MAR Chart) will be needed for the person using the service as it is a requirement that staff members administering medicines add their signature or initials for each dose that they administer/or regularly prompt and watch the person take.

9.2.4 Prescribers, supplying pharmacists and dispensing doctors should provide clear written directions on the prescription and dispensing label on how each prescribed medicine should be taken or given, ("as directed" is not an acceptable direction) including:

- for medicines to be taken at regular times:
  - what dose should be taken
  - what time the dose should be taken, as agreed with the person
- for 'when required' medicines:
  - what dose should be taken (avoiding variable doses unless the person or their family member or carer can direct the care worker)
  - the minimum time between doses (when clinically significant)
  - the maximum number of doses to be given (for example, in a 24-hour period) (when clinically significant).

9.2.5 The person preparing the medicines administration record must take information from an authoritative source. Examples of authoritative sources include: pharmacy labels (most recently dispensed i.e. less than 56 days ago),

recent discharge summaries, letters from doctors, pharmacists, and repeat prescription order slips.

9.2.6 The person preparing the medicines administration record should (if possible) also talk to the person using the service, and / or their representative to ensure they have got a complete list of their current medication, and that the directions are current.

9.2.7 If the person using the service or their representative provides information that differs from the pharmacy labels or repeat prescription, the person preparing the chart should check with the prescriber (or another health professional if the prescriber cannot be contacted) for advice on correct action to take.

9.2.8 For all changes to medication directions the GP/Prescriber will need to be contacted to arrange an amended prescription and supply.

9.2.9 When preparing the medicines administration record, staff members (as far as possible) must do this in a quiet environment to minimise the chance of distractions and errors being made.

9.2.10 All items administered by staff members will be recorded on the chart including medical moisturisers, but not cosmetic moisturisers i.e. those without a product licence, or moisturisers used as soap substitutes.(Those with a product licence will have 'PL' with some numbers after it printed on the manufacturer's pack). Body maps should be used for topical application of creams and ointments and transdermal patches to provide clarity about the area where they are to be applied.

See Appendix B - Recording topical medicines and Appendix C - Transdermal Patch Application Chart.

9.2.11 The staff member who completes the chart must sign and date it to show who completed it.

9.2.12 When a medication administration record is initially written it is best practice that second person (who has received medication training) check the medicines administration record has been completed accurately; they must also sign and date the chart. We appreciate that this is not always possible when working alone. If an alternative worker is administering medicines at a subsequent visit they should check the MAR chart and countersign to confirm accuracy.

9.2.13 For 'when required' medicines, a 'when required protocol' is needed included as appendix D

9.2.14 Any visiting health professionals who administer medicines to the person using the service will be requested to record this on the persons medicines

administration record. If not and where care staff are aware of this, they should record this in the person's records.

9.2.15 When administering medicines, the staff member must check the pharmacy label against the medicines administration record, ensuring that the 6 rights of administration are met:

- right person
- right medicine
- right route
- right dose
- right time
- person's right to decline

Medicines records should:

- be legible, in black or blue ink (able to be read if photocopy taken)
- be signed by the service staff
- be clear - accurate and factual
- have the correct date and time of administration
- be completed as soon as possible after administration
- avoid jargon and abbreviations
- be easily understood by the person using the service, their family and carers

9.2.16 If the label is incomplete or ambiguous, the care worker should inform their manager who should refer this to the prescriber, in order to gain a correct direction of administration.

9.2.17 It is intended that Level 2 administration of medication takes place from original pharmacy containers with an accompanying MAR chart. This reduces the risk of compliance aid dispensing errors and also ensures each medication can be correctly selected and identified by the dispensing label.

9.2.18 A medicines pot or other suitable container may be used to transfer medicines from the pharmacy labelled container to the person for immediate administration. The MAR chart must be completed immediately after the dose has been administered.

9.2.19 If the care worker suspects that medication is causing side-effects or adverse reactions, they should inform their manager, who must discuss this with the person's GP or pharmacist. Any actions should be documented in the daily record.

9.3 Medicines Compliance Aids

9.3.1 The NICE guidance in relation to managing medicines for people receiving social care in community settings includes some advice on the use of monitored dosage systems. Rather than adopt a blanket approach to all people using the

service, the guidance states that a provider should **"consider using a monitored dosage system only when an assessment by a health professional (for example, a pharmacist) has been carried out, in line with the Equality Act 2010, and a specific need has been identified to support medicines adherence. Take account of the person's needs and preferences and involve the person and/or their family members or carers and the social care provider in decision-making."**

9.3.2 It should be clear that a relevant health professional's assessment indicates that this method is required to enhance the person's ability to take their medicines safely and correctly and should only be used as an aid to compliance for the person to achieve **self-administration.**

Where this is not supporting independence, then a review of the suitability of the aid needs to be undertaken.

9.3.3 Supplying pharmacists and dispensing doctors should provide a description of the appearance of each individual medicine supplied in a monitored dosage system. In addition, the supplying pharmacists and dispensing doctors must supply a patient information leaflet for each medicine supplied, in line with The Human Medicines Regulations 2012. This includes medicines supplied in monitored dosage systems.

9.3.4 Patient Information Leaflets should be left with the person, to enable them and the care worker to have access to information about the medication. Care workers may need to assist people to access this information e.g. by reading the leaflet to them if required.

9.3.5 Staff members cannot administer medicines from family filled dosset trays or boxes. This is because there would be no pharmacy label fixed with details of the medication. In addition, the family would not be professionally liable for any mistakes made during the filling process.

9.3.6 Care workers who administer medicines are expected to be able to individually identify each medicine they administer and record it separately on a MAR chart. Therefore, medicine compliance aids are not usually considered appropriate when giving level 2 support. If medicines are for some reason being supplied in this way, the supplying pharmacy should be requested by the care provider to include descriptions of each tablet on the label to enable identification.

9.3.7 Any removal of tablets from a medicines compliance aid, including where the care worker has selected and opened and removed medication from a particular section, is considered to constitute level 2 support.

