THE MANAGEMENT OF MEDICINE IN CARE HOMES GUIDELINES

Version:	1.0
Approved By:	NHS Barnsley CCG Quality and Patient Safety Committee
Date Approved:	24/07/2014
Name of originator / author:	Chris Lawson, Marie Cook & Richard Staniforth
Name of responsible committee / individual:	Quality and Patient Safety Committee
Name of executive lead:	Richard Staniforth
Date issued:	24/07/2014
Review Date:	24/07/2016
Target Audience:	Staff working in Care Homes

Version No	Type of Change	Date	Description of change

Table of Contents

1. Introduction 3
1.5 Key Points 4
2. Purpose 5
3. The risks of not having these guidelines in place 6
4. Definitions 6
5. Principles 7
6. Roles and responsibilities 8
7. Monitoring the compliance and effectiveness of these guidelines 11
8. References & Resources 11
9. Review of these guidelines 12
10. Training & Competency 13
11. Reviewing Medicines 15
12. Prescribing Medicines 15
13. Obtaining Supplies of Medication 16
14. Dispensing & Supplying Medicines 19
15. Medication Administration Charts (MAR) 20
16. Storage of Medicines 28
17. Administration 30
18. Disposal of Medicines 37
19. Medication Labels 39
20. Record Keeping 39
21. Adverse Effects from Medicines and Medication Errors 41
22. Unidentified Medication 43
23. Administering of insulin, injections, enemas and suppositories or medicines needing to be administered via a percutaneous endoscopic gastrostomy (PEG) tube. (level 3 administration) 43
24. Over the Counter Medicines (Homely Remedies) 44
Appendices 45

THE MANAGEMENT OF MEDICINE IN CARE HOMES GUIDELINES

1. INTRODUCTION

1.1 NHS Barnsley Clinical Commissioning Group is committed to working together with local health providers to ensure the commissioning and delivery of high quality services for the people of Barnsley.

1.2 The Care Quality Commission (CQC) Outcome 9: Management of medicines, states that people using a service regulated by CQC:

1.2.1 Will have their medicines at the times they need them and in a safe way.

1.2.2 Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

1.3 This is because providers who comply with the regulations will:

1.3.1 Handle medicines safely, securely and appropriately.

1.3.2 Ensure that medicines are prescribed and given by people safely.

1.3.3 Follow published guidance about how to use medicines safely.

1.4 In line with the principles of Medicines Optimisation these guidelines aim to:

1.4.1 Set out the principles by which medicines are managed in line with standards and legal requirements.

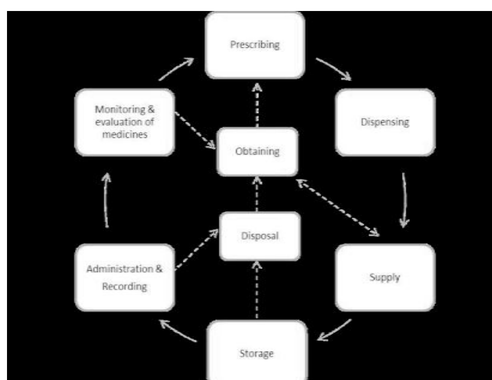
1.4.2 Ensure that all members of staff working within the home are aware of their roles, responsibilities and limitations.

1.4.3 Manage the risks that medicines can pose to residents and staff.

1.4.4 Ensure that residents receive their appropriate medication safely and effectively.

1.4.5 Provide a structured framework to enable lines of responsibility to be clear and comprehensible

Figure 1 Overview of the Medicines Management System



1.5 Key Points

These guidelines provide comprehensive guidance for all aspects of Medicines Management in relation to Care Home settings. They support the National Institute for Health and Care Excellence Guideline Managing medicines in care homes and Checklist for health and social care staff developing and updating a care home medicines policy. **Care home providers should have a care home medicines policy that includes written processes for:**

1.5.1 **Sharing information about a resident's medicines, including when they transfer between care settings**. Consideration should be given to; training requirements, the definition of responsibilities, overcoming communication problems and monitoring compliance to compliance with A guide to confidentiality in health and social care Health and Social Care Information Centre (HSCIC).

1.5.2 **Ensuring that records are accurate and up to date.** The policy should cover the recording of information in the resident's care plan, medicines administration record and correspondence and messages about medicines. It should take into consideration information required for the transfer of care even when the resident is away from the home for a short time.

1.5.3 **Identifying, reporting and reviewing medicines-related problems,** including a process for recording and reporting all suspected adverse effects from medicines, medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm. The policy should cover how incidents will be reported to the resident, their family and carers, how incidents will be investigated and how the results and any lessons learnt will be shared, both with the staff of the care home and more widely.

1.5.4 **Keeping residents safe (safeguarding),** how to identify incidents and concerns, who to notify and training needed by care home staff.

1.5.5 **Accurately listing a resident's medicines (medicines reconciliation),** including who to involve, responsibilities and training needs.

1.5.6 **Reviewing medicines (medication review)** identifying need and documenting the agreed frequency of planned multidisciplinary medication review.

1.5.7 **Ordering medicines** defining a safe, timely process, which ensures the maintenance of adequate stock of medicines whilst avoiding waste.

1.5.8 **Receiving, storing and disposing of medicines** responsibilities including necessary record keeping, who care home staff should obtain advice from and how to dispose of medicines. Determining the best system for supplying medicines (original packs or monitored dosage systems) for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible (see appendix 20).

1.5.9 **Helping residents to look after and take their medicines themselves (self-administration) including** when and how to carry out an individual risk assessment to find out how much support a resident needs to carry on taking and looking after their medicines themselves.

1.5.10 **Care home staff administering medicines to residents, including staff training and competence requirements.** The policy should give practical consideration of, for example, how to record medicines administration (including medicines administered by visiting health professionals or when there is a separate administration record), how to administer specific medicines such as patches, creams, inhalers, eye drops and liquids. What to do if the resident is having a meal or is asleep, how to record and report a resident's refusal to take a medicine. How to manage medicines that are prescribed 'when required' or have a variable dose. How to record and report administration errors and reactions to medicines

1.5.11 **Care home staff giving medicines to residents without their knowledge (covert administration)** considering the legal context including how to undertake an assessment of the resident's mental capacity, how and when to hold a best interest meeting recording proposals and assigning an appropriate review schedule.

1.5.12 **Care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.** Specifying a process for managing and administering non-prescription medicines and other over-the-counter-products (homely remedies) for treating minor ailments.

2. PURPOSE

2.1 These guidelines have been produced to clarify the responsibilities of care home providers. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2009) Regulation 2010 states that "The registered person must protect service users against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administrative and disposal of medicines used for the purposes of regulated activity." The compliance is monitored by the CQC's essential standards of quality and safety outcome 9.

3. THE RISKS OF NOT HAVING THESE GUIDELINES IN PLACE

3.1 The Clinical Commissioning Group (CCG) recognises that risk is integral within medicines themselves and in their use. Safe and effective use of medicines is thus an important aspect of risk management. The CCG will promote and adopt measures designed to minimise those risks. Measures will include:

3.1.1 Appropriate reporting mechanisms for incidents relating to medicines

3.1.2 Ensuring that lessons are learned from complaints and incidents.

4. DEFINITIONS

4.1 For the purposes of this guideline the term 'care home' covers the provision of 24-hour accommodation together with either non-nursing care (for example, a residential home) or nursing care (for example, a care home with nursing).

4.2 The term 'care home provider' is used for the registered provider of care. If regulation or practice differs between different types of care homes (for example, a children's care home, an adult's care home, a non-nursing care home or a nursing care home), then the type of care home is specified in the text.

4.3 When the term 'organisations' is used, this includes all commissioners and providers (including care home providers), unless specified otherwise in the text. Commissioners are those individuals who undertake commissioning which is 'the process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated'.

4.4 Providers are organisations that directly provide health or social care services (such as a care home).

4.5 Individual people who live in care homes are referred to as 'residents' or 'care home residents' in this guideline.

4.6 A 'care home' can be of any size (number of residents) or have any type of resident (children, older people, people with cognitive impairment, young disabled people, people with a learning disability), but should be a registered provider of care (for example, in England with either the CQC or Ofsted).

4.7 For the purposes of this guideline, the term 'care home staff' includes registered nurses and social care practitioners working in a care home.

4.8 The term 'carer' is used for an informal or unpaid carer.

4.9 The term 'health and social care practitioners' is used to define the wider care team, including care home staff (registered nurses and social care practitioners working in care homes), social workers, case managers, GPs, pharmacists and community nurses. When specific recommendations are made for a particular professional group, this is specified in the recommendation, for example, 'GPs'.

4.10 The term 'pharmacist' is used for all pharmacists, including primary care pharmacists, care home pharmacists and supplying pharmacists. Primary care pharmacists work in the primary care setting and may have a role working with care homes. Care home pharmacists have a dedicated role working in care homes. Supplying pharmacists work in a community pharmacy or chemist shop.

4.11 When a care home resident is able to look after and take their own medicines, this is referred to as 'self-administration'.

4.12 When the guideline refers to the administration of medicines, this is when care home staff check and give, or help to give, a resident their medicine(s).

5. PRINCIPLES

5.1 Health and social care practitioners should ensure that care home residents have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes, and that residents get the support they need to help them to take a full part in making decisions.

5.2 The health professional prescribing a medicine or care home staff should record a resident’s informed consent in the resident’s care record. Consent does not need to be recorded each time the medicine is given but a record of the administration should be made on the medicines administration record.

5.3 Care home staff (registered nurses and social care practitioners working in care homes) should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident’s care record and medicines administration record, unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.

5.4 Health and social care practitioners should identify and record anything that may hinder a resident giving informed consent. Things to look out for include mental health problems, lack of (mental) capacity to make decisions, health problems (such as problems with vision and hearing), difficulties with reading, speaking or understanding English and cultural differences. These should be taken into account when seeking informed consent and should be regularly reviewed.

5.5 Health professionals prescribing a medicine should:

- Assume that care home residents have the capacity to make decisions

- Assess a resident's mental capacity in line with appropriate legislation (for example, the Mental Capacity Act 2005 if there are any concerns about whether a resident is able to give informed consent)
- Record any assessment of mental capacity in the resident's care record

5.6 Health professionals prescribing a medicine should review mental capacity, in line with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice 2007, when a resident lacks capacity to make a specific decision. How often they do this should depend on the cause as this may affect whether lack of capacity fluctuates or is temporary.

5.7 Health and social care practitioners should ensure that residents are involved in best interest decisions, in line with the Mental Capacity Act Code of Practice 2007 and:

- Find out about their past and present views, wishes, feelings, beliefs and values
- Involve them, if possible, in meetings at which decisions are made about their medicines
- Talk to people who know them well, including family members or carers (informal or unpaid carers) and friends, as well as care home staff
- Deliver care and treatment in a way that empowers the resident to be involved in decisions and limits any restrictions to their care.

5.8 Care home staff should follow the rules on confidentiality set out in the home's process and training on managing information about medicines and only share enough information with health professionals that a resident visits to ensure safe care of the resident.

5.9 Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents.

5.10 All stakeholders should contribute to a strategy to improve the safety of residents and reduce medication errors in care homes in line with other local and national strategies and governance arrangements.

6. ROLES AND RESPONSIBILITIES

6.1 Commissioners

6.1.1 Commissioners should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.

6.1.2 Commissioners should review their commissioning arrangements with their provider organisations to ensure that any information about a resident's medicines that is transferred contains the information set out in recommendations. Commissioners should monitor this through their contracting arrangements.

6.1.3 Commissioners should ensure that requirements for reporting medicines-related adverse events, errors and safeguarding incidents are included in commissioning and contracting arrangements.

6.2 Care Home Providers

6.2.1 Care home providers should have a care home medicines policy, which they review to ensure it is up to date and based on current legislation and the best available evidence.

6.2.2 Providers should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.

6.2.3 Providers should have processes in place for sharing, accurate information about a resident’s medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital).

6.2.4 Care home providers must follow the relevant legislation to ensure that appropriate records about medicines are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

6.3 The Registered Care Home Manager

It is the Registered Manager's responsibility to:

6.3.1 Ensure that safe systems of ordering, receipt, storage, administration and disposal of medicines are in operation within the care home.

6.3.2 Ensure safe custody of all medicines (including controlled drugs) within the care home.

6.3.3 Ensure that a named member of staff is trained to take responsibility for management of medicines within the home, in their absence.

6.3.4 Recognise that medicines are the property of the resident, and they should be given the choice of controlling their own medication.

6.3.5 Ensure that all care staff involved in medication administration have received training appropriate for their level of administration, and competency assessments.

6.3.6 Ensure medication records are maintained and kept for the required period of time, in line with legislation and recommendations.

6.3.7 Ensure that there is a system in place to ensure adequate supplies of medication are always available.

6.3.8 Ensure systems are in place for the reporting of any incidents associated with medicines use, including the reporting of incidents involving controlled drugs.

