Cumberland Care Services

M4 Medication Policy and Procedures for Supported Living and Day Services

April 24

Contents

List of Appendices

Section 1:

Policy Details

Policy

To ensure all staff are fully aware of their roles and responsibilities when administering medication/creams, and to safeguard service users against the misadministration of medication.

Overview

The manual provides operational instruction to standardise and inform good practice about the Administration, Control and Disposal of Medication.

When dealing with medication there is always Health Professional involvement.
It is the overarching responsibility of a health professional to prescribe any treatment and /or medication to an individual. If an individual has capacity with regard to their treatment and /or medications, it is ultimately their decision as to whether they take them or want to seek further medical advice. For a person who lacks capacity their medication regime may be subject to a Best Interest Decision by health. Should a situation arise where there is a conflict between various prescribing health professionals, it is NOT for Care Services to make any decisions in this regard and further advice should be sought from either legal at Adult Social Care or the treating team / GP.

Managers Responsibility

For all services it is the duty and responsibility of the manager to ensure the safe administration of medication within the service. It is the STATUTORY duty of the registered manager.
Some service users are unable to manage their own medication or may wish to delegate some of the responsibility. In this instance the Manager will act as agent for the service user in enabling them to administer their medication appropriately within the prescribed guidance. The task of administering medication will be delegated to staff that have received training in Provider Services operational procedures in the Administration, Control and Disposal of Medication. It is the manager's responsibility to ensure staff are kept up to date with any amendments to this policy and training.

Supervisor Responsibility (Older Adults Residential)

Supervisors will be responsible for any ordering or returns of medication, the completion of audits and stock checks and the administration of controlled drugs.

Support Worker (Older Adults Residential)

Where support workers are required to administer medication as part of their contract and role profile, staff that do not feel confident or competent to administer medication will be able to 'opt out' during a period of 12 months following the implementation of the new staffing structures. It is expected that throughout the twelve-month period and following appropriate advice, support and guidance, Support Workers will be supported to be fully confident to administer medication. Support Workers will be provided with additional training and shadowing opportunities to support them becoming competent and comfortable in administering medication.

It is recognised that for some Support Workers it may never be safe for them to be able to give medication and a permanent opt out will be approved. This will be for specific reasons which will be confidentially discussed by the Support worker and their supervisor and Registered Manager of the home. It will be for the Registered Manager of each home to approve the permanent opt out position based on an assessment of ensuring safe and quality care is provided to all residents.

Value Statement

Service users must be encouraged where possible to, maximise personal control in safely administering their own medication.

Developed and Reviewed By

Following clearance by the Provider Services Senior Management Team and signed off at the Policy group.

Implementation and Reviews

Implementation date 12 May 2000
Reviewed; May 2002, July 2004, March 2005, May 2005, June 2006, July 2007, Sept 2007, Sept 2009, February 2012, May 2015, January 2017, April 2017 - Amendment Number 9, July 2018 Amendment Number 10, April 2019 Amendment Number 11.
Amendment Number 12, October 2019. Amendment Number 13, December 2021
Amendment Number 14, October 2022.
Amendment Number 15, February 2023.
Amended with Care Services information and Residential taken off Version: New Date 01/04/23

Section 2:

Training

It is the responsibility of the manager or supervisor(s) to ensure that staff required to administer prescribed medication (including creams) have received appropriate training and instruction in procedures and safe handling.

Only staff that have been trained and deemed competent in the medication/cream administration procedures can be authorised to administer service user's medication.

All staff training and instruction will be based on the agreed procedures within this Policy and Procedure and be directly relevant to service user needs.

Following M4 policy training face to face or eLearning two assessments by observation of competency must be completed to deem the member of staff competent.

Following all Health Care Task training face to face or eLearning one assessment by observation of competency must be completed to deem the member of staff competent.
Competency checks must be carried out as outlined in the annual competency document (Appendix 2 ACC)
All observations must be completed within 2 months of the training date. Only when training and assessments are completed is the member of staff competent to administer medication/creams. This must be recorded on the competent person record sheets (Appendix 1a CPR & Appendix 1b)
Appendix 1a and 1b must be used to record training dates and signatures.

Health care task training consists of prescribed creams, eyes, ears and nasal strays/drops, inhalers, transdermal patches, and support stockings.

The manager/supervisor must review and confirm on the competent person record sheet (Appendix 1a and 1b CPR) on a yearly basis that the member of staff is deemed as competent. An annual competency check (Appendix 2 ACC) must be carried out and this should also be recorded on the Competent Person Record sheets. Annual competency checks must be stored on the staff files (paper copy or electronic).

The manager/supervisor will arrange any further training needs as identified through observations / competencies.

Any specialist medication training should be person specific, and dates recorded on the training matrix and (Appendix 2 ACC)

Section 3:

Record Keeping

3.1 Medication Administration Records (MAR)

It is the responsibility of the manager, supervisor, lead support worker / support worker / senior support worker / and night support worker to ensure that a formal record of each individual service users prescribed medication, including patient information leaflets, is in place. (Appendix 3a, 3b and 3c MAR). *Good practice would be to store the patient information leaflets all together in an accessible file and available to all staff.*

On admission, new service users (including respite/interim placements) must have a list of current medication. This can be provided by the social worker, health professionals or families.