9.3.8 There may, however, be a limited number of situations in which, upon risk assessment, it is considered appropriate for care worker to administer from a medicines compliance aid. A MAR chart must also be used. The medicines compliance aid must have the tablet identifiers written onto the labels by the pharmacy in order for a care worker to administer from this.

9.3.9 **In no circumstances should care workers provide level 2 administration from a compliance aid that has been filled by the person, their relatives or friends etc.** Assistance with medicines from unlabelled compliance aids, or those filled by family or informal carers will be limited to prompt only (level 1 support). Care workers are advised not to handle these containers to avoid dropping the container and spilling the contents.

9.3.10 If the person who usually fills the compliance aid is unable to complete this task e.g. due to a personal emergency, the care worker should seek guidance from their manager. Care workers are not permitted to fill compliance aids for people.

9.3.11 When administering oral medications (excepting liquids), it is usual practice to place the medication in the person's hand or a medication pot for them to take. In instances where they are unable to place tablets in their mouth themselves, e.g. due to physical or cognitive disability, medicines may be placed in the mouth by the care worker using a suitable implement e.g. spoon. This should be risk-assessed with details of administration method written in the care plan or risk assessment.

9.4 Altering medication form for administration e.g. crushing tablets

9.4.1 Tablets or capsules may need to be crushed or opened to enable the person to take their medication. This should be carried out with the patient's consent, it is NOT for covert administration. In these circumstances the following must apply:

- Crushing or opening must be agreed with the prescriber as the efficacy and legal status of the medicine can be altered
- Crushing/opening requires **both** the prescriber and the supplying pharmacist to give authorisation
- Guidance on how to prepare medication for administration by care workers in this way may be sought from the supplying pharmacy i.e. administer with food, dissolve in water etc.
- Information and authorisation must be recorded in the care plan
- The direction to crush/open should be added to the dispensing label
- The correct equipment should be used to crush tablets e.g. pill crusher

9.5 Splitting Tablets

9.5.1 It is always preferable for solid dose forms (tablets or capsules) to be administered as single or multiple units (e.g. one or two tablets) per dose. Occasionally it may be necessary to split a tablet to achieve the required dose. In such cases tablets may be split if they are scored by the manufacturer. Non-scored tablets should only be split after confirming with the pharmacist that splitting is safe. If the split is to enable the person to swallow the medication, the care worker is permitted to assist them after checking with the pharmacist that this is acceptable. The pharmacy may be requested to split the tablets on dispensing if this will not affect the stability of the medication for the duration of its use.

9.5.2 If splitting a tablet is required to achieve administration of the correct dose, this should be undertaken by the care worker using a commercially available tablet splitter. The remaining half should then be disposed of appropriately. If the split is to enable the person to swallow the medication, the care worker is permitted to assist them to split the tablet.

9.6 Administering "PRN" medication

9.6.1 Medication with a when required ("PRN") dose is usually prescribed to treat short-term or intermittent conditions. The person may not need the medication at every dosage time or may required to take it in-between other medication dosage times e.g. over-night pain relief.

9.6.2 Care workers who are administering PRN medication must be able to demonstrate that they know what the medication is for, how frequently it should be offered with dosage intervals, an awareness to record on the MAR chart and the circumstances when the medication should be offered and given. The care worker must check that the person has not already self-administered the medication. The exact time the medication is given, and the amount given should be recorded on the daily record.

9.6.3 A "When Required (PRN) Medication Protocol" is available (See Appendix E) to assist with this information which may be completed and kept with the MAR chart. The information may be gathered from the prescriber, supplying pharmacy/dispensary or nurse involved in the treatment of the person.

9.6.4 Staff members should be able to see the exact time when the last when required dose was given so they can ensure enough time has elapsed between doses (for example, paracetamol requires a 4-hour gap between doses).

9.6.5 For most PRN medicines, staff members should check if the person using the service needs the item (the when required protocol should provide this information). If the item is not administered, staff members should record the

fact that they have checked if the item is needed by recording this on the medicines administration record. (e.g. NR=not required).

9.6.6 There are some PRN items that don't need to be offered to the person. Examples include emergency medicine such as adrenaline for allergic reactions. Because these items are not 'offered' an NR code is not needed, and the chart can be left blank when the item is not administered.

9.6.7 If the person is eating when the medicine is due, check the medicines label to see if there are any warnings stating that the medicine should be taken on an empty stomach. If so, check with a pharmacist regarding when the medicine can be given.

9.6.8 If the person using the service is asleep when the medicine is due, then check with a pharmacist to see if the medicine is critical. For example, they should not be woken up for medicines such as vitamins or pain killers.

9.6.9 Before supporting a person to take a dose of their medicine, care workers should ask the person if they have already taken the dose and check the written records to ensure that the dose has not already been given.

9.6.10 Care workers should ask the person if they are ready to take their medicine, before removing it from its packaging, unless this has been agreed and it is recorded in the provider's care plan.

9.6.11 Care workers should give medicines directly from the packaging/container they are supplied in. They should not leave doses out for a person to take later unless this has been agreed with the person after a risk assessment and it is recorded in the person's care plan.

9.6.12 A risk assessment should check:

a. If the person who uses the service can remember doses left out

b. If the dose is stable for the time it's left out (check with a pharmacist);

c. If any other people might take doses left out

9.6.13 Doses left out should be coded "P" (for 'prepared') or an equivalent code. The care worker should also initial the record to take responsibility for the preparation of the dose. Staff members should keep an eye out for any prepared doses not taken. This might indicate that it is not suitable to leave doses out.

9.6.14 When a person declines to take a medicine, care workers should consider waiting a short while before offering it again. They should ask about other

factors that may cause the person to decline their medicine, such as being in pain or discomfort.

9.6.15 Social care providers should ensure that care workers are able to prioritise their visits for people who need support with time-sensitive medicines.