6.3.9 Record all medicines-related safety incidents, including all ‘near misses’ and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these should be reported to the CQC (or other appropriate regulator).

6.4 Care home workers

It is the responsibility of care home workers to:

6.4.1 Follow the care plan and their policy.

6.4.2 Provide the level of support specified in the care plan:

- Level 1 support (which includes reminding/prompting residents who self-administer their medications) in accordance with the care plan and the resident's instructions.
- Level 2 support (which includes administration of medications) in accordance with the care plan and the prescriber's instructions

6.4.3 Follow the procedure for administration of medicines and the use of Medicine Administration Record (MAR) charts.

6.4.4 Record **Level 1** support in the **care record.**

6.4.5 Record **Level 2** medication administration/assistance on the **MAR chart** provided.

6.4.6 Be alert to factors which might pose a risk to the resident, and report concerns to the Registered Manager. If the Registered Manager is not available, concerns may be reported to the assistant manager on duty. Concerns reported may include the accuracy of MAR charts.

6.4.7 Immediately report any mistakes in the administration of medication to the Registered Manager or assistant manager on duty, including omitted doses.

6.4.8 Ensure that all medication errors are reported as incidents within 24 hours using the appropriate incident forms within the home.

6.4.9 Contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. An agreed process which sets out who to contact in normal office hours and out-of-hours should be followed.

6.4.10 Document refusal of medication by resident.

6.4.11 Care home workers are only accountable for medication they themselves administer or personally provide administration assistance.

6.4.12 Promote self administration where appropriate.

7. MONITORING THE COMPLIANCE AND EFFECTIVENESS OF THESE GUIDELINES

7.1 Compliance with these guidelines will be scrutinised and its effectiveness evaluated through a process of monitoring quality and incident reports and trends from these.

7.2 Information may be obtained from Barnsley Metropolitan Borough Council Care Home service specification contract outcomes reporting, Care Quality Commission compliance reports and ad hoc reports received from pharmacists and other healthcare professionals.

7.3 Training implications identified through this process will be reported.

8. REFERENCES & RESOURCES

8.1 Alldred, DP; Barber, N; Buckle, P (2009) Care Home Use of Medicines Study (CHUMS)

8.2 Care Quality Commission (2010) Essential standards of quality and safety - Outcome 9 - Management of Medicines

8.3 Commission for Social Care Inspection (2006) 'Professional Advice: medicine administration records (MAR) in care homes and domiciliary care'; April 2006

8.4 Commission for Social Care Inspection 'Professional Advice: Safe management of COs in care homes' January 2008

8.5 Commission for Social Care Inspection 'Professional Advice: Training care workers to safely administer medicines in care homes' August 2007

8.6 Department for Education (2011) Children's Homes: National Minimum Standards

8.7 Department of Health (2009) Reference guide to consent for examination or treatment (second edition)

8.8 Health and Social Care Information Centre (2013) A guide to confidentiality in health and social care

8.9 Health Foundation (2011) Making care safer: Improving medication safety for people in care homes: thoughts and experiences from carers and relatives

8.10 Ministry of Justice (2007) The Mental Capacity Act (2005) Code of Practice

8.11 National Institute for Health and Care Excellence (2014) Managing medicines in care homes

8.12 National Institute for Health and Care Excellence (2014) Checklist for health and social care staff developing and updating a care home medicines policy

8.13 Nursing and Midwifery Council (2007 amended 2010) Standards for medicines management

8.14 Royal Pharmaceutical Society of Great Britain (2007) The handling of medicines in Social Care

8.15 Royal Pharmaceutical Society (2012) Keeping patients safe when they transfer between care providers – getting the medicines right

8.16 Safety of medicines in care homes project (2013) Free resources for supporting the safe use of medications in care facilities

9. REVIEW OF THE GUIDELINES

9.1 These guidelines will reviewed be at the earliest opportunity following changes to guidance or service specification or after a period of 2 years should there be no relevant changes.

9.2 Members of NHS Barnsley CCG's Quality and Medicines Management Teams will be responsible for leading the review.

10. TRAINING AND COMPETENCY

10.1 The training provided for Registered Managers, Assistant Managers and care home workers must be provided by an 'accredited learning' provider incorporate the requirements of these guidelines.

10.2 The Registered Manager must ensure that a record of training for medication administration is available for every care home worker. This must include the date the training was completed and the name and signature of the trainer.

10.3 Annual competency assessments in medicines administration are to be completed for all care home workers. This annual competency assessment must be documented and signed off by both the care worker and the Registered Manager. This training record must be made available for inspection by authorised Quality Inspectors upon request.

10.4 There are 3 different levels of training for care workers:

10.4.1 Induction Training – providing Level 1 Support

10.4.1.1 Providing Level 1 support means that care home workers are able to remind, or prompt residents who self-administer their medications to do so at the appropriate time. Level 1 care home

workers **may not administer** medications to residents themselves.

10.4.1.2 All care home workers must receive level 1 (Induction) training. This training raises awareness of medicines management within the home, and identifies how the care home worker may offer support and those actions that the care home worker is not yet able to do before they have completed level 2 training.

10.4.1.3 Care home workers providing level 1 support with medication must clearly understand the limits of the support to be provided, and work strictly to the instructions within the individual residents care plan.

10.4.1.4 If care home workers identify that the resident requires a greater level of support, they must report this to the Registered Manager or assistant manager on duty.

10.4.1.5 All newly employed care home workers must provide documented evidence of any previous medicines management training. If this cannot be provided, the care home worker must receive medicines management training before any medicine administration can take place.

10.4.2 Basic training in safe handling of medicines- Level 2 Support

10.4.2.1 Care home workers must not be permitted to give level 2 support with medication until they have:

- Received training in medicines management
- Been assessed as competent by the Registered Manager of the care home

10.4.2.2 Competencies should be:

- Clearly defined
- Assessed consistently
- Re-assessed annually

10.4.2.3 The essential elements of level 2 training are:

a) How to prepare the correct dose of medication for ingestion or application.

b) How to administer medication that is not given by an invasive technique, including tablets, capsules and liquid medicines given by mouth; ear, eye and nasal drops; inhalers; and external applications.

c) Training on controlled drug administration. Care home workers required to 'witness' controlled drug administration must also have received this training.

d) The responsibility of the care home worker to ensure that medicines are administered only to the person that they have been prescribed for and to ensure that these medicines are given as prescribed i.e. the right dose, at the right time and by the right method / route.

e) Checking that the medication 'use by' date has not expired.

f) Ensuring that medication is being stored correctly (e.g. refrigerated products).

g) Checking that the medication has not already been given by anyone else.
h) Recognising and reporting possible side effects.
i) Recording refusals to take medicines.
j) How a care home worker should administer medicines prescribed 'as required', for example pain killers, laxatives.
k) What care home workers should do when people request non-prescribed medicines
l) Understanding the service provider's policy for record keeping.
m) How to report a medication administration, recording, storage or disposal error within 24 hours using appropriate incident forms within the home.

10.4.3 **Specialised training to give medicines- Level 3 Support**

10.4.3.1 Care home workers must not be permitted to give level 3 support with medication unless the task is delegated by a healthcare professional for an individual resident, who must train the care worker and be satisfied they are competent to carry out the task.

10.4.3.2 A record of such delegation must be retained by the care home and the nurse. This includes administration of medicines by rectal administration, injection, administration through a Percutaneous Endoscopic Gastrostomy (PEG) and giving oxygen.

10.5 **Record of Training**

10.5.1 Only care home workers who have received medicines management training incorporating the requirements of these guidelines, a period of supervision, and successfully completed the competencies detailed on the competency forms which must be signed off by the Registered Manager are authorised to administer medication. (Appendix 1 & 2)

10.5.2 Medicines management must be discussed regularly in individual supervision sessions and at staff meetings to check care home workers understanding on medicines management training and to provide support to individual care home workers. The Registered Manager should encourage staff to openly discuss any training needs which they feel have not been addressed during their period of training.

10.5.3 Weekly spot checks of MAR charts completed by newly trained care home workers are to be undertaken by the Registered Manager to ensure that the care home worker is competent in the medicines administration and recording procedure. The check will be a balance and signature check on the MAR chart and will take place for a period of one month. The competency form Appendix 1 should be completed as necessary.

10.5.4 If, at any time, the Registered Manager has concerns about the competency of a care home worker with regard to the medication procedure, they should follow the medication investigation within Appendix 15.

All medication has the potential to cause harm and so should be handled with care at all times.

11. REVIEWING MEDICINES

11.1 Arrangements should be in place to ensure patients who are residents in care homes have medication reviews as set out in the residents' care plans.

11.2 The reviews should involve the resident and/or their family members or carers and a local team of health and social care practitioners. The multidisciplinary team may comprise of identified named professionals from the following backgrounds; a pharmacist, community matron or specialist nurse, such as a community psychiatric nurse, GP, member of the care home staff, practice nurse or a social care practitioner.

11.3 The frequency of planned medication reviews should be recorded in the resident's care plan and should be based on both the resident's safety and their health and care needs. The interval between medication reviews should be no more than 1 year. Most residents will have their medication reviewed every six months.

11.4 During a medication review the following should be discussed and reviewed:

- 11.4.1 The purpose of the medication review
- 11.4.2 What the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand
- 11.4.3 The resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines
- 11.4.4 All prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
- 11.4.5 How safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
- 11.4.6 Any monitoring tests that are needed
- 11.4.7 Any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
- 11.4.8 Helping the resident to take or use their medicines as prescribed (medicines adherence)
- 11.4.9 Any more information or support that the resident (and/or their family members or carers) may need.

12. PRESCRIBING MEDICINES

12.1 GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for their patients who live in care homes.

12.2 Instructions should be provided on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate), so that this can be included on the medicine's label.

12.3 Prescribing should usually be based on a 28-day supply cycle for medication taken on a regular daily basis.

12.4 Records of prescribing should be made in the GP patient medical record and resident care record and making any changes as soon as practically possible.

12.5 The GP practice should have a system in place to ensure that the tests required for monitoring treatment are undertaken at necessary intervals.

12.6 The health professional prescribing a medicine, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines to ensure that residents in care homes have the same access to anticipatory medicines as those people who do not live in care homes.

12.7 Health and social care practitioners should work together and communicate to make sure that everyone involved in a resident's care knows when medicines have been started, stopped or changed.

12.8 Health professionals prescribing medicines should use telephone, video link, messaging or online prescribing (remote prescribing) only in exceptional circumstances and when doing so should:

12.8.1 Follow guidance set out by the General Medical Council or the Nursing and Midwifery Council on assessing capacity and obtaining informed consent from residents

12.8.2 Be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing

12.8.3 Ensure that care home staff understand any instructions

12.8.4 Send written confirmation of the instructions to the care home as soon as possible.

13. OBTAINING SUPPLIES OF MEDICATION

13.1 Ordering Medicines from a Community Pharmacy

13.1.1 The Registered Manager is responsible for ordering repeat prescriptions for residents from the GP practice and should not delegate this to the supplying pharmacy.

13.1.2 The Registered Manager should give the dispensing pharmacy full details of a resident's medicines (all regular medicines and "when required"- prn -medicines) as soon as possible / before prescription forms are sent for dispensing when:

- They initially take up residence.
- They return from a period in hospital.
- There is any change to the medicines prescribed

13.1.3 The care provider should present prescriptions to the pharmacy in sufficient time for the medication to be prepared and delivered in time to

start the new supply. The pharmacist will be able to tell you how long this will normally take. If the pharmacy is arranging for the prescription collection service it will include the time that the GP surgery needs to produce the prescription. This allows the pharmacy to order any medicines for which there is insufficient stock in anticipation of the prescription.

13.2 **Repeat Prescription Requests for the GP**

13.2.1 The Registered Manager of the care home must ensure that medication does not run out (most GP surgeries require at least 48 hours' notice to produce repeat prescriptions). If requests are posted to the surgery, at least 10 days should be allowed. All medication must be checked, including topical preparations, eye/ear drops and inhalers to ensure they are ordered when required. When stocks are becoming low, care home workers should alert the Registered Manager. Care home workers must also check the expiry date on medicines, for both those medicines currently in stock and those newly received.

13.2.2 Medication is re-ordered every 28 days. The Registered Manager or, in their absence, the assistant manager on duty is responsible for this task Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.

13.2.3 Care home providers should ensure that care home staff have protected time to order medicines and check medicines delivered to the home, the due dates are to be highlighted to ensure all care home workers are aware.

13.2.4 The current MAR chart must be checked for accuracy against the repeat medication form (attached to the previous month's prescription). Items required are 'ticked' off, adding any additional items. If a repeat medication form is not available, the care home's 'repeat prescription order form' should be used. (Appendix 4)

13.2.5 Stock levels of homely remedies should also be checked to maintain supplies for the next month. If there are sufficient medicines to last for the next month and they have not exceeded their expiry date, a new order must not be placed.

13.2.6 **It is unacceptable to return unused medicines each month to the pharmacy, and at the same time request more supplies.** Before disposing of a medicine that is still being prescribed for a resident, care home staff should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.