Every MAR chart should include the following information:

a) The service users name and date of birth
b) A current dated photograph of the service user must be held with the MAR chart.
c) Health professional name and the practice name
d) The date of receipt of the medication and the quantity received
e) Full medication details; name of the drug, date commenced, dosage form, strength, and route of administration
f) The times when the medication should be administered e.g., breakfast, lunch, or teatime. If the medication is to be administered at a specific time, then the 24-hour clock must be used e.g., 08:00, 17:00. If medication is only to be administered once daily, this should be allocated a time (e.g., breakfast, evening) so that it is clear who should take responsibility for administering this medication.
g) Details of any known medication allergies/sensitivities i.e., penicillin, aspirin
h) Any advisory information provided by the pharmacist i.e., only to be taken with food
i) All medication administered to the service user must be recorded on the MAR chart
j) If the medication or cream is delegated to another member of staff or a Health Professional, this must be clearly written on the MAR chart.
k) Medication the service user has refused, or any other reasons medication has not been given must be recorded using the appropriate key and must be recorded on the reverse of the MAR chart
l) Date the medication was stopped or changed
m) All entries must be clear and legible, in capital letters and preferably in black ink.
n) When using a Provider Services MAR chart, this must be completed/checked /signed, and dated by 2 people (one of which must be a manager/supervisor in an older adult's residential service).
o) All amendments / changes to the document must be completed immediately and signed for by two people. (In lone working services; where it is necessary to change/amend a document, it must clearly state “lone working” and detail written on the reverse of the MAR chart).
p) A new chart should be completed each month / 4-week period

Where a service user has custody and control of their own medication within the service (fully self-administers), this must be recorded on their Person Centre Care Plan. There is no need to complete a MAR chart unless staff are reminding the service user to take this medication. In this case, staff should record on the MAR chart using the key ‘S’ for self-administered.

All MAR charts should be kept in a ring binder clearly marked – Medication Administration Records. Completed records must be retained for a period of six years on a rolling basis.

3.2 Medication Received and Returned Form

All medication recorded on a Provider Services MAR chart should also be recorded on a Received and Returned Form (Appendix 4 RRT) by the manager or delegated person. on. Each item should be recorded on a separate RRT form along with the name of the service user for whom they were prescribed. ed. Medication returned to the pharmacist or home must also be recorded on this form. If returning medication to the pharmacy for disposal, a signature from the pharmacy/collector verifying this must be obtained.

When using a pharmacy MAR chart, received, and returned information must be recorded on the original pharmacist MAR chart.

Older Adults Residential must use the MAR chart (whether pharmacy or Provider Services MAR chart) to record the quantity received and the quantity returned/destroyed. An RRT form is not necessary unless the service user takes their medication out of the building.

In Older Adults Residential, all returns of medication will be completed by the supervisor.

It is good practice for 2 people to be present when booking in/out medication.

3.3 Medication Receipt into Day Services

Where possible medication received in day services should be supplied in amounts measured to last no more than one week at a time.

All medication should be received in the original containers as supplied by the Pharmacist.

Medication must always be received in the Pharmacists original container.

Accommodation staff / families receiving dispensed medication, which are for specific use in day services, should be asked to inform the pharmacist of the service user's planned day service attendance and when possible, obtain separately dispensed medication for provision to day services (e.g., for lunchtime only medication).

Before sending medication to the day service, accommodation staff / families should ensure that the medication is accurately dispensed according to the original prescription or directions from the Health Professional.

Local arrangements must be made for the safe transfer of medication between services and home. This is normally the responsibility of the Adult and Local Services department or the family / carer.

3.4 Handling of medication by Medical Professionals (Prescribing recognised registered practitioner)

All medication handled by the District Nurse but held in stock by Provider Services establishments needs to be recorded on the RRT Form (Appendix 4) or Pharmacist MAR chart.

It is good practice that the health professional who administers medication to a service user, records, and signs on the MAR chart.

Any controlled drugs administered by a Health professional must be signed for in the controlled drugs book and the controlled drugs procedure followed.

If medication is administered by CHOC (Cumbria Health on Call), details of the medication administered must be entered onto the MAR chart and signed for where appropriate.

3.5 Information Transfer to Other Services

Where a service user's Person-Centred Care Plan requires that they be discharged from the unit / service, all the information contained on the MAR must be photocopied and kept. The original MAR must be forwarded to their next place of care.

If a service user is admitted to hospital staff must follow the H2 Hospital admissions procedure.

3.6 Patch Based Medicine

A risk assessment must be completed for the service user prescribed transdermal patch medicines. The risk assessment must be completed using the information in the service users care/support plan and the patient information leaflet.

For the administration of a controlled drugs patch you must follow Section 10.

Where a service user has a prescribed patch medicine, a Patch Application record should be kept with the MAR chart and completed in full. This can be either a pharmacy patch record or Appendix 13 Transdermal Patch Application Record.

On each shift staff must check that the patch is still in place and record this on the Appendix 14 Transdermal Patch Visual Check Record. If there are any concerns, this should be recorded and reported immediately. The record should be initially completed at the same time as the patch record (appendix 13), so they correspond with each other.

Removal / Disposal

Controlled Drug (Patch) – When a patch is removed it must be folded in half (adhesive sides together) and then placed in a clear plastic zip bag. The bag must be labelled with the service user's name, name of patch and the date it was removed.