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

9.6.17 PRN medication that is still in use and in date should be carried over from one month to the next and not disposed of. PRN medication is best supplied in an original box and not in a Medicines Compliance Aid. This allows for a check on the expiry date and reduces waste. The expiry date printed on the box and foil strip may be used to determine if the medication is still suitable for use.

9.7 Administration of variable doses

If a variable dose is prescribed (e.g. one or two tablets), the care worker must ask the person how many they want to take. If they lack capacity for a variable dose or PRN, the prescriber should be contacted about amending the dose.

The care worker must:

- Ask the person how many they wish to take. If the person is unable to decide or respond the care worker should document the circumstances in which the variable dose is to be taken – further advice may be sought from the prescriber or pharmacy.
- Clearly make a record on the MAR chart of the quantity taken.

9.8 Administration by specialist technique

9.8.1 The following types of medication are considered to involve 'administration by specialist technique' and can be different for different people:

- Nebulisers
- Buccal midazolam
- Rectal diazepam
- Medicated dressings (staff members can apply prescribed dry dressings for protection)
- Adrenaline auto injectors
- Administration by enteral feeding tubes

9.8.2 Staff members must have additional training provided by a health care professional in addition to their medicines training for specialist medicines administration.

9.8.3 The health care professional must assess competency to ensure that the staff members are able to administer these items safely. This assessment of competency could involve staff members demonstrating the task back to the healthcare professional and a certificate or letter confirming competence must be provided by the health care professional.

9.8.4 Training for administration and checking of competency by specialist technique needs to be repeated. How often depends on the type of administration. The training provider should specify for how long the training is valid. Training for buccal midazolam and rectal diazepam must be repeated every two years (as recommended by the Joint Epilepsy Council UK and Ireland).

9.8.5 There are some tasks of a more invasive nature that Suffolk County Council (Home First) care staff will not accept responsibility to provide in any circumstances. These include administering injections, intravenous drips, administering suppositories, pessaries and suctioning.

10 TRAINING REQUIREMENTS AND COMPETENCY CHECKS

10.1 All care providers staff members who provide general support, administer medication, or administer by specialist technique must receive medicines training. This training should be provided by a Suffolk County Council approved supplier.

10.2 Training updates are needed at least two-yearly.

10.3 There must be a formal system to assess staff members' competency when administering medication including assessment through direct observation. This must be recorded. This can be achieved by a suitably competent person accompanying the care worker as they give medication and observing that they carry out key important tasks linked to the medication procedure. It is expected that competency is checked annually as a minimum.

11 NON-PRESCRIBED MEDICINES AND HOMELY REMEDIES

11.1 Staff members must obtain advice from a pharmacist or prescriber using the 'advice to administer a non-prescribed medicine' before administering any non-prescribed medicines, homeopathic preparations, vitamins, minerals or supplements.

They must be added to the medicines administration record. They must be administered and recorded in the same way as prescribed medicines.

11.2 Only staff members who have received medication training can administer homely remedies.

11.3 Homely remedies must be checked once a month to ensure that they are in date.

11.4 People using the services and visitors/relatives should be encouraged to inform staff if any non-prescribed medicines are kept or required by a person using the service.

11.5 If following discussion with the pharmacist or prescriber, the advice is not to give the non-prescribed medication, staff should record this, discuss with the person using the service and inform the SCC ACS responsible worker.

11.6 Once advice has been sought which supports giving the medication, the non-prescribed medication must be added to the Medication Administration Record.

12 VERBAL ORDERS

Verbal instructions to stop medicines or amend doses should be avoided wherever possible must only be accepted when the person who uses the service's health would be put at risk if they were not acted upon immediately.

12.1 If taking a verbal order, staff members must record:

- the time and date of the call
- the name of the prescriber they are speaking with
- the new instructions

12.2 The staff member should repeat the instructions back to the prescriber to confirm that they have heard them correctly, spelling out any drug names if they are unsure. It is best practice that a witness be present to confirm the information (it is accepted that this is not always possible for lone workers in the community).

12.3 During the call staff members must ask the GP or prescriber to send written confirmation (via email or a letter) within 24 hours (or within 72 hours at weekends or bank holidays).

12.4 When written confirmation is received, this must be kept on file as evidence of the change.

12.5 Text messages from telephones can be used as written confirmation in exceptional circumstances. They should check that the sender is a prescriber for the person and the message is received from their designated number. Staff members

must record the details of any text message received, including the content of the text message, telephone number it was sent from (it should be a pre-agreed designated number), the time sent, any response given. The recipient of the text should then sign and date this record. They should then delete the text from the phone.

12.6 Given the fluctuating nature of Warfarin doses verbal orders to make dose changes are often communicated via the phone by the Anticoagulant clinic.
Due to the high risk of harm associated when Warfarin doses are administered incorrectly doses should only be altered when accompanied with written instructions.
To enable an agreed method of communication for individual care providers it is crucial that care providers contact the area hospital Anticoagulant clinic to provide email contact details. (see section 26 for further details relating to Warfarin).

12.7 When the prescriber needs to give a verbal order for a person in their own home, they should do this by ringing the office of the care provider.

13 RECORD KEEPING

13.1 If a mistake is made when recording on the medicines administration record it may be corrected by adding an appropriate code and writing an explanation at the bottom or reverse of the chart. On no account should the entry be deleted with correction fluid.

13.2 The prescriber is encouraged to amend the medicines administration record themselves, if this is not possible changes should only be made and checked by people who are trained and assessed as competent to do so.

13.3 Cancelling items of medication on the medicines administration record: When an item of medication is stopped, staff members should cross the item through to make it clear that it has been stopped. The former record should still be legible. Staff members should name the authorising prescriber, sign and date the cancellation and make a reference in the person using the service's notes or on the back of the medicines administration record explaining why the item was stopped and the written confirmation must be attached to the medicines administration record.

13.4 Changing doses (only when authorised by the prescriber and written confirmation obtained).

13.5 First cancel the item on the medicines administration record (as set out above) then add the item with the revised details as a new entry. Once an item has been added to the existing medicines administration record, it should be signed and (only if possible in community settings) a colleague should check that it has been prepared correctly and countersigned. The date the new item was added to the medicines administration record should be written on the medicines administration record.