13.2.7 The original order sheet should be sent to the surgery, the care home must keep a copy of the order.

13.3 **How to check the prescription on return from the GP**

13.3.1 All newly issued prescriptions from the GP must be checked against the copies retained by the home. All details below must be correct:

- Personal details – name, DOB.
- Each medication -name, strength, form and dosage, frequency of administration and amount of medication

13.3.2 Any discrepancies must be completed on the 'Medication Ordering Discrepancy Form' and queried with the surgery in question. (Appendix 5). The outcome must be documented on this form.

13.3.3 The Registered Manager must complete the reverse of all prescriptions, signing and dating as required. A copy must be taken and retained by the care home. The original is then sent to the community pharmacy for dispensing.

13.4 **How to check medicines delivered from the community pharmacy**

13.4.1 The community pharmacy will deliver the dispensed monthly medication in locked cases which must be kept in a locked cupboard in the medication room until the contents have been checked in by the Registered Manager or nominated staff member. The community pharmacy must indicate if there is a refrigerated item in the delivery and this item must be checked in and refrigerated immediately. All medicines dispensed from a community pharmacy will have a pre-printed MAR chart with them.

13.4.2 All medication must be checked against the copied prescription and the current MAR chart. The current MAR chart should then be checked against the new MAR chart which came with the medication. All details below should be checked:

- Personal details – e.g. name, DOB, GP, any allergies, week commencing
- Each medication -name, strength, form and dosage of medicine
- Any specific instructions regarding storage or administration, e.g. store in fridge, take an hour before food etc
- The quantity of the medication received e.g. 28 tablets

13.4.3 If there are discrepancies, these should be recorded on the 'Discrepancy Form' and queried with the community pharmacy. (Appendix 6)

13.4.4 The amount of medication received must be entered in the appropriate box on the MAR chart, signed and dated by the Registered Manager, or the assistant manager on duty, of the care home. If the pharmacy does not deliver the full amount of medication, the Registered Manager, or assistant

manager in their absence, must follow this up with the pharmacy immediately and obtain an estimated date of delivery. **The resident must not be left without medication at any time.**

13.4.5 Resident's individual controlled drugs should be entered into the care home's controlled drugs book by the Registered Manager or assistant manager on duty and witnessed by a second person, who has had a minimum of level 2 medicine administration training. The controlled drugs book is a bound book with numbered pages and the entries should be made using a separate page for each person and medicine.

13.5 Obtaining acute medicines

13.5.1 When a prescription is written for a medicine that the person has not had before or does not take regularly, it is an 'acute' supply and must be started as soon as possible, and within 24 hours at the latest. Acute medication is usually for a limited time such as five or seven days (e.g. antibiotics). The Registered Manager or assistant manager on duty must contact the dispensing pharmacy immediately to arrange supply. If the GP is to supply the medication it must be in the original packaging, or have been packed down for use by a registered pharmacy, with a label for the GP to complete the name of the patient, date and any dosing instructions.

13.6 Verbal orders

13.6.1 The home must have a written prescription, signed by the prescriber, before the medicines can be given. In exceptional circumstances a prescriber may give a verbal order to give medicines, however they must authorise the change (by email or fax) before any new dose is administered. This must be followed up by the issue of a prescription, as soon as possible, usually within 24 hours of the verbal instruction (within 72 hours at weekends or over bank holidays). The form at Appendix 9 could be used to capture processing of verbal orders by the home.

13.6.2 Verbal orders are not appropriate for the administration of Controlled Drugs.

13.6.3 Text messaging should be used in exceptional circumstances only, for example, in life-threatening situations when no other option exists as sending of personal and sensitive information by text message may breach the requirements of NHS IT data security and lead to breaches of patient confidentiality.

14. DISPENSING AND SUPPLYING MEDICINES

14.1 Care home providers should determine the best system for supplying medicines for each resident based on the resident’s health and care needs and the aim of maintaining the resident’s independence wherever possible. If needed, they should seek the support of health and social care practitioners. A Comparison between monitored dosage systems and original packs is available in Appendix 20.

14.2 Supplying pharmacies should be requested to produce medicines administration records (MAR) wherever possible.

15. MEDICATION ADMINISTRATION RECORDS (MAR CHARTS)

15.1 Purpose of the MAR Chart

15.1.1 The MAR chart is the formal record of administration of medicines. It is required for all residents receiving level 2 or level 3 support with medicines and it is a useful tool in improving the quality of administration and it is therefore important that they are clear, accurate and up to date. It also may be required as evidence in clinical investigations and court cases.

15.1.2 MAR charts are not required for Level 1 assistance (where the care home worker reminds or prompts the resident to take their own medicines, but does not assist in administering the medicines). The episode of a resident self-administering their own medication must be recorded in the care record. Medication balances for those residents self-administering their medication must be checked on a monthly basis to ensure that residents are taking their medicines and that they have sufficient supply. This can also be discussed with the resident at their monthly review.

15.1.3 A MAR chart is a confidential medical record and should therefore not be kept where everyone can see it.

15.1.4 The MAR chart must provide an accurate account of the medicines being administered to the resident by the care home staff. It should document all prescribed medicines, including externally applied medicines and dressings with a legal classification of 'prescription only' (POM), if applied by a care home worker. Those applied by nurses will be recorded in the nursing record and in the resident's care home record to ensure that care home staff and other professionals (e.g. GP, tissue viability nurse etc) are aware of the nurse's medicine administration.

15.2 New residents and residents returning to the care home and MAR charts

15.2.1 For all new residents (long term, short term, transfer from hospital or inter-unit transfer within the home or unit to unit), medicines reconciliation should be completed by the Registered Manager. As part of a full needs assessment and care plan to ensure that all medication a resident is currently taking is accurately documented.

15.2.2 The Registered Manager must reconcile at least two **RELIABLE** sources of information available at the time. Sources might include, for example:

- A printed discharge summary
- Resident's supply of labelled medicines
- Discharge prescription
- GP summary

- Repeat prescription
- The resident/carer
- MAR chart

15.2.3 Resident-held records should be checked where applicable e.g. warfarin, methotrexate.

15.2.4 The Registered Manager must ensure that the medicines are suitable for use by checking expiry dates and that the pharmacy issued labels attached to the medicines show the resident's name etc. Unfamiliar medicines or doses must be checked and unusual doses should be confirmed with the appropriate prescriber or pharmacist before writing on the MAR chart and before administration of the medicine takes place. Where medicines are labelled 'as directed' the correct dose must be established.

15.2.5 The MAR chart must only be written by the Registered Manager or assistant manager on duty if no computer printed MAR chart is available.

15.2.6 A new prescription must be requested from the GP as soon as possible.

15.2.7 The Registered Manager must advise the community pharmacy of the resident's current medication, including any 'PRN' medicines.

15.3 **The MAR chart must:**

15.3.1 Be legible, with clear details, written in indelible and permanent ink.

15.3.2 Only include items which are still being currently prescribed and administered.

15.3.3 Include all externally applied medicines to be administered by care home staff.

15.4 **The MAR chart must detail:**

15.4.1 The resident's details including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents).

15.4.2 GP's details

15.4.3 Details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse).

15.4.4 Known allergies and reactions to medicines or ingredients, and the type of reaction experienced.

15.4.5 The name, form (e.g. tablets or suspension) and strength of all medicines the resident is currently using.

15.4.6 The dose, timing and frequency (e.g. two tablets at breakfast, and one at bedtime).

15.4.7 How the medicine is taken (route of administration), if not to be taken by mouth, e.g. 'to be inhaled'

15.4.8 Any important special information, e.g. store in the fridge, take an hour before food

15.4.9 The names of those preparing the MAR chart and the date prepared

15.4.10 The quantity of the medication received

15.4.11 If more than one chart is in use, reference to the other charts, e.g. ‘chart 1 of 2'

15.4.12 When required “PRN medication” as a cross reference to the PRN medication chart.

15.4.13 An up to date photograph of the resident (attached to the MAR chart and medication folder) is useful to assist care home workers with identification.

15.5 **Audit of MAR charts**

15.5.1 The Registered Manager must have a system in place for a nominated individual within the care home to audit 50% of all MAR charts each month. The MAR chart audit must check for:

- care home workers signatures, ensuring that there are no gaps
- cross referencing with the remaining balance of each medicine

15.5.2 The outcome of the audit is to demonstrate that staff are following administration procedures which will improve numbers of residents receiving their medication as prescribed.

15.5.3 All MAR charts are to be checked on a daily basis for missing signatures by the Registered Manager. If the Registered Manager finds signatures are missing, the procedure described in section 12 of this document must be followed.

15.6 **Respite residents**

15.6.1 Medicines for a respite resident should be:

15.6.1.1 Counted in at the beginning of the resident's stay and counted out at the end of the period of respite
15.6.1.2 Re-ordered if there are insufficient medicines to cover the period of respite
15.6.1.3 Re-ordered if the respite stay is extended

15.6.1.4 Recorded on the MAR chart, signed by the Registered Manager, or assistant manager on duty in their absence, witnessed by a member of staff who has been trained to a minimum of Level 2 medications administration, and dated.

15.6.2 The information on the MAR chart must exactly match that on the prescription form, or the dispensing label, provided by the doctor, community pharmacy or hospital dispensary. It should be in plain English avoiding jargon and abbreviations and as such should be easily understood by the resident, their family member or carer.

15.7 **Use of MAR charts**

15.7.1 Each time a dose of medication is due, the care home worker administering it must follow the instructions step by step.

15.7.2 The care home worker must immediately record the administration of a dose by signing the MAR chart in the correct place.

15.7.3 Prescribed medication not given must be clearly recorded and the reasons documented.

15.7.4 The information on the MAR chart will be supplemented by information recorded in the resident's care plan/care record.

15.7.5 It is important that MAR charts which are no longer in use (e.g. MAR charts dating from previous months) are removed and segregated from the current charts.

15.8 **When required (PRN) administration**

15.8.1 Care home workers must not assist with administration of these medicines unless there are specific instructions which clarify:

15.8.1.1 What the medicine is being used for e.g. pain
15.8.1.2 The minimum interval between doses
15.8.1.3 Maximum number of doses in 24 hours
15.8.1.4 Quantity of medication to be given (dose)

15.8.2 Care home workers must inform their manager if there are not enough instructions.

15.8.3 Care home workers must:

15.8.3.1 Always check the time of the previous dose in order to ensure that it is within the minimum time interval specified by the prescriber.
15.8.3.2 Record the date and time the dose was administered.
15.8.3.3 Record the current balance remaining after each dose has been administered.
15.8.3.4 Inform the Registered Manager, who should contact the resident's doctor, if:

15.8.3.4.1 The resident wishes to take prn medication more frequently than prescribed
15.8.3.4.2 Consumption increases markedly
15.8.3.4.3 They have reason to believe the medication is not effective for the resident

15.8.4 If "prn" (when required) medicines are used infrequently, it is important to check before administering:

15.8.4.1 That the medicine was originally prescribed for the purpose for which it is now required
15.8.4.2 That the resident is not taking any new medication that might interact with or duplicate the action of the prn medicine. If in doubt, check with the doctor or pharmacist
15.8.4.3 That it has not been replaced by a more recently prescribed prn or regular medicine
15.8.4.4 That the supply is still in date, bearing in mind that some medicines have a shortened expiry date once opened. Check pack for details. If in doubt, refer to a pharmacist for advice

15.9 Variable Doses

15.9.1 Resident's Choice- If a variable dose of a medicine is prescribed (e.g. one or two tablets to be taken, as required, for pain) the decision regarding the dose to be taken rests with the resident and the prescriber.

15.9.2 Care home workers must ask the resident how much of the medication they wish to take. If the resident is unable to decide, or respond, care home workers should request specific instructions from the prescriber. Care home workers are not permitted to assist with the administration of these medicines unless and until a decision has been made by the resident or the prescriber regarding the dose to be taken.

15.9.3 Clearly record on the MAR chart the number of tablets/amount of liquid taken.

15.9.4 **Warfarin:** Warfarin requires extra caution.

15.9.4.1 The dose of warfarin to be taken varies according to the results of the resident's most recent blood test.
15.9.4.2 It is important to take great care to administer the correct dose of Warfarin. The dose to be taken will be recorded in the resident's yellow, anticoagulant record book following their most recent blood test results. Blood tests are carried out regularly (they can be weekly, fortnightly or monthly).
15.9.4.3 The warfarin drug and dose must be written onto the MAR chart.
15.9.4.4 If a yellow, anticoagulant record book is not available, dosage directions from the anticoagulant clinic nurse or doctor must only be accepted in writing (a fax is OK), signed and dated by the prescriber. The written confirmation must be filed in the resident's care plan.

15.9.4.5 The warfarin yellow, anticoagulant record book must always accompany the resident when attending the warfarin clinic/GP surgery for review.