The bag must be stored within the controlled drugs cupboard / safe until it can be returned to the pharmacy.

Patches must be booked out using either the RRT form or the Pharmacy documentation to provide a clear audit trail. For the return to the Pharmacy the zip bag must be placed together in an envelope clearly marked "Controlled drug."

Non-Controlled Drug (Patch) - When a patch is removed it must be folded in half (adhesive sides together) and then placed in a clear plastic zip bag. The bag must be labelled with the service user's name, name of patch and the date it was removed.

Non controlled drug must be held securely with general returns and must be booked out following the returns process in section 11.

Section 4:
Compliance with Prescribed Instructions

4.1 Containers

All medication must remain in the pharmacist's container until it can be directly administered to the service user following the instructions. Medication must be dispensed from a pharmacy filled compliance aid or directly from the original prescribed pharmacist's container. Any other practice would be deemed as secondary dispensing and is illegal under the Poisons Act 1972.

Provider Services staff are not permitted to mix suspensions.

4.2 Labelling

All medication must be clearly labelled with the service users name and medication details. If a label becomes detached from a container, or is illegible, the advice of the pharmacist must be sought before any further dispensing occurs.

"As directed" cream instructions can be accepted if there has been clear guidance provided from the health professional. This can be in writing (fax, email or using appendix 16). Full instructions should be included on the service user daily notes (as a record) which should include the time, date and who gave the instructions. The written confirmation must be kept with the MAR chart. Where possible and as soon as possible, this should be followed up in writing.

4.3 Changes to prescribed medication

No change of medication shall take place without the authority of the Health Professional or Consultant concerned.

Where a Health Professional or Consultant changes the dose of medication to be administered, alterations must be entered onto the service users MAR chart by the manager/supervisor or designated individual. Alterations must be written clearly and dated onto the containers and MAR charts immediately. Any changes will need to be forwarded to the pharmacy for information.

In the event of any changes being given (via a phone call) by the service users health professional, these changes must be confirmed in writing and the date and time they are received must be recorded. This record must be kept with the MAR chart.

In exceptional circumstances, where there is a change, staff must clearly record in the diary / communication books; the date, time, who they spoke to about the change and the detail of the change.

Written confirmation may be in the form of a copy of the health professional note or letter, a fax or email, a copy of the pharmacy MAR chart or a copy of a new prescription. If no other information is available, new medication received in the original pharmacist's container with clear labelling will also be acceptable.

If a service user accesses more than one Provider Services Service, details of the authorised changes must be given to all services. The Changes to Medication Information form (Appendix 5 CMI) may be used.

4.4 Non – compliance

Concerns regarding the medication prescribed to a service user should be discussed with the service user and prescribing health professional. It is the right of a service user to refuse to take their medication.

Non - compliance with medication must be recorded on the MAR chart (and detailed on the reverse) and communicated to colleagues in order that they can monitor and observe the service user closely.

a) Non-compliance must be recorded in the communication book and/or the daily diary.
b) Other agencies or families must be informed if people are transferring between services and home.
c) If a service user refuses to take their medication, the patient information leaflet must be consulted and instructions for missed doses must be followed.
d) The health professional may need to be consulted.
e) All actions must be recorded.

Section 5:

The Administration of Medication

5.1 Administration Procedure

Administration of medication will only be carried out by trained competent staff. The Manager / Supervisor will take responsibility to ensure support workers are competent and feel happy to undertake the medication tasks required. This will be an ongoing process for staff requesting additional assistance at any time.

The following procedures must be followed at all times:

a) Hands must always be washed prior to administering medication.

b) Staff must provide medication to the person from a locked container/trolley/provision, which must be kept secure at all times i.e., whilst administering – either locked or in full sight.

c) If medication is supplied in blister packs (all tablets in 1 pocket), a description of each tablet should be available.

d) Staff must ensure they are prepared with medication pot(s) and spoons.

e) Unless a service user has been prescribed medication for sleep purposes the service user can and must be awakened to be given their medication (unless specifically stated in their care plan).

f) Carefully check the identity of the service user against the details and the photograph at the front of the service user's MAR charts.

g) Read the MAR chart and dosage instructions. Note any recent changes in medication and ensure that the medication has not already been given. (Check the MAR chart and PRN recording form).

h) Identify the appropriate medication container(s) checking that the label(s) and MAR charts match. If there is a discrepancy do not administer the medication. Check with the pharmacist and inform your manager or operations manager.

i) Staff must wear disposable gloves when handling any medication or applying creams, lotions or drops

j) Administer the medication as agreed in the service user's person-centred care plan and directed on the MAR chart. To the best of your ability observe that the medication has been swallowed.

k) The administration records must be signed immediately by the person giving the medication to the service user and not at the end of the medication round. This recording will take the form of initials in the appropriate column.

l) If the medication has been refused or wasted this must be recorded on the MAR chart using the appropriate key and an explanation recorded on the reverse of the MAR chart. Where a medication has been prescribed as PRN (when required), reference must be made to the service users PRN protocol and/or Person-Centred Care Plan, where clearly defined administration guidelines will be recorded.

m) Where Controlled Drugs are to be administered the Controlled Drug procedure will be followed (Section 10).

n) Where a non-prescription medication needs to be administered, this must be entered onto the service users MAR chart (See section 5.3).