13.6 Care must be taken to ensure that this written record is printed in capitals using indelible ink. The information that is printed on the medication label must be copied

directly to the recording chart. There should be a reference in the person using the service's notes or on the back of the medicines administration record explaining why the item was changed and the written confirmation must be attached to the medicines administration record.

13.7 Use of MAR Charts

13.7.1 The legal direction is to administer is as per the dispensing label. The MAR chart is a record of medication to be given and medication taken. Both the dispensing label and MAR chart should be an exact match. If it is not clear from the dispensing label how the medicine should be taken the prescriber/pharmacy should be contacted to offer clarity before recording on the MAR chart. Until this is clear, the medication should not be administered, and the care worker should advise their manager.

13.7.2 The MAR Chart is a record of medication that has been administered to the person; therefore, a signature on the chart indicates the medication has been taken. Medicines not given should be recorded using the appropriate code.

13.7.3 When a medication prescribed as when required is not needed by the person, the MAR chart should be marked to show non-administration with an appropriate code with a corresponding record in the care notes i.e. "medication offered but not required".

13.7.4 The MAR chart is a supplementary record to the daily care notes and should be reviewed together when necessary.

13.8 Changes in medication

13.8.1 Verbal orders must only be accepted in an emergency when the person's health would be put at risk if the order was not acted upon immediately (See section 12)

13.8.2 Changes to medication must always be confirmed with a prescriber, not a family member etc.

13.8.3 When changes to medication in medication compliance aids are made, care workers should not attempt to remove or change medication within the aid but contact the pharmacy or dispensing surgery, so a replacement prescription and compliance aid may be obtained.

13.8.4 If a prescriber makes a verbal order to stop a medicine, the Registered Manager or Team Leader (Home First) should action the request and ensure that written confirmation is obtained from the prescriber within 24 hours.

13.8.5 Changes or discontinuation of medication by written authority must be fully documented on the MAR chart, together with the date, time and name of the authorising health professional. The person completing the form must sign and print their name on it.

13.8.6 Care workers must ensure they are working to current instructions on the MAR chart or care plan and/or risk assessment and must not continue to use medicines which the doctor/hospital has discontinued/adjusted. These may remain on the premises but should be disposed of at the earliest opportunity.

13.8.7 Care workers must ensure following a hospital discharge that people are receiving the correct medication as there may have been changes to the medication list. Information may be found on the discharge medication list, or by liaising with the person's GP.

14 ORDERING MEDICATION

14.1 Care staff members can help self-medicating individuals order prescriptions but should always encourage individuals to remain independent with this task where possible. It should be recorded who is responsible for ordering prescriptions, especially if more than one care provider provides support.

14.2 Staff members must make efforts to check a person who uses the service does not run out of their medicines. Staff members must order a new prescription at least SEVEN DAYS before the person runs out (or earlier depending on what is agreed with the surgery and pharmacy). It is recognised that this may not always be possible with community-based care / reablement.

14.3 If the person using the service runs out of medication and a new prescription cannot readily be obtained and the pharmacist concludes that it is appropriate to do so, the person using the service's regular pharmacy may supply up to 30 days' worth of medication as an emergency supply (but not controlled drugs). The request for an emergency supply must come from the person using the service or their formal representative and the person using the service may be required to pay.

14.4 If a pharmacy is out of stock or cannot obtain a supply in time for the person using the service, the pharmacist may be asked if there is an alternative pharmacy who can supply the medication. If unable to obtain from another pharmacy the prescriber may need to be contacted and asked to prescribe an alternative treatment.

15 TRANSPORTING, STORING AND DISPOSING OF MEDICINES

15.1 Responsibility for transporting, storing and disposing of medicines usually stays with the person and/or their family members or carers. However, if it has been agreed that a social care provider is responsible, effective medicines management systems need to be in place.

15.2 If there is a planned trip, where medication will need to be sent with the person to enable administration e.g. day centre, outing etc. the original packets with the dispensing label attached should go with them in order that care workers can still administer the medication.

15.3 The MAR chart should not be transferred to another setting e.g. day service but may be taken out if the home care provider is providing access to the community. Care must be taken with the security of the medication and the MAR chart in this instance.

15.4 In the event of an unplanned trip when it is impractical to arrange a separate supply of medication, and where there is more than one care worker available – a small supply of medication may be decanted into a suitable container. All information on the pharmacy label must be transcribed by one care worker and checked by a second care worker. One of these should be the person who will be administering the medication whilst the person is out. A written record must be made to explain why it was not safe or practical to take the medication out in the original containers. This should not be a routine procedure and should be referred to the Registered Manager for authorisation.

16 RECEIVING OR COLLECTING MEDICATION

16.1 If the care provider orders medicines, then they must retain a copy of that order so that they can check it against the medicines when they are received.

16.2 If the care provider orders medicines on behalf of a self-medicating individual, then they must record the total quantity handed over to the person to self-medicate with.

16.3 When prescribed medicines are collected, staff members are required to show the pharmacy proof of identity and sign the back of the prescription for schedule 2 and 3 controlled drugs.

16.4 Medicines collected or received from the pharmacy (including controlled drugs) will be recorded in a 'medicines received book' or form, the format of which can be agreed with the local manager. They must be signed for and stored immediately in the appropriate place.

17 STORAGE AND SECURITY OF MEDICINES

17.1 There are medicines that are better kept by the person who uses the service (e.g. asthma relievers and glyceryl trinitrate spray for angina). Storing these away from them may delay treatment.

17.2 All current medication (including controlled drugs) should be stored together in one container in a safe place known and accessible to the person who uses the service if appropriate.

17.3 Storing medicines away from a person using the service

17.3.1 If there is a risk identified that a person using the service would be in danger by accessing their medicines, of causing themselves harm, then a decision may be needed to store medication securely away from them (for example, in a locked box).