15.9.4.6 Changes to the dose of Warfarin prescribed must be recorded on the MAR chart by the Registered Manager, or assistant manager in their absence, and checked by a second person trained to a minimum of Level 2 Medicines Administration. The MAR chart must be signed by both persons.

15.10 Transfer to another setting

15.10.1 A printed or electronic summary outlining the patient's condition and treatment (if possible), or a copy of the current MAR chart, PRN chart and any remaining medication belonging to the resident are to be sent with resident when transferring to another care setting or when being admitted to hospital. This is to ensure continuity of care for the resident. The Registered Manager should ensure that a record of medicines sent with the person is completed and checked. Please see the Medication Transfer Form at Appendix 10. The following should be recorded:

15.10.1.1 Date of transfer
15.10.1.2 Name, strength and form of medicine/s
15.10.1.3 Quantity/ies of medicines
15.10.1.4 Medicines requiring refrigeration/maintenance of the cold chain
15.10.1.5 Signature of the care home worker arranging the transfer of medicines.

15.11 Changes in Medication

15.11.1 The residential care home must have a system to check the accuracy of any changes in medication. The Registered Care Home Manager should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan.

15.11.2 The following people should be involved in the medicines reconciliation:
15.11.2.1 The resident and/or their family members or carers
15.11.2.2 A pharmacist
15.11.2.3 Other health and social care practitioners involved in managing medicines.

15.11.3 The following information should be available as a result:
15.11.3.1 Resident's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents).
15.11.3.2 GP's details.
15.11.3.3 Details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse).
15.11.3.4 Known allergies and reactions to medicines or ingredients, and the type of reaction experienced;

15.11.3.5 Medicines the resident 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.

15.11.3.6 Changes to medicines, including medicines started, stopped or dosage changed, and reason for change.

15.11.3.7 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).

15.11.3.8 Other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support).

15.11.3.9 What information has been given to the resident and/or family members or carers.

15.11.3.10 Providers should ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded.

15.11.4 When a resident's medication is altered the GP must issue a new prescription and the Registered Manager is responsible for ensuring that the MAR chart is amended as follows:

15.11.4.1 The original medication and instruction for administration are cancelled with a written entry to say why this has been actioned in the resident's care record

15.11.4.2 New medication and instructions for administration are written legibly in ink on a new line of the MAR chart

15.11.4.3 Entries and amendments are written by the Registered Manager and signed and dated by a care home worker who is trained to a minimum of level 2 in medicines administration

15.11.4.4 The date the medication was received from the pharmacy is recorded on the MAR chart

15.11.4.5 If a visiting GP changes a resident's medication, they should be asked to write the details on the MAR chart, sign and date the change. The GP should also be asked to record details of the new instructions in the resident's care records. If the GP is unable to fulfil these tasks, the Registered Manager may complete them as described in the bullet points above

15.11.4.6 New medication should be requested by the Registered Manager, or the assistant manager in their absence, from the pharmacy as a matter of urgency.

15.12 **Discharge from Hospital**

15.12.1 When a resident leaves hospital, even following a short stay, it is likely that changes will have been made to their medicines.

15.12.2 The Registered Manager must ensure that the previous MAR chart is reviewed and updated following discharge from hospital.

15.12.3 The labelled supply of medicines sent home with the resident and the discharge summary of medicines from the hospital is the authority to administer those medicines and supersedes any previous MAR chart. Medicines should be administered according to the instructions on the label and discharge summary. All doses given must be recorded in the care record if the MAR chart is not yet available. The updated MAR chart must be made available as soon as possible.

15.13 **Recording verbal instructions to alter medication or doses of prescribed medication**

15.13.1 Under **exceptional circumstances,** the Registered Manager may accept verbal instructions to change or stop, **one day's treatment only** if the prescriber is unable to do so directly, provided:

15.13.1.1 The Registered Manager receives the instruction first hand from the doctor or other prescribing healthcare professional and carefully records the details of the conversation in the care record and on the 'verbal orders' form'. (refer to Appendix 9)

15.13.1.2 The individual care home worker receiving the instruction directly from the Registered Manager is the only person who may then act on the instruction.

15.13.1.3 The Registered Manager must ensure the prescriber follows up verbal instructions in writing by fax or email as soon as possible.

15.13.1.4 The Registered Manager must double check full understanding of the instructions received by reading them back to the authorising doctor or other prescribing healthcare professional.

15.13.1.5 The Registered Manager must record the time and date of the conversation.

15.13.1.6 The Registered Manager must record the name of the authorising doctor or other prescribing healthcare professional.

15.13.1.7 The prescriber and the Registered Manager must involve the resident as much as possible to ensure they are aware of, and consent to, the change. Residents should understand that they may check the actions of care home workers when administering medications to them at any time.

15.13.1.8 The Registered Manager must ensure the MAR chart is not amended, as the verbal instruction applies to a single day's treatment only. Any regular change to medication must be made on receipt of written authorisation from the doctor or other prescribing healthcare professional.

15.13.1.9 The care home worker must record the dose given in the care record with a cross reference on the MAR chart to the care record, (e.g. 'see care record')

15.14 **Retention of MAR chart records**

15.14.1 The MAR chart must be retained in the care home's current MAR chart folder whist in use.

15.14.2 Any MAR chart no longer in use (e.g. from a previous month) must be removed promptly and segregated from the current charts.

15.14.3 Used MAR charts must be retained by the care home for a minimum of 6 years.

16. STORAGE OF MEDICINES

16.1 Self-administering residents

16.1.1 All medicines should be stored in the resident's own room in a locked cupboard.

16.1.2 The keys must be kept in the resident's and/or carer's possession at all times.

16.2 Non self-administering residents

16.2.1 All resident's medicines are stored in a locked medicine trolley which, when not in use, must be securely fixed to the wall.

16.2.2 The keys to this trolley must be kept secure at all times, in the care home worker's or Registered Manager's possession.

16.2.3 All medicines must be kept in the packaging in which they were obtained from the pharmacy or dispensary.

16.2.4 Stock medication will be kept in locked cupboards in a locked room, where the temperature should not exceed 25 degrees centigrade.

16.2.5 Internal medication e.g. tablets, must be stored in different cupboards from external medication e.g. creams.

16.2.6 Nutritional supplements and dressings must be stored in a lockable room.

16.2.7 Medicines supplied in monitored dosage systems, needing more storage space to cover the change over period each month, must be locked away until needed in a locked cupboard in a locked room.

16.2.8 The keys to the stock drug cupboards and room should be kept secure at all times in the possession of the care home worker or Registered Manager.

16.3 Medication requiring refrigeration

16.3.1 Must be kept in a locked medication fridge, with a calibrated maximum and minimum thermometer, within a locked room.

16.3.2 The Registered Manager for the care home has overall responsibility for maintaining the cold chain of refrigerated products. The assistant manager on duty must be responsible in the Registered Manager's absence.

16.3.3 The medicine fridge must not store anything other than medication, no food or samples should be stored in it.

16.3.4 Monitoring of fridge temperatures must take place every day by reading and recording the temperatures displayed by the integral maximum and minimum fridge thermometer. The fridge should be adjusted so that readings should remain between 2 and 8 degrees centigrade. The maximum, minimum and current temperature should be recorded every day by the care home worker and must be recorded on a temperature monitoring log form. Once this is done, the care home worker should reset the thermometer. (Please see Appendix 19).

16.3.5 Any temperature that falls outside the 2 to 8 degrees centigrade range must be reported immediately to the Registered Manager who will decide on the action to take by getting advice from a Community Pharmacist or the manufacturer. If necessary an engineer must be called. Until instruction has been given regarding medicines in the fridge, stock within that fridge must not be used. A notice should be attached to the fridge stating 'stock in quarantine - do not use until further notice'. The notice should be dated and should direct enquiries to the Registered Manager or the assistant manager on duty.

16.3.6 The refrigerator requires defrosting and cleaning in accordance with the manufacturer’s recommendations or sooner in the case of spillages etc.

16.4 Storage of controlled drugs

16.4.1 Providers of adult care homes must comply with the Misuse of Drugs Act 1971 and associated regulations when storing controlled drugs. Providers of children’s homes should have robust processes for storing controlled drugs.

16.4.2 Controlled drugs must be stored in a locked controlled drugs cupboard which is bolted to a solid wall and only used for the storage of controlled drugs.

16.4.3 The keys for this cupboard must be kept secure at all times in the possession of the Registered Manager or assistant manager on duty in their absence.

16.4.4 The residential care home cannot purchase and keep stocks of controlled drugs without a home office licence.

16.4.5 A weekly check of resident's own controlled drugs is to be carried out by the Registered Manager.

16.4.6 When a resident is self-administering controlled drugs, the drugs are to be stored in the care home's controlled drugs lockable cupboard. The care home will make the necessary arrangements for the administration of the controlled drug(s) to the resident at the appropriate time. No one should be

deprived of receiving controlled drugs because only one member of staff is on duty when the resident requires it.

16.4.7 If any medicine cupboard keys become lost, including the keys to the controlled drugs cupboard, the Registered Manager should be informed immediately. The Registered Manager is responsible for investigating this incident fully, the appropriate incident report should be completed and provided to the CQC and possibly the Police.

16.4.8 Any incident involving a controlled drug (including stock shortage) should be reported to the CQC and the Accountable Officer for Controlled Drugs within NHS England's South Yorkshire and Bassetlaw Team.

17. ADMINISTRATION

17.1 Self Administration for Residents

17.1.1 Care home workers should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise. If the risk assessment highlights concerns these must be discussed with the resident, Registered Manager and their GP if necessary. (Appendix 11).

17.1.2 The risk assessment should consider:

- Resident choice
- If self-administration will be a risk to the resident or to other residents
- If the resident can take the correct dose of their own medicines at the right time and in the right way (for example, do they have the mental capacity and manual dexterity for self-administration?)
- How often the assessment will need to be repeated based upon individual resident need
- How the medicines will be stored

The responsibilities of the care home staff, which should be written in the resident's care plan.

17.1.3 It may be appropriate to put measures in place to minimise identified risks which still enable the resident to self-administer e.g. the care home stores the medication away from the resident, carers take the medication to the resident at the appropriate times and supervise them taking their medicines. If care home workers have assisted the resident to administer medication, they must sign the MAR chart.

17.1.4 The resident should sign an agreement form to self-administer their own medication, to keep the medication safe in the lockable storage facility in their room and give permission that a duplicate key may be used by the care home worker, if required. Residents may wish to manage ordering of medication from their GP or pharmacy themselves and this is to be discussed and recorded. (Appendix 12).

17.1.5 The care home must provide secure storage in the resident's room. This can be a lock fitted to a drawer and does not need to be made of metal or even look like a medicines cupboard.

17.1.6 The level of support, and resulting responsibility of the care home worker, should be written in the care plan for each resident. This should also include continual monitoring of the resident to ensure capability to self-administer medicines. Monitoring how the resident manages to take their medicines, and regular review, form part of the resident's care. The medicine records will help the review and monitoring process. The risk assessment should be reviewed at the monthly care plan review and a discussion with the resident regarding self administration should take place.

17.1.7 All residents who self-administer should have a completed MAR chart indicating this. Hand/computer written entries made by the Registered Manager are to be signed by the Registered Manager and another care home worker or resident. Refer to section 4.4 for MAR chart details.

17.1.8 Compliance aids which may assist the resident to manage their medication should be made available.

17.2 **Administration of Medicines by Care Home Staff**

17.2.1 Care home workers may only assist with administration of medicines that have been correctly labelled by a pharmacy with the resident's full name and date of dispensing. The medicine name, prescribed dose and frequency should also be included except where the dose is variable and given in accordance with separately written instructions e.g. warfarin.

17.2.2 Care home providers should consider the 6 R’s in a medicines administration process:

- Right resident
- Right medicine
- Right route
- Right dose
- Right time
- Resident’s right to refuse

17.2.3 They should also consider:

- What to do if the resident is having a meal
- What to do if the resident is asleep

17.2.4 Care home providers should consider ways of avoiding disruptions during the medicines administration round, such as:

- Having more trained and skilled care home staff on duty at that time
- Reviewing the times for administering medicines (for example, administering once daily medicines at lunchtime rather than in the morning, if the health professional prescribing the medicine agrees that this is clinically appropriate)
- Avoiding planned staff breaks during times of medicines administration

- Ensuring fewer distractions for care home staff administering medicines.

17.2.5 Care homes with nursing care should also include the correct use of infusion and injection devices (for example, syringe drivers).

17.2.6 Medicines must not be given after their expiry date. Note: many medicines have a reduced expiry date after opening. Check pack for details. If in doubt, ask the community pharmacist for advice.