o) In exceptional circumstances and with the agreement of the Manager, if a service user refuses to take their medication from the member of staff responsible for administering the medication, it can be requested that another member of staff assists with this. The responsible person must closely observe this process and will remain responsible for the administration of the medication at all times. This needs to be detailed on the reverse of the MAR chart.

p) Where identified in the person-centred care plan, the service user requires a longer time to take/ingest their medication i.e., laxido or calcichew; this task can be delegated to a support worker who will ensure it is taken. It still remains the responsibility of the administrator to sign the MAR chart and both staff must sign the reverse of the MAR to confirm this.

q) A thorough visual check of the MAR charts and the pharmacy filled compliance aids should be made at the end of each medication round to ensure medication has been administered and recorded in accordance with this policy and procedure.

r) Tablets can only be halved where there is a break line, and the full tablet is being administered. (Gloves must be worn).

s) Crushing tablets must be approved by the GP. Written confirmation must also be in place from the pharmacist to confirm that the effectiveness of the medication is not compromised.

5.2 Exceptions to the procedure for the administration of medication

Food Supplements / additives

- Food supplements and additives e.g., Fortisip, Ensure, Thick and Easy etc., do not need to be stored in the medication cabinet / trolley but the thickeners must be stored in a lockable facility.
- Instructions for their use must be followed and must be recorded in the Person-Centred Care Plan and / or in the medication file.
- Thick and Easy type supplements do not need to be signed for or recorded unless there is a specific need to do so as identified in the Person-Centred Care Plan.
- Other nutritional supplements / additives should be recorded on either the MAR chart, Fluid Monitoring Chart, or the Weekly Monitoring Food Intake Chart.

Creams / lotions / mouthwash / toothpaste etc.

- Creams / lotions / mouthwash / toothpaste etc, do not need to be stored in the medication cabinet / trolley. Instructions for their use must be followed and must be recorded in the Person-Centred Care Plan and / or in the medication file.
- A MAR chart for creams (Appendix 3c MAR) must be completed for each cream unless the pharmacy has provided the MAR chart including a body map.
- It is good practice and supports person centred approaches to keep the MAR chart and the prescribed cream (and PRN protocol if used) together in the most convenient location for their use, e.g., in a service user's bedroom or own bathroom. If creams are being stored in communal bathrooms; they must be stored securely and in a way that complies with the Infection Control Policy. All documentation and the cream must be checked before any application. A PRN recording form for creams is not necessary as long as all the details are fully completed on the MAR chart. You may however need a recording form if specific times between applications are needed.
- Cream, lotions etc. should be clearly marked with the date first opened and with the required disposal date/use by date (see patient information leaflet for this information). If the box is discarded, ensure the dates are added to the cream prescription label.
- Any flammable cream, ointment, or gel, which has been prescribed to a service user must have a completed risk assessment in place.
- It is not necessary to seek the advice of the GP or pharmacist to apply non-medicated creams; emollient creams, sun creams, moisturisers, and beauty products, if the service user purchases them and has used them before. These preparations can be used as part of the personal care routine. The supervisor should include information of the application, frequency, and reactions etc in the support plan. The support worker should record all assistance given in the communication sheets / diary. The service user should purchase their creams which should be labelled with their name and date of opening / expiry date added.

5.3 Non-Prescription Medication (Homely Remedies)

An up-to-date list of non-prescription medication (homely remedies) suitable for the service users within the unit can be obtained from the pharmacist to treat minor ailments.

The manager or supervisor is responsible for ensuring that appropriate consultation takes place with the service users prescribing recognised registered practitioner prior to administering any homely remedies. All non-prescription medication (homely remedies) can only be given with the consent of the service user and agreement of the prescribing recognised registered practitioner. A consent form must be completed (Appendix 8 NPM) and stored with the MAR charts. This form must be reviewed at least annually or when any medication changes occur. Any non-prescription medication (homely remedies) not on the agreed list on appendix 8 cannot be given without consultation with the service users prescribing recognised registered practitioner.

Where a non-prescription medication (homely remedies) has been purchased by a service user and is for their exclusive use; the medication must be clearly labelled with the individual's name and entered onto the individuals MAR chart (and RRT where needed). This medication must not be used for any other person.
Any concerns staff have about service users purchasing and taking medication inappropriately must be discussed with the service user and Line Manager and a review arranged (if necessary).

All administration of non-prescription medication (homely remedies) will follow the prescribed administration procedure and a PRN protocol must be completed in order to guide staff when to administer. (See section 9 for PRN details).

5.4 Offsite Procedure

Whenever the service user leaves the establishment, it must be confirmed with a competent person that appropriate medication has been taken with them according to the information on the individual service users MAR chart. Medication should remain in the prescribed container and should be administered at the correct time unless agreed with the Health Professional otherwise. All medication should be carried in a locked carrier.

MAR charts should accompany service users on offsite activities and administration must be in accordance with Section 5.1 above.

RRT forms (Appendix 4) must be completed when taking medication off the premises and re-completed on return. PRN protocols should also be taken on any off-site activities.

5.5 Stock Checks

Stock checks must be conducted once per week. Managers and supervisors are responsible for carrying out random stock checks.

At least 10% of the service users who take medication should have their stock of medication checked once per week.

Any medication in the benzodiazepine family e.g., diazepam, lorazepam, etc., which is not stored in a pharmacy filled compliance aid must be stock checked weekly.