This is an important and sensitive decision, which could deny a person their rights. Therefore, this decision should only be made after consultation and discussion with the GP or community nurse, allocated worker from the SCC ACS locality team and involved carers/relatives.

17.3.2 The decision should be documented on the risk assessment. The decision must be reviewed at least annually and if the risk changes. Where the person lacks the capacity to consent to such arrangements a mental capacity assessment and best interest's decision should be undertaken and recorded.

18 AUDITS

18.1 Audits of medication and records should be carried out at regular intervals. Audit tools should be designed at each location and the frequency can be agreed locally.

19 DISPOSAL OF MEDICINES

19.1 The disposal of medicines requires that they to be taken to a local pharmacy for destruction rather than placing them in the general waste.

19.2 Returned medicines should be recorded on "a medicines received / disposed of book", which should be filed with the notes of the person who uses the service.

19.3 In the event of the death of the person who uses the service medicines should be retained for seven days in case they are required by the Coroner's office or courts.

19.4 The person who uses the service or their representative will normally be expected to dispose of medication. Staff members may do this if the person or their representative is unable. Staff members must notify the office to say which medicines they are disposing of (by phone) and this should be recorded. See Appendix F – Disposal of unwanted medication.

19.5 Staff members are not expected to visit a pharmacy to return small quantities of tablets or capsules (for example if a person who uses the service refuses a dose). They may ask pharmacy staff members for an empty tablet bottle to keep wasted doses in alternatively sealed bags can be used to store medicines until able to be returned to the pharmacy. This bag or bottle should be labelled with 'waste medicines' stored safely and securely and then returned to a pharmacy on the next available occasion.

20 ADVERSE EFFECTS

20.1 Care staff members should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional (such as the supplying pharmacist). They should also inform the person's relatives subject to the person's consent or best interests' considerations as appropriate.

20.2 Staff members should record the details of the adverse effect and who was notified and when, in the person's care plan.

20.3 Staff members should tell the supplying pharmacy (if the person using the service agrees that this information can be shared).

20.4 People using services and/or their family members should be made aware of how they can report adverse effects of medicines by using the Medicines and Health Care products regulatory agency's Yellow Card Scheme

21 MEDICATION ERRORS AND INCIDENTS

21.1 If an incident occurs regarding medication, care workers must immediately report this to their manager. This also applies to errors that staff identify but have not made themselves e.g. errors made by prescribers, pharmacists and other care workers. If an error has been made by one of these providers, then these need to be contacted directly. If unable to contact the manager, the care worker should not delay seeking medical advice.

When an error occurs the two most important things to establish are:

- Will the person who uses the service have suffered any harm?
- How do SCC minimise the chance of the error occurring again?

21.2 If a mistake occurs, staff members must IMMEDIATELY report this to their line manager or senior staff member on duty so as to prevent any harm to the person who uses the care/ reablement service.

Upon discovery of the error, medical advice should be promptly obtained from the relevant GP surgery or through the NHS 111 service. This should establish:

- Whether any immediate medical attention is required
- Serious adverse reactions may require an emergency 999 response
- Whether any harm is likely to have been caused
- If or when the next dose should be given
- Whether there needs to be any special observation of the person concerned for a period of time and what symptoms should care staff be aware of

The staff members manager should ensure the following action has been or is taken:

- Advice sought from the GP or appropriate health professional immediately e.g. Out of Hours service, 111 etc. This medical advice should be documented in the person's care records
- Details of the error has been recorded in the care record, and on the MAR chart if appropriate
- Make a note of any changes or deterioration in the person's health or behaviour.
- Ensure the error is fed into the care provider's incident reporting system

- Consider any need for a Safeguarding referral and/or CQC notification

The manager must inform the County Manager where appropriate and this must be recorded on the Risk and Quality Assurance reporting log and on the Health & Safety Event reporting system (OSHENS). This procedure also applies to errors recognised by the care worker but for which they have not necessarily had any direct involvement.

21.3 To minimise the chance of the error occurring again, SCC wish to create a culture where staff members feel able to report all errors and near misses. This ensures that we learn from as many incidents as possible. The log of medication errors within the Risk and Quality Assurance reporting log should be used as a learning resource.

21.4 The local manager (or someone they delegate) will work with any staff members involved in the incident, to learn any lessons, change any systems, and spread the learning from the incident to other staff members and senior managers to ensure continuity of best practice and recording procedures.

21.5 Medication errors are notifiable to CQC in circumstances where the error led to serious injury and/or the error was referred to the local authority as a safeguarding concern.

21.6 Recurring incidents

21.6.1 If the same or a similar incident occurs that relates to the same or another person, 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 a visible impact on the person or others; however, raising a safeguarding alert should be considered, to prevent harm being experienced in the long-term.

21.6.2 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 by those recording incidents and those responsible for monitoring the effective implementation of that organisation's incident policy.

21.6.3 Managers and staff have a duty to have systems in place that enable them to identify patterns/cumulative incidents and to raise an alert if there are a number of these, even if some are retrospective.

21.6.4 The following examples though not exhaustive, provides assistance in identifying when poor practice could be abusive and when an alert should be raised under the adults safeguarding procedures.

Poor Practice - internal action (incident-reporting)	**Possible Abuse - raise an alert**
A person does not receive their medication on one occasion, but no harm occurs (their doctor / pharmacist was contacted for advice regarding the impact of the missed medication).	Medication error on one occasion, causing harm, e.g. Diabetic - insulin. Or could have caused significant harm. Recurring event, or happening to more than one person. Harm suffered, e.g. pain, health deterioration, side effects.

21.6.5 If there is any doubt regarding whether an alert should be raised under these procedures this should always be discussed with Suffolk MASH Consultation Line on 0345 6061499. You can also make an online referral on our adult referral page and/or the allocated social care team

22 CONTROLLED DRUGS

There are no specific legal requirements that apply to controlled drugs in a person's home. It must be ensured that such medicines are kept out of the reach of children. If a risk has been identified, then the care provider should consider putting in place systems to ensure that controlled drugs are managed safely.