17.2.7 If oral liquid medicines need to be measured by a syringe, a designated oral syringe must be used.

17.2.8 Health and social care practitioners should only use the best available evidence to find up-to-date information about medicines. Information can be found at the following UK-based websites:

- Medicines and Healthcare Products Regulatory Agency
- NHS choices
- NICE Evidence
- www.patient.co.uk

17.2.9 Additionally health professionals could use the following:

- British National Formulary (BNF)
- British National Formulary for Children (BNFC)
- Clinical Knowledge Summaries
- Electronic Medicines Compendium
- The patient information leaflet supplied with the medicine

17.2.10 Agency workers must not be involved in administering oral medication unless agreement from the Registered Manager has been obtained. Agency workers must have completed a training programme to the same standard as that described in section 10.0 of this document, and must be working very regularly within the care home, e.g. on a shift pattern where they will be familiar with the residents etc. It will be acceptable for agency workers to apply topical preparations as appropriate by following the instructions.

17.2.11 Medication may only be administered to the resident for whom it is prescribed and in accordance with specific prescribing instructions.

17.2.12 Only use a MAR chart that has had the medication details added by a Registered Manager or a registered, prescribing healthcare professional (this may be a pharmacist, Registered Manager or other responsible person of a social care service, a doctor or nurse). Care home workers must never tamper with the instructions on the MAR chart.

17.2.13 Where care home workers are required to administer medicines that are considered a risk, a medication risk assessment should be undertaken of those medicines that must be "handled". Examples include external applications such as steroids, and cytotoxic medicines such as methotrexate. (Appendix 13).

17.2.14 If a resident's medication is dispensed in a monitored dosage system (MDS) by the community pharmacy, and the medication is then changed by the GP, a completely new prescription must be requested from the GP, and the MDS returned to the pharmacy so that a new MDS can be issued.

17.2.15 Tablets must not be crushed or dissolved, or capsules opened, unless it is stated on the dispensing label. Where residents have serious difficulty in swallowing, the problem can be discussed with a pharmacist who will be able to find out if a suitable liquid product is available. This could be a liquid version of the original medicine or a different medicine that has the same effect. In either case this will have to be discussed with the prescriber and community pharmacist. Licensed liquid preparations should be used wherever possible.

17.2.16 Staff must minimise interruptions prior to medication administration and if possible ask a colleague to answer resident's bells and resident's needs. A notice is to be placed on notice boards to advise residents and visitors when care home workers are administering medication. The notice will ask that residents and their visitors refrain from disturbing staff engaged in medication administration duties unless absolutely necessary, e.g. emergency situations (Appendix 17).

17.2.17 Care home staff should keep a record of medicines administered by visiting health professionals on the resident’s medicines administration record.

17.3 **Covert Administration**

17.3.1 Medicines must not be administered covertly to any resident who is deemed to have capacity to make a decision about whether or not they wish to take medication. If a resident refuses medicines offered, the care home worker must provide them with information about the medicine, which may enable the resident to reconsider their decision. Medication must not be given, or withheld, as a way of influencing or controlling a resident's behaviour.

17.3.2 The care home worker must try to ascertain the reason for medication refusal and record this on the MAR chart using the appropriate code and inform the Registered Manager. The refusal must also be recorded in the care record along with the reason why, if this is known.

17.3.3 The Registered Manager will contact the prescriber for advice (where refusal falls within part of a course of treatment, the GP needs to be informed after the first refusal). The GP is responsible for deciding what action is required. Continual problems or difficulties with medicines compliance must be discussed with residents, the staff team, family and carers where appropriate and their GP.

17.3.4 If a resident declines medication that is essential to their health and well-being, the resident's mental capacity to consent or refuse medication must be assessed in accordance with the Mental Capacity Act 2005. The resident's GP may be involved with this assessment. If the resident is assessed as capable to make their decision, their right to make this choice must be respected.

17.3.5 A best interest meeting should otherwise be held involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.

17.3.6 If it is agreed by all parties that medication should be given covertly, this must be clearly documented in the resident's care plan stating the method to be used. All residents who are given medication covertly must have this agreement reviewed at the monthly care plan review meeting.

17.3.7 Tablets should not be crushed and capsules should not be opened either to make them easier to swallow or to hide them from the patient because this may affect the way that the medicine works.

17.4 **Procedure for Administering Medication**

17.4.1 **If there is any doubt or inconsistency, the medication is not to be given until it has been checked and confirmed to be correct or professional advice has been sought:**

17.4.1.1 Care home workers must wash their hands prior to giving medication.
17.4.1.2 The medication tabard must be worn.
17.4.1.3 The MDS or trolley must be taken to the resident.
17.4.1.4 If the medication is kept in a locked fixed cupboard away from the resident, the medicine must be dispensed at the cupboard and taken to the resident.
17.4.1.5 Only one MDS or similar should be taken to one resident at a time.
17.4.1.6 The correct MAR chart must be selected.
17.4.1.7 The resident's name, photograph, allergies, medication, dosage, time on the MAR chart and pharmacy label must all be checked. The date on the MAR chart must also be checked and a check that the medication has not previously been given.
17.4.1.8 The care home worker must select the medication required and confirm that it is still current by checking the expiry date on the dispensing label, or the expiry date on the box or packaging.
17.4.1.9 The medicine must be removed from the pack/container/bottle supplied by the community pharmacy and placed into a suitable dispensing pot to avoid contact with hands; if this is unavoidable gloves may be worn.
17.4.1.10 Liquids must be dispensed into a 5ml measuring spoon or graduated measuring pot.

17.4.1.11 Doses less than 5mls must be measured using an oral medicine syringe.

17.4.1.12 Tablet cutters must be used to cut tablets.

17.4.1.13 When dispensing PRN medication, care home workers must check the time and date when the medication was last taken. After administration to the resident, remaining tablets must be counted and recorded on the PRN chart. Care home workers must ensure that the actual amount taken is recorded on the MAR chart.

17.4.1.14 The MAR chart and resident's photograph should always be taken to the resident to ensure that care home workers check that the photograph matches the resident and that the tablets are signed when taken.

17.4.1.15 The medication should be given immediately to the resident addressing them by name.

17.4.1.16 If the medication is to be taken orally, the resident must be standing or sitting as upright as possible, and have a glass of water available.

17.4.1.17 The resident must be observed taking the medicine. Dispensed medication should not be left with the resident to take later.

17.4.1.18 If a topical preparation is applied for a resident, plastic gloves must be worn.

17.4.1.19 The MAR chart should be signed using the appropriate codes.

17.4.1.20 If a resident refuses medication, the reason must be recorded and reported to the Registered Manager. This refusal and the reason why should also be recorded on the daily communication sheet and care record. If necessary, the GP should be informed.

17.4.1.21 If the resident is having difficulty taking or using their medication e.g. inhalers, inform the Registered Manager and if necessary the GP.

17.4.2 **It is unacceptable at any time to:**

17.4.2.1 Leave the medication trolley/cupboard unlocked and unattended in a public area.

17.4.2.2 Leave the medication keys in a unit cupboard etc, they must always be held by the care home worker administering the medication.

17.4.2.3 Leave medication unattended e.g. in a resident's bedroom or on a dining room table.

17.4.2.4 Pass the medication to another care home worker to take to the resident on your behalf.

17.4.2.5 Transfer medication from its original dispensing pack into an unsealed container for administering at a later stage or by another person.

17.4.2.6 Not sign the MAR chart at the point of administration.

17.5 Administration of Controlled Drugs

17.5.1 Care home workers should follow the procedure for administering all medication, **plus:**

17.5.1.1 Two care home workers, who have been assessed as competent in relation to controlled drugs, must complete the entire medication administration process at all times.

17.5.1.2 Ensure that correct entries are made in the controlled drug book; this includes the date and time, medication, dose to be given, name of resident and the remaining balance. The entry must be checked with the instructions on the resident's MAR chart and with the label on the medication container.

17.5.1.3 The controlled drug book must be signed by two, appropriately trained members of staff (i.e. to at least the minimum of Level 2 in medicines administration) completing the activity.

17.5.1.4 The MAR chart must also be signed by both care home workers who completed the medication administration activity.

17.5.1.5 Liquid controlled drugs must be measured using an oral dispenser (oral syringe & bottle adaptor) which can be obtained from the dispensing pharmacy.

17.5.2 In the event of a discrepancy in the quantity of a controlled drug the Registered Manager must be contacted immediately:

17.5.2.1 The Registered Manager, with the person who has discovered the discrepancy, must check the date of receipt of the controlled drug and the amount of tablets I liquid entered into the controlled drug book.

17.5.2.2 This amount is then checked against the subsequent entries for administration of this drug.

17.5.2.3 If it is still calculated that there is a shortfall, the Registered Manager must investigate fully.

17.5.2.4 If there are facts that lead to a suspicion of theft, the police and the CQC must be informed.

17.6 **Re-dispensing Medication**

17.6.1 Medicines should never be removed from their original container until the time of administration.

17.6.2 If a resident is leaving the care home either permanently or for a period of time long enough to "miss" taking their medication at the expected time, they should take the medicine containers (MDS or bottles) with them.

17.6.3 When the resident is temporarily away from the care home the following information should be given to the resident and/or their family members or carers.

17.6.3.1 The medicines taken with the resident

17.6.3.2 Clear directions and advice on how, when and how much of the medicines the resident should take

17.6.3.3 Time of the last and next dose of each medicine

17.6.3.4 A contact for queries about the resident’s medicines, such as the care home, supplying pharmacy or GP.

17.6.4 Care home workers should ensure:

17.6.4.1 The appropriate code is entered on the MAR chart.

17.6.4.2 Medication is checked on return to ensure medication has been taken by the resident.

17.6.4.3 The remaining quantity is recorded on the MAR chart.

17.6.5 Repackaging medicines into another container with the intention that a different care home worker will give it to the resident at a later time is called secondary dispensing. Both the Royal Pharmaceutical Society and the Nursing and Midwifery Council state that this is unsafe practice which can potentially cause drug errors. Taking a tablet / capsule from its original container and putting in a medicine pot for immediate administration to the resident is not classed as secondary dispensing.

17.6.6 Whoever removes, or decants, medication from its original container must oversee the administration of the 'decanted' medication. The responsibility cannot be delegated.

18. DISPOSAL OF MEDICINES

18.1 Medicines that have been prescribed for, and dispensed to, individual residents remain their property. If a resident leaves the care home their medication must be returned to them, or handed to their relative or carer, or returned to the community pharmacy with the permission of the resident or a relative. The action taken must be recorded in the resident's care record. At no time may one resident's prescribed medication be used for any other person. Refused medication should not be returned to the packaging but must be disposed of in the correct manner. Medication that is refused after it has been in the resident's mouth can be safely put into a yellow clinical waste bag.

18.2 Medication no longer required must be returned to the community pharmacy with the following exceptions:

18.2.1 Used Medicated dressings / patches to be folded in half and placed in yellow infectious waste bag.

18.2.2 Emptied cream tubs/tubes to be disposed of in yellow clinical waste bag.

18.2.3 Empty inhalers or medicated aerosols to be placed in yellow clinical waste bag.

18.2.4 Other empty containers / bottles to be thoroughly rinsed out and placed in domestic waste.

18.2.5 Equipment used to administer medication e.g. droppers, plastic spoons and measuring pots to be placed in yellow clinical waste bag.

18.3 **All pharmacy labels to be removed before containers/tubes are disposed of and labels shredded or the confidential text overwritten with a black marker.**

18.4 All medication no longer required is to be returned to the community pharmacy. A duplicate records book or form should be used to include:

18.4.1 Residents Name

18.4.2 Name of Medication

18.4.3 Quantity
18.4.4 Date
18.4.5 Initial of person making the entry

18.5 When returning medication to the pharmacy, the Registered Manager and the driver collecting the returns must sign and print their names. A duplicate copy is to be retained by the care home.

18.6 Special arrangements apply to the disposal of CDs in care homes registered to provide nursing care in England & Wales:

18.7 If supplied for a named person: denature CDs using a kit designed for this purpose and then consign to a licensed waste disposal company.

18.8 If supplied as a 'stock' for the care home (nursing): an authorised person must witness the disposal.

18.9 For other social care providers Controlled Drugs should be returned to the pharmacist or dispensing doctor who supplied them at the earliest opportunity for safe denaturing and disposal. When CDs are returned for disposal, a record of the return should be made in the CD record book. It is good practice to obtain a signature for receipt from the pharmacist or dispensing doctor.

18.10 Medication given to residents when leaving the care home must be counted, the amount recorded on the MAR sheet, initialled and dated.

18.11 When required “PRN” medications in bottles or packs should be checked for expiry dates and sent back to the pharmacist when out of date. Any out of date items should be re-ordered from the individual resident's GP if still required.

18.12 It should be noted that unused medicines dispensed in a monitored dosage system must be discarded no later than 8 weeks after the dispensing date.

18.13 Medication belonging to recently deceased residents must be kept for seven days before being returned to the pharmacist for disposal, this is in case the coroner's office, police or courts require them as evidence.