A cross check between the MAR charts and all medication held should be made. Staff need to demonstrate a stock check has taken place. Good practice would be to complete the bottom row of each profile box on the MAR chart with the quantity of stock and detail (date, time, and staff initials). Example below:

Cumbria Care MAR Page 1 of 2 — M4 Appendix 3b M

NAME: JOE BLOGGS — D.O.B 23.04.1932 — START DATE OF MAR: 01.07.2016

ADDRESS: PETTERIL HOUSE, CARLISLE — ALLERGIES/ADVISORY INFO: NONE KNOWN

DOCTOR: DR JEKYLL, HARRABY SURGERY

Medication Profile: PARACETAMOL 500MG TABLETS — TWO TO BE TAKEN FOUR TIMES DAILY

Time/ Dose	Week 1							Week 2							Week 3							Week 4						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MORN	ST	JE	PR	PR	PR	SI	SI	LH	LH	JR	SE																	
NOON	SI	JR	PR	PR	PR	ST	ST	LH	LH	JR	JR																	
TEA	PR	LH	LH	LH	ST	JR	JR	PR	PR																			
BED	PR	LH	LH	LH	ST	JR	JR	PR	PR																			

Stock Check (14) JR 11.07.16

Commenced: 04.01.15 — Route: ORAL

Quantity Received: 224 — By: JR LH — Date: 28.06.16

Quantity Returned/destroyed: By: Date:

Medication Profile: FUROSEMIDE 20MG TABLET — TAKE ONE DAILY

Time/ Dose	Week 1							Week 2							Week 3							Week 4						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MORN	SI	JR	PR	PR	PR	ST	ST	LH	LH	JR	LH																	

Stock Check (17) JR 11.07.16

Commenced: 04.01.15 — Route: ORAL

Quantity Received: 28 — By: JR LH — Date: 28.06.16

Quantity Returned/destroyed: By: Date:

Medication Profile: SENNA 7.5MG TABLETS — TAKE ONE OR TWO AT NIGHT WHEN REQUIRED — C/F 4

Time/ Dose	Week 1							Week 2							Week 3							Week 4						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
BED		LH		LH	ST			JR	PR																			

Stock Check (50) JR 11.07.16

Commenced: 31.12.14 — Route: ORAL

Quantity Received: 56 — By: JR LH — Date: 28.06.16

Quantity Returned/destroyed: By: Date:

Section 6:

Medication Storage

6.1 Storage Units

Medication should be stored and administered from locked wall mounted cupboards or trollies which will be held on the units or in a secure location and must be kept secure during the administration procedure. In cases where Service Users are responsible for the custody of their own medication, provision should be made for a secure facility (cupboard / drawer) for the secure storage of medication. Service users who live in supported living must be encouraged to hold medication securely. Each case should be dealt with individually.

The cupboard, trolley or carrier should, where possible, be locked in a room not generally accessible to service users or visitors and where possible locked securely to a fixed point. These should be used exclusively for the storage or dispensing of medication.

Where possible medication for internal use and external application must be segregated into different compartments within the medication cupboard, trolley, or carrier.

Controlled drugs must be stored in a separate metal locked compartment within the medication cupboard.

Storage room temperatures for medication should be below 25˚c. This should be recorded daily on the Room Temperature check sheet. (Appendix 7a RTC) and action taken where needed. A risk assessment should be completed in Supported Living Services to identify the appropriate storage area. The form should be completed if an issue was identified.

6.2 Refrigerated Medication

A separate lockable refrigerator should be available for the exclusive storage of refrigerated medication only. In Supported Living Services, individual arrangements would be made, and a temperature check sheet used if required.

Temperatures should measure between 2˚c and 8˚c (NHS guidelines). Fridge temperature checks should be carried out daily and recorded on the Fridge Temperature check sheet (Appendix 7b FTC). Any issues need recorded, and actions noted on the check sheet. In the event of malfunction with fridges, advice must be sought from the pharmacist before dispensing the medication.

6.3 Keys

Keys for all medication cupboards / trolleys / provisions should only be issued to staff that have the delegated responsibility for the administration of medication in the establishment. Keys for the controlled drugs cabinets must only be issued to staff that have the delegated responsibility. Where there is a designated Medication room, the keys or fobs are the responsibility of the manager/supervisor.

Designated holders must ensure keys or fobs are kept secure at all times. A written record must be kept reflecting who is responsible for the keys whilst on duty.

Spare keys or fobs for the medication cupboard (including controlled drugs) or trolley should be kept in a secure place by the Manager and separate from other keys. It would be good practice to keep the controlled drug key separate from the main keys in a secure place.

Section 7:

Self-Administration of Medication

(Only to be used where service users have capacity)

7.1 Self-Administration of Medication

(All Services with the exception of Older Adults Day Care)

Service users must be encouraged to, and be supported in, maximising personal control in administrating their own medication. Prior to, or on admission, service users must be asked if they wish to be in control of their medication.

If they wish to continue administering their own medication, this should be recorded on a Self-Administration of Medication Risk Assessment (Appendix 10 SAM) which must be fully completed before self-administration commences.

The following people may be consulted as appropriate: service user, Health Professional, family, social worker, carers, CPN, Advocate or consultant.

On completion of the assessment, a decision must be made regarding the service user's suitability to self-administer. A decision regarding suitability should be reached through analysis of information contained within the risk assessment.