23 INSULIN AND BLOOD SUGAR TESTING

23.1 Staff members will try to store at least 2 vials of insulin in the fridge in case of breakage.

23.2 Some people may need help with blood sugar testing. This need should be recorded in their care plan and written consent obtained. Staff members must be trained in how to carry out testing (this training may be available from the person who uses the service's diabetes nurse). Where the person who uses the service lacks capacity to give permission a Best Interest Approach should be adopted.

24 EMERGENCY MEDICATION

24.1 For people who have emergency treatments (e.g. medicines to stop a seizure or adrenaline EpiPen for anaphylactic reactions) the local manager (team manager) will establish if staff members are required to administer these. If they are, we will we require a treatment plan from the prescriber. In general cases most of this type of medication would need to be administered by staff members due to capacity at the time of needing the medication, for example if someone is having a seizure they would be unable to self-administer the medication or indeed identify it was needed.

24.2 The manager must ensure that there are sufficient trained staff members available to administer medicines by specialist technique if required, as outlined in section 9.9.

25 OXYGEN

25.1 In the event of any problems regarding oxygen, the oxygen supplier should be contacted.

25.2 Oxygen must not be stored within 10 feet of any naked flames or subjected to extremes of heat or cold. No smoking is allowed when oxygen is being used.

25.3 The number of cylinders stored should reflect the person who uses the service's needs. It is dangerous to store unnecessarily large quantities of oxygen.

26 WARFARIN

26.1 Warfarin is regarded to be a high-risk drug because of the risk of significant harm resulting from the administration of an incorrect dose. Blood tests (INR – International Normalised Ratio) are carried out to determine the dosage of warfarin required. Robust arrangements are required to ensure that care workers administer warfarin at the correct dose.

26.2 It is recommended by the National Patient Safety Agency that people who are prescribed an anti-coagulant drug such as warfarin be provided with a 'Oral Anticoagulant Therapy Pack' (sometimes called 'the yellow book'). This often includes a yellow record book to record blood results and dosages. However in Suffolk, Ipswich, West Suffolk and James Paget Hospital Anticoagulant Clinics do not currently issue patients with a yellow record book; they send the patient by post or email a new dosage advice slip (and INR test request form) every time they have an INR check.

26.3 On dosage advice slips it outlines INR blood tests results along with Warfarin dosage advice. These slips should be kept with the medication chart. It is recommended practice to complete a Warfarin Administration Record separate to the MAR chart (see appendix document)

26.4 Where care providers administer warfarin, it is crucial that they have a negotiated method of communication with the hospital anticoagulation clinic to ensure changes to doses are received in a timely manner both verbally as well as in writing by either email or fax.

It is good practice for care providers to contact the area clinic as soon as possible when commencing medicine support for an individual prescribed Warfarin using the contact methods below:

Ipswich Hospital:
Telephone: 01473 703228
Email: ams@ipswichhospital.nhs.uk or
ihn-tr.Anticoagulant-Monitoring@nhs.net

West Suffolk Hospital:
Telephone: 01284 713085
E-mail: wsh-tr.anticoagulation@nhs.net
Post: Anticoagulation Service, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk. IP33 2QZ.

James Paget Hospital:
Telephone: 01493 452452 – Bleep 1473
E-mail: AntiCoagservice@jpaget.nhs.uk

26.5 Doses of warfarin should be expressed as "mg" rather than number of tablets required. Warfarin is normally prescribed as 1mg (brown), 3mg (blue) and 5mg (pink) tablets. In some situations, 0.5mg (white) tablets are also made available. Care workers must ensure they can clearly identify the different strengths in order to administer the correct dose. A combination of tablets may be required e.g. a dose of 6mg may be 2x3mg tablets or 1x5mg and 1x1mg tablets. It is not recommended that 0.5mg and 5mg tablets are used together due to the potential for errors.

If at any time a care provider has concerns about the availability of tablets or dosages, they should contact the anticoagulant clinic for advice immediately.

26.6 The pharmacy should be requested to label the warfarin directing the care worker "To be taken as per dosing schedule/yellow book" to prompt the care worker to check this information on the dosage advice slip. As directed on its own is not sufficient on the label.

26.7 When updating the dose required the following should occur:

- The INR dosing schedule is posted to the person's care setting or emailed/faxed to the care office. The schedule should be placed with the person's Warfarin Administration form and/or MAR Chart as soon as is practically possible.
- Verbal messages should only be accepted in an emergency (refer to Section 12) and NOT to communicate routine dose changes.

26.8 If the dosing schedule or yellow book is not available, care workers must not administer until the correct dose has been clarified. The care worker or manager must contact the local anticoagulant service, or if recently discharged contact the hospital ward. The GP should only be contacted if these options are not available and advice is needed urgently. Any advice taken from the ward or GP should then be confirmed with the anticoagulation service as soon as they are available. The intervals of INR tests might vary between a few days to a maximum of 10 weeks.

When the new dose is confirmed, the next blood test date will also be notified on the dosage advice slip.

27 LIST OF APPENDICES

The following attached documents are provided as examples to support and enhance practice in line with this policy and procedure. It is not a requirement to adopt the use of these templates in replacement of forms and documents which are already assisting to achieve the standards outlined in this policy.