18.14 If a resident has a syringe driver running at the time of death, this can be taken down by either the GP at the time of death or by the community or district nurse, providing that:

18.14.1 The care home Registered Manager or assistant manager on duty acts as witness
18.14.2 The syringe driver is stopped by removing the battery
18.14.3 The syringe is removed from the device
18.14.4 The syringe is placed into a yellow rigid sharps bin complete with remaining contents and line. Do not discharge contents of the syringes.
18.14.5 A record is made on the monitoring chart, nursing notes, care record of the resident and in the care home's controlled drugs book if the medication was a controlled drug. The date, time, and amount of solution remaining in the syringe to be disposed of must be recorded, and signed by the GP or

nurse witnessed by the care home Registered Manager or the assistant manager on duty.

18.14.6 Any unopened ampoules must be returned to the community pharmacy for disposal after seven days.

19. MEDICATION LABELS

19.1 To enable care home workers to administer medicines, there must be a printed label on every container with the following information, showing no discrepancies against the MAR chart:

19.1.1 Resident's name

19.1.2 Date of dispensing

19.1.3 Name and strength of medicine

19.1.4 Dose and frequency of medicine, which must be the same as the current MAR chart

19.2 If the label becomes detached from the container or is illegible a new label must be requested from the pharmacist. Care home workers must never alter labels on dispensed medicines or, indeed, any medicines except with the GP's explicit written instructions. The instructions from the GP must be recorded in the resident's care record. The Registered Manager must initial the change on the label. A new entry on the MAR chart must be made to reflect the change and it should be signed by two people – see verbal message procedure at 4.5. The community pharmacist must be contacted to communicate the new medicine dosage.

20. RECORD KEEPING

20.1 Health and social care practitioners should ensure that all information about a resident’s medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another.

20.2 A process should exist which checks that complete and accurate information about a resident’s medicines has been sent or received, recorded, and is acted on after a resident’s care is transferred from one care setting to another. The process should take in consideration occasions when the transfer may take place at less convenient times for example during shift handovers.

20.3 The process should cover:

- Recording information in the resident’s care plan
- Recording information in the resident’s medicines administration record
- Recording information from correspondence and messages about medicines, such as emails, letters, and transcribed phone messages
- Recording information in transfer of care letters and summaries about medicines when a resident is away from the home for a short time
- What to do with copies of prescriptions and any records of medicines ordered for residents.

20.4 All records must be completed fully; they must be legible and up to date and preferably produced using the computer rather than hand written records. Any exceptional entries or alterations made by the Registered Manager must be signed and dated by two trained and skilled members of staff before it is first used.

20.5 It is **not** permissible to erase any record with correction fluid at any time.

20.6 All documentation is to be retained by the care home. Used MAR charts should be retained for a minimum of 6 years.

20.7 The care home must keep a copy of the signed, original prescription and copies of medications returns documentation issued to community pharmacists.

20.8 An up to date record should be kept of care home staff authorised to administer medication. The record should document their name, signature and initials (Appendix 3). All medication documentation should be kept in a secure place when not in use.

20.9 **Records for controlled drugs:**

20.9.1 Separate records of the receipt, administration and disposal of controlled drugs should be kept by all residential care homes.

20.9.2 Administration should be recorded on both the MAR chart and in the controlled drug record book.

20.9.3 The controlled drug record book must be a bound book with numbered pages.

20.9.4 There should be a separate page for each controlled drug for each resident.

20.9.5 The balance remaining for each product should be included. This should be checked against the amount in the pack or bottle at each administration.

20.9.6 Controlled drugs given by injection are the responsibility of the district nurses. It is important to ensure that the care home retains a record of all controlled drug administration, especially when the district nurse completes a record that is not left in the care home. The community nurse must make a record of this in the care home's Controlled Drugs register witnessed by a care home worker (trained to a minimum level 2 in medicines administration). The community nurse must write in the resident's care record details of the drug and dosage that has been administered. This must be cross referenced to the MAR chart.

21. ADVERSE EFFECTS FROM MEDICINES AND MEDICATION ERRORS

21.1 All suspected adverse effects from medicines should be report to the health professional who prescribed the medicine or another health professional as soon as possible, this would usually be the GP or out-of-hours service.

21.2 Staff should record the details in the resident's care plan and tell the supplying pharmacy (if the resident agrees that this information can be shared).

21.3 All MAR charts will be checked by the Registered Manager at the end of each shift for missing signatures. Missing signatures will be investigated further by the Registered Manager.

21.4 Care home staff should give residents and/or their family members or carers information on how to report a medicines-related safety incident or their concerns about medicines using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process. Residents should be able to use advocacy and independent complaints services when they have concerns.

21.5 The root cause of medicines-related incidents should be investigated. Any training needs in relation to root cause analysis should be identified in contracts with commissioners.

21.6 **Mistakes in Administration**

21.6.1 In the event of a resident receiving the wrong medication, an appropriate home incident report form and a medication investigation form must be completed. (Appendix 15). If there is any doubt about the person's wellbeing, a 999 call for an ambulance must be made immediately.

21.6.2 The care home worker must:

21.6.2.1 Inform the Registered Manager.

21.6.2.2 Inform the resident and/or relative as appropriate, as advised by the Registered Manager and follow the "Being Open Policy" if appropriate in the circumstances.

21.6.2.3 Contact the resident's GP, on-call service or pharmacist for advice.

21.6.2.4 Monitor the resident in accordance with the instruction from the GP.

21.6.2.5 Record full details of the incident, including time, medication given, action taken and full signature in the resident's care plan.

21.6.2.6 The Registered Manager will decide whether further action or investigation is required.

21.6.2.7 The Registered Manager will inform CQC if required by regulations.

21.6.3 Failure to follow any part of the medication administration procedure by any care home worker is considered to be a medication error and will be investigated in line with the procedures described in this document.

21.6.4 Each medication administration error made by a care home worker is to be assessed for seriousness and the appropriate action will be taken by the Registered Manager. For example, "no signature on the MAR chart" would be a "first error", whereas giving the "wrong medication to a resident" would be a "serious error".

21.6.5 The residential care service lead(s) must be informed of all administration errors.

21.7 **First Error**

21.7.1 The care home worker responsible for the error must be given immediate, individual supervision to confirm the following: (See Appendix 15 and 16):

21.7.1.1 How the incident occurred?
21.7.1.2 Was correct procedure followed?
21.7.1.3 What contributed to the error?

21.7.2 The Registered Manager, or assistant manager on duty in their absence, must investigate fully to prevent re-occurrence.

21.7.3 If this is the first error, the care home worker will be monitored over the next 7 shifts, which includes:

21.7.3.1 Supervised sessions with the Registered Manager to check that the care home worker is administering medication according to policy.

21.7.3.2 The care home worker must undertake a competency assessment on the seventh shift (refer to Appendix 16a)

21.8 **Second Error within a 6 Month Period**

21.8.1 The care home worker responsible for the error must be given immediate individual supervision to confirm the following: (See Appendix 16)

21.8.1.1 How the incident occurred?
21.8.1.2 Was correct procedure followed?
21.8.1.3 What contributed to the error?

21.8.2 The care home worker must be closely monitored during medicines administration activities over the next 14 shifts, which must include:

21.8.2.1 Daily medicines administration sessions with the Registered Manager over the next
21.8.2.2 14 shifts, ensuring that the care home worker is administering medication as required by this GUIDELINESs.
21.8.2.3 The care home worker must undertake a competency assessment on the fourteenth shift
21.8.2.4 Training and support must be offered and the care home worker must co-operate and participate with the weekly monitoring of practice for a 3 month period.

21.9 **Third Error within a 6 Month Period or a Serious Medication Error**

21.9.1 The care home worker responsible for the error must be given immediate individual supervision to confirm the following (See Appendix 16)

- 21.9.1.1 How the incident occurred?
- 21.9.1.2 Was correct procedure followed?
- 21.9.1.3 What contributed to the error?
- 21.9.1.4 Immediate suspension from medication duties and a formal investigation must be carried out.
- 21.9.1.5 If appropriate the care home worker will also be managed under procedures required by the Care Home.
- 21.9.1.6 A two month period of re-training must take place, which must include participation in a medication administration training course
- 21.9.1.7 Supervision of administration of all medication by the Registered Manager.
- 21.9.1.8 A competency assessment will be carried out at the end of this period.
- 21.9.1.9 Weekly spot checks for a further month by the Registered Manager or assistant manager on duty.

22. UNIDENTIFIED MEDICATION

22.1 Medication found on the floor or elsewhere should be identified if possible, and an appropriate home incident report form completed. If identified, an attempt should be made to ascertain which resident it belongs to and whether the resident has had that medication. If it is clear who the medication was intended for, the Registered Manager should decide on course of action and contact the resident's GP if deemed necessary. Missed doses of certain medicines can have a detrimental effect on resident's health and well-being.

22.2 After the investigation has taken place, the medicine can be safely put in a yellow clinical waste bag.

23. ADMINISTERING OF INSULIN, INJECTIONS, ENEMAS AND SUPPOSITORIES OR MEDICINES NEEDING TO BE ADMINISTERED VIA A PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE. (LEVEL 3 ADMINISTRATION)

23.1 The administration of the above to residents in residential care homes always remains the responsibility of the GP or District Nurse. The giving of enemas and suppositories is considered invasive therapy and should only be carried out by a registered practitioner.

23.2 Oxygen may be prescribed for some residents. If this is the case, then:

23.2.1 All care home workers should be aware that oxygen is in use in the area.

23.2.2 Smoking or use of naked flame is prohibited in the area and notices stating "Compressed Gas: Oxygen": "No Smoking": "No Naked Lights", etc. should be used on the door of every room where oxygen cylinders are present, including the front door of the care home.

23.2.3 In the case of a fire, the Fire Service should be notified that oxygen cylinders are present on the premises and advised of their location.

23.2.4 Oxygen cylinders should be stored under cover, preferably inside, kept dry and clean and not subjected to extremes of heat or cold.

23.2.5 Oxygen cylinders should not be stored near stocks of combustible materials or near sources of heat.

23.2.6 Full and empty oxygen cylinders should be stored separately. Full oxygen cylinders should be used in strict rotation.

23.2.7 Oxygen cylinder valves should be closed when oxygen is not in use.

23.2.8 When the oxygen cylinder is empty the valve should be closed and the plastic cup refitted to the valve outlet to prevent moisture entering the oxygen cylinder.

23.2.9 If care home workers are involved in the movement of oxygen cylinders, a manual handling risk assessment should be completed and the findings and recommendations communicated to all workers.

24. OVER THE COUNTER MEDICINES (Homely Remedies)

24.1 Homely Remedies can be used to treat minor ailments for residents who do not need immediate consultation with a GP, if the GP has consented to their use in principle.

24.2 On admission to the residential care home, residents will be required to tell the Registered Manager or assistant manager on duty which homely remedies they use. The homely remedy should be recorded on the MAR chart as a
homely remedy, and the 'homely remedies form' should be completed. This form must be signed by the GP and the Registered Manager. (Refer to Appendix 18 for more details of medicines allowable and procedure).

24.3 Residents who are self-administering must inform care home workers when they take the non-prescribed medication, so that it can be recorded in the care record.

24.4 Consideration should be given to the potential harm ‘homely remedies’ can cause and any maximum daily dose recommended.

24.5 New homely remedy stock medication is stored in the main medication room and must be recorded on the 'Stock Sheet Form for homely remedies' (Appendix 7). This must be updated when medication is taken to unit cupboards/trolleys for audit trail.

24.6 New homely remedy stock received must be rotated, checking for out of date stock.

Appendix 1 – Med 001

Assessment of Competency to Administer Medication

Name of Staff Member	
Name of Assessor	

	The member of staff……..	***(please circle)***
1	Has read and understood medication policy and documentation	Yes / No
2	Understands the resident's rights in respect of medication	Yes / No
3	Understands self-administration	Yes / No
4	Demonstrates safe practice regarding storage of medication	Yes / No
5	Has been able to demonstrate safe administration of each medicine, including controlled drugs	Yes / No
6	Has completed all documentation correctly	Yes / No
7	Has described correct procedure when medication is refused	Yes / No
8	Has identified immediate action to be taken if a mistake has occurred	Yes / No
9	Have a basic knowledge of the medication prescribed and how to obtain further information, if required	Yes / No
10	Is aware of importance of reporting any changes in health after administration of medicines	Yes / No
11	Understands PRN medication – when to administer and when to advise against taking it	Yes / No
12	Understands the process and guidelines for the administration of Homely Remedies	Yes / No

	In addition to the above, a Manager	***(please circle)***
13	Understands and demonstrates safe practice regarding ordering and receiving medication	Yes / No
14	Understands the safe disposal of unused medicines	Yes / No

Staff Member's Signature		**Date**	
Assessor's Signature		**Date**	
Unit Manager's		**Date**	

Signature			

Appendix 1 – Med – Med001

Guidelines for Good Practice

Oral Medicine Administration

Definition

The administration of a medicine to a resident by a member of staff or authorised person.