Information regarding self-administration (whether all medication or just some of their medication) should then be entered onto the service user's Person-Centred Care Plan together with clear guidelines that identify any special requirements and the appropriate level of support required to enable the individual to exercise maximum control.

7.2 Monitoring

(All Services with the exception of Older Adults Day Care)

Staff may need to have access to the service user's lockable facility where the Person-Centred Care Plan, risk assessment, and level of monitoring required indicate that this is necessary.

If it has been identified that Provider Services are responsible for re-ordering the service user's medication, the agreed level of monitoring should ideally be a maximum of 21 days to enable staff to re-order medication in. me.

Where monitoring reveals that compliance is poor**,** an emergency review, involving all relevant parties should be arranged to discuss concerns and agree the most appropriate course of action.

The agreed outcome of this review must be recorded on the service users Person Centred Care Plan.

Any changes in the person's ability to self-administer must trigger an immediate review.

7.3 Self-Administration of Medication (Older Adults Day Care)

Where people are deemed to have capacity, the MM1 or MM2 (Medication Management) will identify that the service user is capable of administering their own medication.

This must be recorded on the Person-Centred Care Plan. The service user must be made aware that they are responsible for the safety of the medication during their time in the Day Centre.

The Person-Centred Care Plan should specify if any help is required to open bottles/packs etc.

If there is a change in the service user's ability to self-administer, the Social Worker must be notified. A referral should be made to the nominated Social Worker or via customer services.

The Person-Centred Care Plan must be updated to record these changes.

The Person-Centred Care Plan will also indicate if family/carer/relevant others need to be contacted.

Section 8:
Specialist Medication Procedures

8.1 Definition

A specialist treatment prescribed by their Health Professional that is outside the usual administration, practice and procedure and is known to have implications for health and safety.

Managers or supervisors must seek advice and support to ensure safe practice and they must ensure staff are appropriately trained by, for example, the district nurse, Health Professional, community nurse (DMH). Any in-house training provided must be entered onto a course register and all delegates must sign. This register must be sent to LD Admin.

For any such treatment, particularly where it may be deemed to be invasive e.g., rectal diazepam, gastronomy tube (peg feeding), nebulisers, oxygen, Buccal Midazolam, all types of drops, insulin, blood sugar monitoring etc.

Health Call App – Health Call is an App that allows residential care homes to provide basic health monitoring information directly to their NHS colleagues using a secure portal. Delegated staff will be supported and trained in the safe techniques, procedures and use of any equipment required, so information can be provided in an accurate and timely manner when there a is concern.

8.2 Advice

Health and safety advice should be sought for some of the procedures, i.e., suitability of the environment for storage of any equipment, security, access, and any appropriate risk assessments.

8.3 Agreement

All specialist treatments must be recorded in the Person-Centred Care Plan prior to administration. Any additional staffing resources required should be considered before agreeing to support these treatments. Prior agreement should be sought from the service user, their carers, the Health Professional, social worker, community/district nurse and family members where appropriate.

8.4 Risk Assessments

Risk Assessments will need to be in place for some specialist medication procedures. For example; service users will need an assessment for Oxygen use.

8.5 Anticoagulants – Supported Living Services

From March 2008 all service users that are prescribed anticoagulants (in particular Warfarin) are entitled to specialist healthcare advice and support. It is the duty of the main care provider to ensure that this support and advice is received and carried out as follows:

a) Ensure the person and the service receives written and verbal information regarding their anticoagulant treatment
b) Make sure that the person receives a Yellow Book or INR information sheet and that the contents are understood
c) That the person has an “alert card” and carries this with them at all times
d) Ensure that regular blood monitoring tests take place
e) Ensure that the Yellow Book or information sheet is available when requesting repeat prescriptions or when receiving the medication from the pharmacist.
f) Maintain accurate records of changes to anticoagulant doses

g) Ensure that all changes to doses are confirmed in writing by the prescriber. This written confirmation should be attached to the MAR chart. Verbal instructions to change the dose should only be accepted in an emergency and must be backed up with written confirmation as soon as possible

h) When a dosage is changed, the current line on the MAR chart should be discontinued and a new line started clearly stating the new dose and commencement date / time.

i) If the person taking anticoagulants requires dental treatment, they may need a blood test up to 72 hours prior to this. The care provider must ensure that this is discussed with the dentist at least 3 days prior to the treatment.

8.6 Anticoagulants - All Day Services

If a service user is prescribed anticoagulants, it must be clearly stated in the Person-Centred Care Plan and the Health Action Plan (if appropriate), who will take the lead responsibility in the management of the anticoagulants. If day services are taking the lead, the process described above must be followed.

Section 9:

PRN Medication

(Pro-renata or as and when required medication)

When any PRN medication is prescribed a Protocol must be completed in full (Appendix 11 PRN)**.** Where an appendix 12 (PRN recording form) is required, a separate form must be used for each medication.

Patient information leaflets must be sought from the pharmacist to assist staff in completing relevant sections of the protocol, i.e., side effects or doses.

Any medication prescribed on a PRN basis (as and when required) should be entered into the service users MAR chart. PRN medication and the protocol should be reviewed and monitored regularly to ensure that there are no changes to the service users' condition/health needs and to monitor the use, need and outcome of the medication. This review must take place annually or sooner if required.