Suffolk County Council

Start date:

MAR Chart

Name:	Address:	DOB:
Surgery:	Dr. Phone:	Precautions/Notes:
Allergies/Sensitivities:		

Medication/Dose *exactly as pharmacy label*			Week 1	Week 2	Week 3	Week 4
		Date				
		Time↓ Day→				
QTY	Date					
Sign	C.F	R/Balance				

Medication/Dose *exactly as pharmacy label*			Week 1	Week 2	Week 3	Week 4
		Date				
		Time↓ Day→				
QTY	Date					
Sign	C.F	R/Balance				

Medication/Dose *exactly as pharmacy label*			Week 1	Week 2	Week 3	Week 4
		Date				
		Time↓ Day→				
QTY	Date					
Sign	C.F	R/Balance				

Medication/Dose *exactly as pharmacy label*			Week 1	Week 2	Week 3	Week 4
		Date				
		Time↓ Day→				
QTY	Date					
Sign	C.F	R/Balance				

Practitioner Notes

R = Refused	A = Absent	N = Nausea/vomiting	H = Hospital	O = Other (see over)	P= Prepared	NR = Not Required

Date	Time	Name	Medication	Notes/Reason	Signature

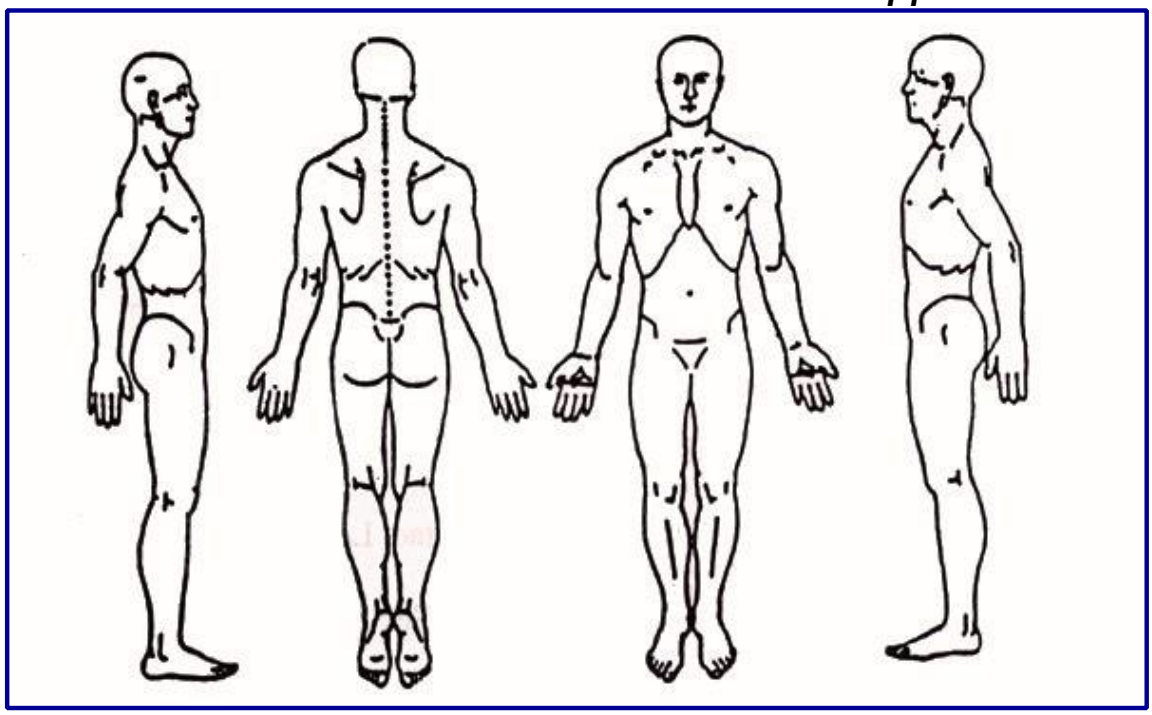
APPENDIX B Recording Topical Medicines (Body Map)

Recording Topical Medicines

Patient name:_____ D.O.B:_____	Name of Topical Medicine:_____ Strength:_____

Record of Observations	Date	Initials

Shade where the medication has been applied



- Hygiene and infection-control procedures are vital
- Ensure your hands are washed before and after administration and gloves are worn
- Follow prescribers directions and clarify, if applicable (e.g. as directed)
- Note any special precautions (e.g. apply sparingly/thinly for steroid creams/ointments)
- Record accurately on MAR chart

Note any observations or special storage requirements below (e.g. keep in fridge, discard after 28 days etc)

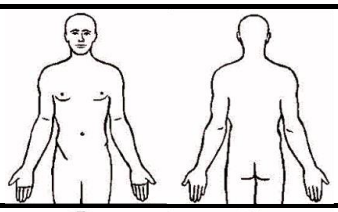
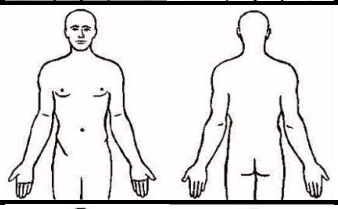
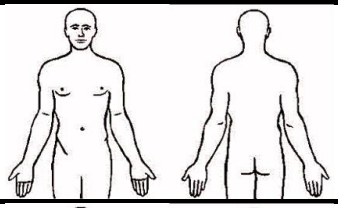
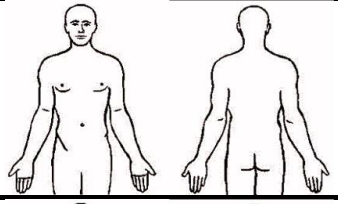
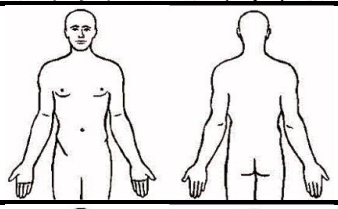
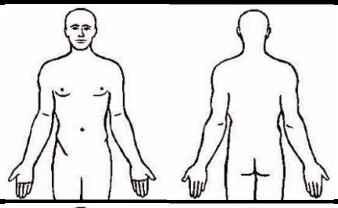
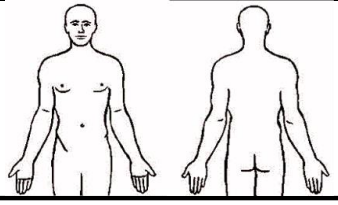
Service User Name	
DOB	
Name of Topical Product	
Type of Product (e.g. Lotion/Cream/Ointment)	
Directions (as prescribed)	
Special Instructions/Additional Notes	

Morning			Lunch			Dinner			Night		
Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Transdermal Patch Application Chart

Patient name:_____	**Name of patch:**_____
D.O.B:_____	**Patch Strength:**_____

*Put a cross **X** where the patch has been placed*

	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	**1**
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	**3**
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	**5**
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	
	Date applied: _____ Signature:_____ Date removed: _____ Signature:_____	**7**

Patch disposal: The used patch should be folded in half, adhesive side in, and then disposed of safely according to the patient information leaflet and your care setting policy.