Indications

Medicines may be administered for the following purposes –

- Diagnostic purposes
- Prophylaxis – heparin to prevent thrombosis
  -antibiotics to prevent infection
- Therapeutic – antibiotics

  -pain relief
  -replace fluids or vitamins

Legislation

Two statutes control the manufacture, supply and use of medicines

The Medicines Act 1968 The Misuse of Drugs Act 1971

To comply with the Care Quality Commission (CQC)

Guidelines

- The member of staff is responsible for the correct administration of medicines to residents in their care
- Medicines should be prescribed for the resident by a doctor either by prescription (FP10) or hospital drug chart. Only medicines prescribed specifically for the individual must be administered by staff
- Medicine dosage changes must be authorised by the doctor
- The entire process of administering Controlled Drugs must be completed by 2 people at all times – counting and balancing the medication, signing the controlled drugs book, witnessing the administration of the controlled drug to the resident, signing the Mar chart.

Residents should be allowed to self-administer medication whenever possible and supported if necessary.

	ACTION	RATIONALE
1	Wash hands	To prevent cross infection
2	Before administering medication, check it is due and not yet given Check the information on the chart is complete, correct and legible and that the resident has no known allergies	To protect the resident from harm
3	Take the dosage box to the resident. Before administering medication, find the resident's MAR chart and check the following: • Medication name • The date on the dispensing label to check that it is still current • Name of resident on container/MAR chart • Photograph of resident • Dose of medication on container/MAR chart • Route of administration – oral, inhaled, applied to the skin • Date and time of administration • The details are the same as on the MAR chart. If they are not DO NOT give the medicine, contact your manager.	To ensure the resident is given the correct medicine, prescribed dose and correct route To protect the resident from harm To comply with the N.M.C. standards for administration of medication
4	If there are several containers of medication, ensure that the correct medication is chosen and check the expiry date. Only use medication prescribed to that person.	Medication outside of its expiry date may be dangerous due to deterioration with storage
5	Empty the required dose into a designated container, avoid touching the medication	To prevent cross infection To prevent harm to the member of staff
6	Take medication and prescription chart to the resident. Check resident's identity and dose to be given	To prevent error
7	Evaluate resident's knowledge of medication offered. If incorrect, offer explanation and then appropriately liaise with registered manager	The resident has a right to information about treatment
8	Administer as prescribed on the chart	To protect resident from harm
9	Offer water, if allowed to facilitate swallowing of oral medicine, ensure the resident is standing or sitting as upright as possible.	

Appendix 1 – Med 001 contd

	ACTION	RATIONALE
10	Confirm that medication has been given by recording and signing in correct place on medication chart	To meet legal requirements
11	If applying a cream for a resident, ensure you are wearing plastic gloves	To prevent cross infection
12	If the dose is variable (e.g. one or two tablets to be taken) record actual amount given and initial	To ensure correct documentation
13	If the medication is not given, enter a large X in the box and enter the reason in the resident's records.	To ensure correct documentation
14	Administer 'irritant' medication with meals or snacks. This should be stated on the MAR chart.	To minimise effects on gastric mucosa (some medication can cause gastric irritation – usually stated on the container or enclosed leaflet)
15	Administer medication that interacts with foods or those destroyed by gastric mucosa between meals. This should be stated on the MAR chart.	To prevent interference with the absorption of the drug
16	Do not break tablets, unless they are scored	To prevent incorrect dosage being given, gastric irritation or destruction of the medication
17	Do not interfere with time release capsules or enteric coated tablets – they must be swallowed, not chewed	The absorption rate of the medication will be altered
18	Sublingual tablets to be placed under the tongue. Buccal tablets are to be placed between the gum and cheek	To allow for correct absorption
19	If administering liquids, an medicine oral syringe should be used to measure the correct dose and then transferred to a spoon	To ensure the correct dose is administered
20	Advise Registered Manager if any stocks of a resident's medication are running low	To prevent residents running out of any medication
21	Dispersible medication should be put in a small amount of water, allowed to dissolve and then given – it is not to be left unattended	The medication is given in the correct way
22	Medication cannot be hidden in food without the procedure in place that covers covert medication	Procedure followed and adhered to
23	Medication cannot be crushed and hidden in food without the procedure in place that covers crushing of medication	Procedure followed and adhered to. May affect the way medication reacts

Appendix 2 – Med 002

Administration of Oral Medication

(date)

(name)

is competent in:

Checking medication has been given

Checking the following against medication chart before administering medication:
name of medication, names of resident on container, dosage and route of medication, date/time of administration, dilute, if appropriate, expiry date of medication

Transfer required dose into suitable container

Check resident's identity and dose to be given

Administer as prescribed

Record and sign medication chart

Explain terminology – sublingual, buccal

Explain why enteric coated tablets must not be crushed or capsules must not be emptied

……………………………………………………

(insert name), Registered Manager,

(insert home)

Appendix 3 – Med003

MEDICATION ADMINISTRATION LEVEL 2

(STAFF ASSESSED AS COMPETENT)

Surname	Forename	Signature	Initials	Date

Appendix 4 – Med 004

REPEAT PRESCRIPTION ORDER FORM

Please issue a repeat prescription and return in the stamped addressed envelope to:

Residents Name ………………………………………………………….. DOB ……………………………………………………………………………

GP Name ……………………………………………………………………. Surgery ………………………………………………………………………..

Date of request …………………………………………………………...

MEDICATION NAME	DOSAGE	QUANTITY	COMMENTS	SIGNATURE

Appendix 5 – Med005

DISCREPANCIES OF MEDICATION FROM GP SURGERY

………………………

WEEK COMMENCING ……………………………………………………………………………..

Please list any discrepancies below

RESIDENT'S NAME and DATE OF BIRTH	DETAIL OF DISCREPANCY	ACTION TAKEN	DATE RESOLVED

Appendix 6 – Med006

DISCREPANCIES OF WEEKLY/MONTHLY MEDICATION FROM PHARMACIST

DATE:

Please list any discrepancies below following checking of weekly/monthly medication

Resident's Name and Date of Birth	Medication	Action Taken & Signature	Date Rectified & Signature

Appendix 7 – Med 007

MEDICATION STOCK CONTROL FORM FOR HOMELY REMEDIES

RESIDENT'S NAME & D.O.B:

	DATE	MEDICATION	MEDICATION	MEDICATION	MEDICATION
OPENING					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					
IN					
OUT					
BALANCE					

Appendix 8 – Med008

PRN MEDICATION CHART

Resident's Name: Address: Date of Birth:	G.P: Known Allergies:
Name and strength of Medication:	Prescribed dose, directions and reasons for use:
Maximum dose in 24 hours	Minimum interval between doses
Registered Manager (who completes chart) Signature:	Second Signature (Witness):

Amount Received	Date	Time *(24 hrs)*	Dose Given	Signature (Print name also)	Balance

Appendix 9 – Med009

VERBAL ORDERS GIVEN BY MEDICAL HEALTH PROFESSIONALS.

For use if practitioner does not FAX the instruction.

The person issuing the instruction should be asked to sign this form as soon as possible

Date of Instruction	Name & Designation of Person giving Instruction	Detail of Instruction Given	Signature of the person receiving the Instruction

Appendix 10 – Med010

MEDICATION TRANSFER FORM

NAME OF RESIDENT and Date of Birth	DATE OF TRANSFER	TRANSFER FROM (UNIT)	TRANSFER TO (UNIT)

PLEASE LIST ALL MEDICATION INCLUDING PRN medication, liquids, creams, food/drink supplements and any other medical equipment to be transferred. Please record if any medicine must be stored between 2 to 8 degrees C.

Name of Medication	Strength of Medication	Frequency of Medication ie bd, tds	Quantity of Medication	MDS box / similar Yes / No

Name of person arranging the transfer:	
Signature of person arranging the transfer:	
Date:	

Appendix 11 – Med 011

Self-Administration Risk Assessment Form

Name of Resident & Date of Birth:	
Name of Assessor:	Date assessed:

Description of activity:	
Significant hazards:	
✓	Assessment check list:
	Is the client able to read the labels on the bottle/blister pack?
	Can the client open the container/blister?
	Does the client understand what the medication is for?
	Does the client understand the special instructions (if any) to be followed?
	Does the client understand the dose to be taken?
	Is the client aware of the need to check for possible side effects of their medication?

	Does the client understand storage requirements
Any other factors:	
Any measure required to minimise the risk:	

RISK GRADING - LOW MEDUIM HIGH
Please circle appropriate grading

Registered Managers name:	Registered Managers signature:
Resident's name:	Resident's signature:

To be reviewed monthly at monthly care plan review meeting

Appendix 12 – Med 012

Self-Administration of Medication By a Resident

Name of Resident & D.O.B	
Unit/Flat:	**Room No:**

I, ______________________________would prefer to manage my own medication and a risk assessment has been completed

I agree to keep it in a locked drawer and administer the pills myself. If I lose a pill or take it wrongly, I will advise the Duty Manager immediately at ______________________. I understand it will not always be possible for the pill to be replaced the same day.

I understand ______________________ will not be responsible for my medication apart from collecting the empty box and delivering the new one on Monday mornings.

I understand I must only take medication for the appropriate day, if I am in difficulty I will speak to the staff.

I understand that the Care Staff hold a key and have access to the locked drawer, if necessary.

I wish to order my medication from the GP/Chemist myself or I would prefer the staff to order my medication from the GP/Chemist

Signature of Resident	
Signature of Registered Manager	
Date	

Appendix 13 – Med013

MEDICATION RISK ASSESSMENT FORM

Name of Medication										
Quantities Used										
Hazards										
Hazards:	☐	Irritant	☐	Corrosive	☐	Toxic	☐	Carcinogen	☐	Flammable
Route of exposure:			☐	Swallowing	☐	Eyes	☐	Inhaled	☐	Skin
Assessment of Risk:	☐	Very Low	☐	Low	☐	Med	☐	High	☐	Unacceptable
Approved Uses					Approved Method of Use					
Who could be exposed										
Control Measures										
☐ Protection			☐	Ensure cuts are covered	☐	Avoid contact with eyes			☐	Ventilation
☐ Other (Please state):										
Protective Equipment to be worn (specify equipment and type)			☐	Eye Protection	☐	Gloves	☐	Apron		
			☐	Other						
First Aid										
Storage Requirements										
Spillage Management										
Assessed By:					Date:					

Appendix 14 – Med014

MEDICATION AUDIT FORM

Daily checks must be performed of all MAR charts to confirm signatures are recorded by care home workers.

A monthly audit of a minimum of 50% of all MAR charts. This audit must check all medicines on the MAR chart are signed for or appropriate code filled in, and a balance check of the corresponding medicine. The findings to be completed below.

Home:		Month/Year:	

Date	Name of Unit & Initials of Resident	Findings	Action Taken	Signature

Appendix 14 – Med014 contd.

Date	Name of Unit & Initials of Resident	Findings	Action Taken	Signature

All incidents of MEDICATION ERRORS are to be investigated.

Appendix 15 – Med 015

MEDICATION INVESTIGATIONS

All incidents of MEDICATION ERRORS are to be investigated.

If a resident takes the wrong medication: **CHECK WITH GP, GIVING DETAILS OF MEDICATION TAKEN ETC IMMEDIATELY**

1. All incidents of medication found in inappropriate places not administered as per instructions are potentially serious. For example:
   a. The resident does not receive medication as prescribed
   b. Other residents may administer medication that they find in inappropriate places.
   c. Wrong medication is given.

2. **The Registered Manager will need to record complete details of the incident.**

3. **The Registered Manager will then investigate the facts, which will include:**
   a. What is the error/where was the medication found etc?
   b. What is the medication?
   c. How did error occur?
   d. Contact GP and/or Pharmacist immediately, what advice given?
   e. Which staff member administered the medication?
   f. Has the medication been signed as given?
   g. Is it necessary for the resident to have the medication?
   h. Did the individual refuse to take the medication?
   i. Does the individual need medication in another form (liquid)?
   j. Was the incident avoidable?
   k. Is there any action that can be taken to avoid a repeat of this incident?
   l. Any other action required?

4. A full report needs to be placed on the individual's file along with a copy of the incident form.

5. The incident should be reported according to policy

MEDICATION IVESTIGATION FORM

Resident Name & D.O.B: Date:

1. Describe the type of incident	
2. Can the medication be identified?	Yes / No
3. What is the medication? List	
4 Are you able to identify who the medication was prescribed for? If yes, please insert name	Yes / No
5. Contact GP and/or Pharmacist. 5a. Contact next of kin	What advice were you given?
6. Was the medication signed as taken?	Yes / No
7. Which staff member gave the medication? If they have not signed, why not? Refer to Medication Procedure for action to be taken in case of error	Yes / No
8. In your opinion was the incident avoidable? If yes what action do you need to take to avoid another similar incident?	Yes / No
9. Is there any other action that needs to be taken to avoid this incident occurring again?	
11. CQC Statutory Notification form may need completing	

Name of person completing form:	Signature: Date:
Copy to file, Registered Manager and Service Manager	

MEDICATION – 1st STAFF ERROR FORM

Where an error is found, discuss with the staff member involved and begin the error process detailed in the Medication Procedure

Please use the back of this form for any other information etc if necessary

Name of Staff Member:

Details of the Discrepancy must include:

Name of Resident, name/dosage of medication, date/time, full details of the error made

NB – whilst suspended from administering medication, creams may be applied by the staff member, with the Registered Manager supervising and countersigning the medication sheet.

