Medication Policy

(including procedures and practice guidelines)

Sunderland Health, Housing and Adult Services
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PLEASE NOTE:  
This is an amended version of the first edition, dated December 2008, which is being made available as a model of good practice for the Independent Sector. The procedures will be amended from time to time in accordance with legislative changes and good practice guidance. Please ensure that you are reading the latest edition.
1.1 **Introduction**

1.1.1 The council will make every effort to ensure that service users benefit from quality care and support, and also protect service users and staff from harm arising from mistakes with medication. This requires continuous improvement of systems, staff training and supervision.

1.1.2 This document sets out the policy of the management of medicines in regard to vulnerable adults who access social care services provided by or commissioned by the City of Sunderland Council, Adult Services Directorate, or any other agency that chooses to adopt this policy.

1.1.3 This policy, and the associated procedures, has been comprehensively revised in order to reflect new legislation and care standards. They provide clear guidance that enables workers to support service users to take their prescribed medication in a range of care settings.

1.1.4 This policy recognises the basic principle that vulnerable people should be able to exercise maximum personal responsibility over their own lives and decisions, as appropriate to their capacity. The expectation is therefore, that people will look after their own medicines, whenever possible, and administer them in accordance with the advice of their own doctor or appropriate health advisor. There are, however, occasions when it is necessary to support people with the administration of their medication.

1.1.5 The policy will clarify, under the Sunderland ‘Boundaries of Health and Social Care Responsibilities’, the procedures and responsibilities when assistance with medication forms part of the service users assessed care plan and to ensure medication concordance for vulnerable people is carried out in a safe and professional manner by trained and competent staff.

1.1.6 The procedures are intended to encompass most medication issues arising in social care settings, but they cannot predict every situation that might arise. If in doubt about the right course of action to take, staff should always consult their line manager, the GP and/or pharmacist.

1.2 **Legislative Requirements**

1.2.1 The following legislation contributes to the regulation of medication within a care setting:

- The Care Standards Act 2000
- The Misuse of Drugs Act 1971
- The Medicines Act 1968
- Guidance from The Royal Pharmaceutical Society of Great Britain ‘The Handling of Medicines in Social Care’ October 2007
- Nursing & Midwifery Council ‘Standards for Medicines Management’ October 2007
- The Mental Capacity Act 2005

1.2.2 Other legislation such as the Data Protection Act, Human Rights Act and the Disability Discrimination Act may also be relevant to particular circumstances, such as providing accessible information or explanations about medicines that can be understood by service users with various disabilities.
1.3 Policy Objectives

1.3.1 The national minimum care standards require regulated social care services to work within written policies and procedures. This policy and its associated procedures promote the safety and well-being of the service users and also provide safeguards for care staff.

1.3.2 The objectives of this policy are therefore:

To make every effort to ensure that service users benefit from quality care and support, and also to protect clients and staff from harm arising from mistakes with medication by:

- ensuring legal compliance and best practice in the management of medication by social care services for adults and older people.
- encouraging clear communication between the social worker, service user, carer and NHS professionals.
- reinforcing the principle of consent in relation to the management and administration of medication.
- supporting risk reduction systems in relation to the management and administration of medication.
- ensuring accurate and comprehensive documentation of all procedures.
- undertaking regular policy review.

1.4 Scope of the Policy:

1.4.1 This policy and procedures replace all previously published policies, procedures, standards and guidance.

1.4.2 The documents reflect the different circumstances of various social care settings and the procedures will be updated from time to time by the Medication Group to reflect changing guidance.

1.4.3 This document has been produced with input from social care registered managers and a member of the Social Care Governance Team. Relevant UK legislation and guidance has been taken into account and the standards produced by the Commission for Social Care Inspection are incorporated.

1.4.4 The policy and procedures are applicable to all employees of Sunderland City Council who provide or commission services to; adults in care homes, short break, Intermediate care, domiciliary care and day care services. An unauthorised breach of the policy and procedures may result in action being taken within the terms of the council’s disciplinary policy.

1.4.5 It is the council’s intention, when purchasing services from independent care providers, to share these policy and procedures documents with them and to review their own documents in line with contractual arrangements. It is expected that their own procedures will provide an equivalent level of safeguards to service users and staff.