Procedure for the use of Transdermal Patches

These patches are applied to the skin and they have a "systemic" effect, not a "topical" effect, i.e. the medicine they contain is absorbed directly through the skin into the bloodstream.

Preparation

As with other medicines, after making all necessary preparations (including the "6 rights" and checking guidance in the information leaflet supplied with the patch) ensure all instructions & warnings are understood, before proceeding. Emphasis must be placed on the following:

Action	Reason
Wash hands with soap & water then dry thoroughly, before & after the procedure	To prevent cross infection & contamination of service user, carer & product
Assemble all necessary medicines & equipment before starting	Have everything ready so that the procedure doesn't get interrupted
Wear disposable gloves prior to applying patches	For hygiene and protection of service user, carer and product
Patches look similar to plasters and are applied in much the same way. It is essential to read the information leaflet on where and how to apply	The leaflet gives important information – some patches must only be applied to specific areas of the body, e.g. below the waistline or to the upper arm.

Administration

Action	Reason
Ensure the skin is clean, dry and undamaged and apply the patch firmly just like a plaster; try not to touch the active centre of the patch	To ensure efficient systemic release of medication across the skin and to minimise the chance of side-effects

Vary the site of each new application. Patch application recording should include site of applications.	To avoid skin becoming sore from repeated application in the same place
Dispose of any removed patch safely by folding in half (so that the patch sticks to itself)	Follow guidance in leaflet & dispose of according to your policy or check with pharmacist
Remove protective gloves and wash hands thoroughly again after procedure is complete	Continuing correct hygiene to prevent cross infection etc.
Patches can be removed (with prescribers permission) if any side effects/adverse reactions occur	Always check (as with other medicines) before taking action

APPENDIX D

When Required (PRN) Medication Protocol

The assessor should obtain information on why the medication has been prescribed and how to give it from the prescriber, the supplying pharmacy or dispensing surgery or other healthcare professional involved in the treatment of the person and record this below. It may be used for additional information, or when the person is not able to indicate when they may need their PRN medication.

Persons name:		
Medication:	Strength:	Form:
Directions (dose and frequency):		
When should this medication be given?		
What should the medication do?		
What time gap should be left between doses?		
What's the maximum dosage in 24 hours?		
How long should the medication work for?		

When should GP or other medical advice be sought?	
Signed (worker completing form):	Name of healthcare professional information obtained from:
Agency Name:	Date:
Date protocol to be reviewed:	

APPENDIX E

Non-prescribed Medicine Authorisation

Complete this form with advice from the pharmacist or GP who supplies the person's regular medication. This form may be completed with advice over the telephone or via a face to face visit.

Name of Pharmacist (or GP)	
Address of Pharmacist (or GP)	
Date of conversation	
Person's Name	
Name of worker completing form	

Complete Section A OR B, then ALL of Section C

Section A: Request for specific medicine by person:	
Record the name of the medicine being requested:	
If the Pharmacist/GP recommends a different treatment, record this below:	

Now complete Section C

Section B: People who have not requested a specific medicine:	
Record the symptoms that the person has and wants treatment for:	
Record the name of the treatment that the Pharmacist/GP recommends here:	

Now complete Section C

Section C: Information about the non-prescribed medication	
Inform the Pharmacist/GP of all medicines currently taken by the person (you may obtain this information from their medicine chart or repeat prescription list) Initial the box to indicate this has been done	Initial:
Ask the Pharmacist/GP how long the person should take this treatment for before seeking further medication advice (record this here):	
Record the dosage directions here – the Pharmacist/GP may tell you to follow the directions on the container	
Ask the pharmacist/GP if there are any symptoms that would need you to seek further attention – should the service user develop these. Record these symptoms here:	
Record any other advice given by the Pharmacist/GP	

Once obtained, if the person requires administration of the purchased medication, it should be written into the daily care notes.

The name and form (tablets, capsules etc) and the dose given should be recorded in the daily notes.

Purchased medication should generally be for short-term use only. If required long-term, the GP's advice should be sought, unless otherwise directed.

APPENDIX F

DISPOSAL OF UNWANTED MEDICATION

Person's Name:	

I authorise that the following medications may be removed, and returned to the pharmacy or dispensing surgery for destruction:

Name of medicine	Quantity

Person's Signature:	Date:

If you are unable to sign this form, a representative may sign for you

Signature of representative:	
Relationship to the person named above:	
Print name:	Date:

For Pharmacy/Surgery use only

I confirm the medicines listed above have been handed over for safe destruction

Signed on behalf of pharmacy/dispensary:	Date:
Pharmacy/dispensary stamp:	

Clinical waste and used needles (sharps) must not be returned to the pharmacy

APPENDIX G Warfarin Medication Administration Form

28 Day Warfarin Administration Form

Name:		D.O.B:	
Address:			
GP/Anticoagulation clinic:		Phone No:	
Transcribed by:		Date:	
Countersigned:		Date:	

Date & Time	Dose prescribed (mg)	Dose frequency (e.g. daily)	No. of tablets administered								Signed
			0.5mg tablets (white)		1mg tablets (Brown)		3mg tablets (Blue)		5mg tablets (pink)		
			Quantity administered	Running balance	Quantity administered	Running balance	Quantity administered	Running balance	Quantity administered	Running balance	

This Warfarin form is intended to be used following Warfarin training. Information regarding Warfarin is recorded in more than one place so it is very important that the information is correct and up-to-date in all places that it is recorded.

Dosage Information - INR Testing

Date of INR test	INR result	Dosage (mg)	Date of next INR test	Recorded by	Signed by