Where a PRN medication/cream has been required daily; this should be reviewed by a health professional.

If the individual transfers to another place of care, including home the carers must be informed verbally and in writing if PRN medication has been administered in order to provide safe further administration, for example to stop duplication of medication.

Only initials for the administration of PRN medication should be recorded on the MAR chart. A PRN recording form (Appendix 12 PRN Form) must be used to record all other details of the administration including the dosage administered and the date and time this took place.

A pain assessment tool might be appropriate to complete to assist staff in monitoring pain.

Section 10:
Controlled Drugs

Controlled drugs are prescribed medicines that are usually used to treat severe pain, induce anaesthesia, or treat drug dependence and they have additional safety precautions and requirements. Some people abuse controlled drugs by taking them when there is no clinical reason to do so. Controlled drugs are therefore subject to additional controls under the Misuse of Drugs Act 2001.

10.1 Recording

Controlled drugs should be recorded separately in a specifically designated bound book as well as on the MAR chart.

The controlled drugs book must be kept as an ***additional*** record of what drugs are received, administered and returned.
The controlled drugs book and medication must be audited weekly. The audit must be recorded on a separate line in red pen by two people.

10.2 Administration of Controlled Drugs

In Supported Living Services (where possible) it would be good practice to have 2 people.

In Older Adults Residential, only the manager, supervisor or night support worker can administer controlled drugs; trained support workers can be the observer and second signatory.

All other services must follow the procedure below:

a) Two staff **(must together)** go to the controlled drugs cupboard and check that the Control Drugs book and the actual stock held match before leaving the storeroom/store area.
b) Any discrepancies must be dealt with immediately and reported to the manager or operations manager.
c) Two staff **(must together)** take the medication in a locked container to the service user.
d) Two staff must check the MAR chart, controlled drug book and PRN protocol/PRN recording form (if required) before administering.
e) When both staff have observed the medication being taken, both staff must sign the controlled drugs book.
f) The administrator must also sign the MAR chart and any other relevant documents, i.e., PRN recording form and patch application record.
g) Two staff **(must together)** return the medication to the secure storage area.
h) All entries in the book must be in chronological (date and time) order
i) A separate page must be used for each controlled drug for each service user.
j) When medication changes occur, the previous record must be ruled off and a new page started
k) Liquid paper must not be used for alterations
l) Mistakes must be crossed through once so that the original entry can still be read. The mistake must be bracketed e.g. (mistake), and the mistake explained on the line below. This must be signed, dated and the time recorded.

10.3 Storage

Controlled drugs must be stored separately in a fixed metal lockable container within the main medication cupboard (if possible).

Metal lockable cupboards must meet the specifications relating to the Safe Custody Regulations 1973.

If a service user self-administers medication this must be kept securely.

Controlled Drug Books must be kept for three years from the date of the last entry.

10.4 Identification

Staff will be requested by the pharmacy staff to produce their Cumbria County Council official identification when collecting controlled drugs.

10.5 References

Controlled Drugs Books can be purchased from some local pharmacies, hospital pharmacies, or ordered through a bookshop.

Refer to a current British National Formula (BNF) or your pharmacist for information on which drugs are controlled (these changes regularly, so keeping a list locally is of little value).

10.6 Controlled Drugs Disposal

Where Controlled Drugs are no longer required, they should be returned to the dispensing pharmacy for destruction. Two people must witness the handover of medication to the pharmacy staff and enter their signatures in the Controlled Drug book.

If a controlled drug liquid medication has been prepared and then refused, this must be drawn into a syringe and returned (in the syringe) to the pharmacy. This must be clearly labelled with the service username, drug name and the reason(s) for the return. This must be witnessed and signed by 2 people.

Section 11:

Disposal of Medication

11.1 Disposal of Medication

Medication should be disposed of when:

- The expiry date has been reached
- A course of treatment has discontinued
- A dose of medication has been removed from the container but not taken by the service user.

NB In the event of a service user dying, all medication prescribed for the service user should be retained by the Unit for seven days in case the Coroner's Office requires them.

All staff are advised to use the pharmacy documentation in the first instance, otherwise use the Received and Returned Form (Appendix 4 RRT).

All outdated and wasted medication (tablet/capsule/cream) should be returned to the community pharmacy where the pharmacist will make appropriate arrangements for their correct disposal. These should be placed in a separate container i.e., envelope or small clear bag and clearly marked what the medication is and who it belonged to. Two people should witness the disposal i.e., CC support worker/supervisor and pharmacy using the RRT form, MAR chart or pharmacy documentation.

Medication found on the floor must be returned to the pharmacy. It needs to be labelled with dates, times and signed.

If a liquid medication has been prepared for administration e.g., put in a measuring cup, but is then refused by the service user, this must be disposed of by following the instructions on the Patient Information Leaflet or contacting the Pharmacy for further instructions. This must be witnessed by two staff members and signed for on either the reverse of the MAR chart or the RRT form (if used).

On returning medication to a pharmacy for disposal, the quantity must be logged, and a signature obtained. This should be recorded on the MAR chart or the Received and Returned Form (Appendix 4 RRT) if used.

11.2 Safe Handling and Disposal of Sharp Objects

Disposable syringes, needles and broken medication phials must be initially placed in the individual service users' Sharp's box prior to collection and incineration by a registered collector. In normal circumstances the District Nurse will monitor the need for a replacement sharps box. Sharps boxes should be replaced when 2/3 full. If necessary, consult with your pharmacist or Health Professional if a replacement box is needed.