1.4.6 In-service and induction training for appropriate staff in all directly provided care settings will be provided to ensure that there is full knowledge of the policy and to enable full compliance. No member of staff will be permitted to administer medication unsupervised unless they have been trained in the relevant procedures. These procedures and training will be clearly specified in training and staff development plans and associated procedural notes for specific interventions.
1.5 **Policy Implementation**

1.5.1 The council will:

- ensure the effective application of this policy through support and monitoring provide employees with training to equip them with the necessary skills, knowledge and understanding to manage medication.
- monitor the effectiveness of training
- monitor and update the procedures as required
- liaise with appropriate external agencies from time to time to ensure that the policy and procedures are kept up to date
- distribute the policy widely to staff, GPs and community pharmacists

1.6 **Indemnity Statement**

1.6.1 The council will, subject to the exceptions set out below, indemnify its employees against liability at law, in the pursuit of their duties on behalf of the council and whilst acting within the scope of their authority.

1.6.2 The indemnity will not extend to liability directly or indirectly arising from personal fraud, dishonesty, wilful negligence, deliberate wrongful act or criminal offences.

1.6.3 The indemnities will not apply where the individual admits liability or engages in negotiations to settle any claim falling with the scope of this resolution.

1.7 **Policy Review**

1.7.1 The council is committed to the continuing development of the policy and procedures and will endeavour to maintain their accuracy and relevance.

1.7.2 It is the responsibility of a designated person within each service to ensure proper maintenance of all of the documentation defined within this policy and procedures and to control issue of the documents and their distribution.

1.7.3 It is the responsibility of the Medication Group to review the entire policy and procedures on an annual basis. A designated person within each service will be responsible for amending any section of the documentation, in a local capacity, in exceptional circumstances only e.g. policy/procedure review following analysis of a medication error or a change in legislation that requires immediate attention.

1.7.4 All amendments must be promptly reported to the Medication Group and considered as a more permanent change as part of the annual review. All such amendments must be clearly marked with the date of change/implementation and the name and signature of the responsible person.

1.7.5 This policy/procedures contain controlled documents and any new or amended controlled documentation will be issued by the designated person, who will remove and destroy old documentation and record amendments on the Document Control Amendment checklist (Appendix 1).
1.8 Equality and Diversity

1.8.1 Sunderland City Council recognise that for some people western medicine is not their preferred or primary health care system of choice of treatment, and may therefore be accessing other health care systems, such as homeopathic medicines. Sunderland City Council values diversity and respects the person’s right to such choices, however social care staff employed by Sunderland City Council, or staff providing a service under contract, cannot participate in any activity other than for those medicines/treatments prescribed by a legally registered medical practitioner or the Over the Counter/homely remedies described within this policy. This will include the purchasing, collection, administering and disposal of medication/remedies/treatments outside the scope of this policy and procedure.

1.9 Choice and Consent

1.9.1 Assistance with or administration of medication can only be provided with the consent of the service user, which can be written, verbal or non-verbal. Consent should be obtained when the initial risk assessment is carried out to establish the category of support the service user requires (Appendix 2).

1.9.2 This consent should also extend to the disposal or destruction of medicines, as these remain the property of the person the medicines are prescribed for.

1.9.3 Peoples cultural and religious requirements should be fully and carefully considered and may include:

- Vegetarians and people from some religious groups who do not want gelatin capsules (made from animal products)
- Having medicines given to them by people of the same gender
- The administration of medicines during religious festivals, including fasting
- Medicines including ‘unclean’ substances

1.9.4 The assessment of capacity to consent is vital and having mental capacity means that a person is able to make their own decisions. The Mental Capacity Act 2005 says that a person is unable to make a particular decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision - this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand

1.9.5 It may be the case that the person lacks capacity to make a particular decision at a particular time but this does not mean that a person lacks all capacity to make any decisions at all.

1.9.6 It is very important that you remember at all times that lack of capacity may not be a permanent condition. Assessments of capacity should be time and decision specific.

1.9.7 Where informed consent cannot be given, or the service user is unable to express their views, advice will be sought from their carer, or any other significant person. If necessary, an independent advocate will be used to ensure the best interests of the service user.
1.10 Mental Capacity Act

1.10.1 There are five principles within the Mental Capacity Act and these principles must be borne in mind when working with, or providing care or treatment for people who lack capacity.