Date	**Signature of Staff Member**	**Name of Registered Manager**	**Signature of Registered Manager**
1st Error – immediate supervision, assessment daily over 7 shifts with Registered Manager, competency review to be carried out on 7th day. (Refer to Medication Procedure) *(continue overleaf, if necessary)*			

Supervision/Date		**Comments**	**Date**	**Signature**
1st				
2nd				
3rd				
4th				
5th				
6th				
7th				

Appendix 16b – Med016b

MEDICATION – 2nd STAFF ERROR FORM
Where an error is found, discuss with the staff member involved and begin the error process detailed in the Medication Procedure

Name of Staff Member:

Details of the Discrepancy must include:

Name of Resident, name/dosage of medication, date/time, full details of the error made

NB – whilst suspended from administering medication, creams may be applied by the staff member, with the Registered Manager supervising and countersigning the medication sheet.

Date	Signature of Staff Member	Name of Registered Manager	Signature of Registered Manager

2nd Error – immediate supervision, assessment daily over 14 shifts with Registered Manager, competency review to be carried out on 14th day. (Refer to Medication Procedure) *(continue overleaf, if necessary)*

Supervision/Date		Comments	Date	Signature
1st				
2nd				
3rd				
4th				
5th				
6th				
7th				

Appendix 16b – Med016b contd.

Supervision/Date		Comments	Date	Signature
8th				
9th				
10th				
11th				
12th				
13th				
14th				

Appendix 16c – Med016c

MEDICATION – 3rd STAFF ERROR FORM

Where an error is found, discuss with the staff member involved and begin the error process detailed in the Medication Procedure

Name of Staff Member:

Details of the Discrepancy must include:

Name of Resident, name/dosage of medication, date/time, full details of the error made

NB – whilst suspended from administering medication, creams may be applied by the staff member, with the Registered Manager supervising and countersigning the medication sheet.

Date	Signature of Staff Member	Name of Registered Manager	Signature of Registered Manager
3rd Error – immediate supervision, immediate suspension from medication duties and formal investigation. Depending on the outcome of the investigation, the minimum retraining for a 2 month period to include dealing with administration of medication course, weekly spot assessments for a further month. *Consideration to invoke disciplinary procedures and start of capability management (Refer to Medication Procedure) (continue overleaf, if necessary)*			

Supervision/Date		Comments	Date	Signature
1st				
2nd				
3rd				
4th				
5th				
6th				
7th				

Appendix 16c – Med016c contd.

Supervision/Date		Comments	Date	Signature
8th				
9th				
10th				
11th				
12th				
13th				
14th				
15th				
16th				
17th				
18th				
19th				
20th				

Appendix 16d – Med016d

MEDICATION – STAFF ERROR FORM
(continuation sheet)

Name of Staff Member:

Supervision No:/Date		Comments	Date	Signature

Appendix 16d – Med016d contd.

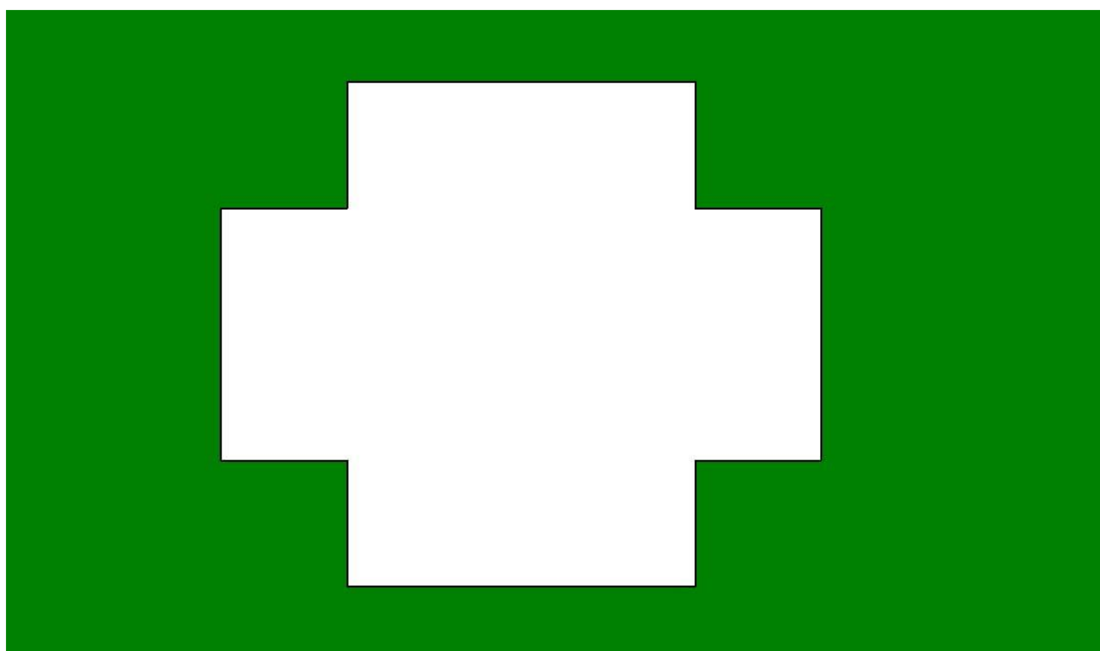
MEDICATION – STAFF ERROR FORM
(continuation sheet)

Name of Staff Member:

Supervision No:/Date		Comments	Date	Signature

ATTENTION

TO AID OUR MEDICATION PROCEDURES YOU
WILL SEE MEMBERS OF STAFF WEARING A
GREEN TABARD WITH A
WHITE CROSS



PLEASE DO NOT DISTURB
EXCEPT IN EMERGENCIES

Appendix 17

Homely Remedies Policy for Residential Care Homes

Care Home:……………………………… Resident……………………………………

Date…………..

Homely Remedies in this Care Home can be used to treat minor ailments of residents that do not need immediate consultation with a GP, if the GP has consented to their use in principle, as below.

The conditions covered by this policy are indigestion, mild pain (eg headache, toothache) cough, constipation and mild diarrhoea. For patients with mild diarrhoea (not more than 3 loose stools per day) who are otherwise well, first encourage fluids, avoid fatty foods, and return to normal diet cautiously if condition resolves. If mild diarrhoea persists for more than 24 hours, or worsens, then Rehydration Sachets may be commenced, but contact the GP, or the Out of Hours Service) as soon as possible, certainly within 12 hours: see also notes overleaf. Mild skin conditions should not be treated by Homely Remedies as creams and ointments for residents must not be shared.

Care Home staff have training to support them in assessing minor ailments, including when and whether it is appropriate to treat them with the Homely Remedies listed overleaf. The decision to administer the remedies or contact the GP will only be made by the Registered Manager of the Care Home.

Homely Remedies should be administered for a maximum of 48 hours only, using the doses given below, before referring to the GP. Rehydration sachets should be used for a maximum of 12 hours before consulting the GP. If the patient's condition does not respond to the Homely Remedy, or worsens, refer to GP, even if this is before the 48 hour maximum period. If the condition responds, discuss continuing/discontinuing the treatment with the GP.

Administration of all Homely Remedies must be recorded immediately on the medicines administration (MAR) chart and in the patient's notes / care plan. Ideally a separate book with a running balance of each Homely Remedy should be kept as well.

The GP should be informed of the administration of a Homely Remedy at the next visit, and also of frequent usage of a remedy.

The only medicines that can be used as Homely Remedies in this home are listed overleaf, together with their indications and suggested doses.

This home purchases a small supply of Homely Remedies Over-the-Counter. These are to be stored securely, but separately from prescribed medicines. Expiry dates are checked regularly.

On no account should medicines prescribed for another resident be used.

Appendix 17 contd.

Homely Remedies should be sold with Patient Information Leaflets included. Please ask the usual supplying pharmacy for advice on the use of these remedies: they can check patient records for any contra-indications or duplications before they are used.

Further information can be found at www.bnf.org

Signature of GP: ……………………………………………………… **Date** ……………………

Print name of GP: ………………………………………………………..

Signature of Care Home Manager/ Representative:

……………………………………………………….. **Date** …………………….

Print Name: ………………………………………………………

Homely Remedies

For Indigestion / Heartburn

Compound alginate Liquid (eg Peptac, Gaviscon or Pharmacy Own Brand)

Dose: 10ml four times a day, to be taken after meals and at bedtime

Cautions: *Maximum single dose: 10ml, maximum dose in 24 hours: 40ml* Do **not** give at the same time as other drugs as it may affect absorption.

Do **not** give to patients with heart failure or those on a low salt diet because it has a high sodium content.

Mark bottle with date first opened.

For Mild Pain / Pyrexia

Paracetamol 500mg tablets / caplets or Paracetamol sugar-free liquid 250mg/5ml

Dose: 1-2 tabs/caps or 10-20ml liquid up to 4 to 6 hours.

Maximum of 2 tabs/caps or 20ml liquid every 4 hours.

Maximum of 8 tabs/caps or 80ml liquid in 24 hours.

Cautions: Do **not** exceed the recommended dose.

Do **not** administer with other medicines that contain paracetamol such as co-codamol, codydramol or paracetamol suppositories. Check MAR chart carefully to avoid duplication. Mark bottle of liquid with date first opened.

For Coughs

Simple linctus, sugar-free

Dose: 5ml four times a day. Maximum dose: 5ml, Maximum dose/24 hours: 20ml

For Constipation

Senna 7.5mg tablets or Senna liquid 7.5mg/5ml

Dose: 2 tablets, or 10ml at night. This is the max single dose/max dose in 24 hours

Cautions: Do **not** give if intestinal obstruction is suspected.

Patients should be referred to the GP immediately if alarm symptoms such as constipation alternating with diarrhoea, rectal bleeding, passing mucus, abdominal pain, anorexia or weight loss occur.

Mark bottle of liquid with date first opened.

For mild diarrhoea: See also previous page

Rehydration sachets (Electrolade, Dioralyte or Pharmacy Own Brand)

Dose: One sachet after each loose motion, in addition to normal fluid intake. Maximum single dose 200ml, maximum dose in 24 hours: 5 sachets.

Cautions: Do **not** give without first consulting GP if more than one resident is affected. Do **not** give to diabetic patients without first consulting GP

Discard any remaining solution 1 hour after preparation.

Appendix 19 – Med 019

Residential Care Home ……………………………………………………………

Please photocopy and store in the appropriate loose-leaf binder on top of or close by the referenced fridge.

TEMPERATURE MONITORING LOG for Fridge……………./ Coolbox……………

Date	Time	Current Temp (℃)	Min temp (℃)	Max temp (℃)	Action taken if temperature outside range of 2℃ and 8℃	Reset temp (℃)	Temperature recorded by & signature

For refrigerators that are NOT self-defrosting record the following information

Fridge defrosted on (date):	By: Name	Signature
Time defrosting started:	Time completed:	

Name of accountable cold chain lead…………………………………………………

Name of deputy………………………………………………………………………….

Appendix 20

Comparison between monitored dosage systems and original packs

	Monitored dosage Systems	**Original packs**
Advantages (Supply)	•'Added value' element of supply by the pharmacy	•Better use of pharmacist's time •Re-packaging not required
Disadvantages (Supply)	•Not all medicines suitable •Re-packaging may often be unlicensed •Lack of evidence to support use •Pharmacies not reimbursed for use of monitored dosage systems •Robust filling and checking procedures required •Time consuming to fill and to check •Issues with variable doses, short courses, once-weekly medicines •Issues with medicines started mid-cycle or interim medicines •All labels may not fit on the monitored dosage system	•Packaging may be too bulky
Advantages (Administration)	•Provide an additional 'visual safety check' to care home staff compared to original packs, when they have been trained to use it correctly •Facilitate self-administration and compliance	•Maintains resident dignity and independence •The resident is taking the medicine as they would do in their own home •Not being re-dispensed (potentially then in an unlicensed form) •Take up less space compared with monitored dosage systems •Patient information leaflet enclosed in original pack supporting medicines information requirements/needs •Resident can see the original pack (identification purposes) •Less waste

		•May be beneficial for patients who go on short-term leave/utilise day services •Easier to amend medication following changes (for example, dose changes or if the medicine is stopped) •Lower risk of infection
Disadvantages (Administration)	•There may be over reliance on monitored dosage systems that may de-skill care home staff •High-risk medicines may be an issue •Difficulties if medicines are stopped, need to be omitted, or to identify if they are being given in an unlicensed way, if a monitored dosage system contains all medicines in single blister •Requires 2 systems to be used, monitored dosage system and original packs for acute and 'when required' medicines •Arrangements need to be made for those on short leave from care home •Over-reliance of the use of monitored dosage system: care home staff may fail to look at the label and description of medicine	