Section 12:

Covert Administration of Medication

The procedure for 'What to do when a Service User who lacks capacity refuses their medication' once all other alternatives have been exhausted is as follows;

NB – Administering medication covertly should be an exceptional occurrence and not a common practice.

1. If a service user is regularly refusing their medication, Provider Services should contact Adult Social Care to request that they arrange a best interest meeting to discuss the medication arrangements.

2. However, in certain circumstances, covert administration may need to be considered to prevent a person missing out on essential treatment. Covert administration of medication is the practice of hiding medication in food or beverages so that it will be undetected by the person receiving the medication. It is sometimes necessary and justified to administer medication covertly **but should never be exercised with people who are capable of deciding about their medical treatment.** Covert administration can only occur where the service user has been assessed under the Mental Capacity Act 2005 and there has been careful assessment of the service user's needs by a multi-disciplinary team.

3. The views of everyone involved in the service user's care should be considered before the decision to administer medication covertly is approved.

4. A multi-disciplinary team (including the Service User's Health Professional, Adult Social Care, the care home Supervisor or Manager) and relatives of the Service User should assess (using Appendix 9 – Record of Decision to administer medicines covertly) whether the Service User has adequate mental capacity to understand if taking the medicines is in their best interests and that the medicine is essential to the Service User's health and well-being. This team must agree that the Service User lacks mental capacity (for example, some people with dementia) to make an informed choice about their medication. The team will then make a decision in the best interests of the Service User for medication to be administered covertly. All decisions will need to be taken in accordance with the Mental Capacity Act.

5. If the decision to covertly administer medication has been agreed, a DOLs authorization must be completed. If a DOLs is already in place for a different restriction and the need arises to administer medicines covertly, the DOLs must be re-applied for. (A DOLs form 10 review request form can be used).

6. At this stage, the Health Professional will need to review the medication to ensure the stability of the medicines and the best methods to be used.

7. The decision taken should respect any previous instructions given by the Service User and be recorded in the risk assessment and care plan with a date for review as capacity can sometimes fluctuate. Instructions for covert administration may include, for example, tablets to be crushed or medication to be used in liquid form.

8. Details of the assessment and those carrying out assessments of 'capacity to give consent' should be kept in the Service User's care plan.

9. Written agreement of the reasons for presuming mental incapacity, the decision to administer medication covertly, the action taken along with the names of all parties concerned should be obtained and documented in the service user's care plan.

10. The Supervisor should ensure that the multi-disciplinary meeting discusses and agrees a management plan for how medicines will be administered without the Service User knowing.

11. The Supervisor should ensure that clear written directions/instructions from the Health Professional are obtained and kept with the Service User's MAR chart. The care plan must be updated accordingly.

12. The Supervisor should ensure that a system is in place to regularly review whether covert administration is still needed. There may be occasions where the Health Professional puts a timescale on covert medication. This must be recorded, and a further best interests meeting may be required.

13. A review should be a minimum of a month and recorded on the Appendix 9. If there are any changes, all parties will need to review, amend, agree, and re-sign this form.

14. Water, juice / squash, jam, or yoghurt are generally considered to be appropriate options as vehicles for administration. Hot food or drink should be avoided. If diluted in milky drinks, it may not be possible to see if the medicine has solidified.

15. If it is necessary to give two or more medications at the same time, these must NOT be mixed in the same portion of drink/food (unless agreed in writing from the Health Professional). The medications must be given separately.

16. Do not use boiling water to dissolve tablets; the heat may affect the medication. In all cases, medication suspended or mixed with food/drink must be given immediately and it is important to make sure the total amount is taken.

17. This information and methods agreed for individual service users must be included in their person-centred care plan.

Section 13:

Reporting Misadministration of Medication and non-compliance with policies and procedures

Any member of staff who has observed or carried out errors in relation to the Administration of medication/ creams or the non-compliance of policies and procedures must report the matter immediately to their manager or service manager. Failure to report any errors may result in a fact-finding exercise and / or management interview.

In the event of a medication error being identified the following procedure must be followed immediately:

a) Contact the Health Professional or out of hours service immediately to clarify if there is any risk, to take advice on any necessary action and to ensure the safety of the service user. If the Health Professional cannot be contacted, call the pharmacist or pharmacy department at your local hospital for advice
b) Gather relevant information such as the MAR chart and corresponding documents.
c) Carry out an immediate stock check of the medication involved in the error
d) Inform the Manager and the Service Manager (if out of normal working hours inform the operations manager on call)
e) Notify the service users next of kin and/or carers as appropriate
f) For registered services, if the error has resulted in the need for medical intervention or has been an incident reported to/investigated by the police, inform the Care Quality Commission (CQC) by completing a notification form and informing the Safeguarding team.
g) Record the incident in the Events of Importance Log/ Significant Events Book.
h) Complete a Medication Error Report for the Service Manager to determine any appropriate intervention / action. (See Appendix 6). A completed copy of this should be placed on the service user's and the staff file.

Medication errors include any missed doses, giving medication to the wrong person, a missed signature or the wrong dosage being given. This list is not exhaustive – if in doubt consult your manager or the Operations Manager on call.

Any deliberate falsification of records could result in disciplinary action being considered.