1 Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise

2 People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. If a lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

3 People have the right to make what others might regard an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.

4 Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

5 Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity you must choose the option that is in their best interests and you must consider whether you could do this in a way that interferes less with their rights and freedom of action.

1.11 Responsibilities

1.11.1 Supporting service users with their medication must only be carried out in a planned, professional and safe manner based upon the needs of the individual service user and in regard to the protection of staff. Assistance with or administration of medication will be provided by appropriately trained staff who will report and be accountable to their manager. If there is any uncertainty or disagreement about the appropriateness of task requested of staff then the issue will be referred to the member of staff’s Line Manager for advice and decision.

The following information acts as a framework setting out individual responsibility for supporting vulnerable people with medicines either living at home or in a social care service.

1.11.2 Service Users

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

The risk assessment will identify the level of support required to facilitate independent living. If support with medication is required then the service user must provide staff with access to the prescription medicines and other information to enable them to carry out the duties identified in the care plan and service plan.
1.11.3 **Unpaid Carers**

Unpaid carers often provide valuable support to service users, particularly those living at home, in regard to their medication. However, unpaid carers often need a break or cannot be always available e.g. work commitments. In these circumstances, it may be appropriate for staff to provide the service during the carer’s absence in compliance with this policy.

For the duration of any absence, the carer must provide the staff with access to the prescription medicines and other information to enable them to carry out the duties identified in the Care Plan and risk assessment safely.

1.11.4 **Service Manager (includes Registered Managers)**

- It is the responsibility of the Service Manager to ensure that this policy is implemented in their service
- Monitor and review the service provided
- Ensure that incidents and ‘near-misses’ are recorded appropriately and used as a learning tool to improve the service
- Provide feedback on this policy to aid its evaluation and review
- Facilitate training for care workers
- Maintain records of staff training
- Ensure that the agreed and documented level of assistance/support is provided to service users on a day-to-day basis by trained and competent staff
- Make all records relating to medication available for inspection by the Commission for Social Care Inspectors, and appointed representatives of Adult Services Department.

1.11.5 **Paid Care Workers (Adult services and Independent Sector Care Workers)**

Following a risk assessment, and taking into consideration the consent and mental capacity of the service user, the level of assistance required will be defined within the Care Plan and detailed in the Service User plan.

It is the responsibility of the care staff to follow the service user plan and this policy and to report any concerns to their line manager.

**Care staff should only assist with medication where they have the required training and they are competent to do so.**

1.11.6 **Care Managers**

- Carries out medication risk assessment
- Identifies the appropriate level of support and records this in the care plan
- Obtains and records service user’s consent
- Liaises with health professionals as appropriate to confirm medication requirements, special storage or administration details etc
- Ensures that a record of medication, the risk assessment, consent and care plan are passed to the care service

The Care Manager continues to hold responsibility for ensuring that reviews are conducted whenever there is a significant change in the service user’s circumstances. When there is no change **reviews must take place every 12 months.**
Care managers, and commissioners on their behalf, must clearly identify medication needs, providing as much relevant information as possible prior to the start of any medication administration. Care managers will be responsible for notifying the G.P that Home Care staff may be involved in administering medication.

### 1.11.7 Senior Managers and Corporate Responsibilities

Where problems arise which cannot be resolved locally, these must be referred to appropriate national bodies. Beyond this, further appropriate specialist support must be sought. In this way a body of knowledge can be generated about problematic issues relating to medication. It is a corporate responsibility to collate and communicate these issues consistently to all relevant personnel.

### 1.11.8 Health Personnel

General Practitioners (GPs) have a responsibility of care for all of their listed service users/patients to provide general health and medical care, or refer for specialist health care or social care. In looking after an individual’s health and well-being, the GP or other non-medical prescriber will prescribe medication to their patient to prevent, treat or relieve medical conditions. It should be noted that individual service users/patients might also receive medication prescribed by specialists, and which might have been supplied to them in hospital. In this case it may not be written on the MAR Chart.

GPs are also expected to undertake medication review in line with NSF targets and identify any compliance problems. They are responsible for providing medicines at the frequency most appropriate for the service user/patient (i.e. 7 or 28 days at once).

Within primary care, other professionals may be involved in prescribing for service users—suitably qualified nurses or pharmacists are able to prescribe.

### 1.11.9 Community Pharmacists

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

Pharmacists have a responsibility for service users/patients eligible under the Disability Discriminations Act (DDA) 1995 to provide them with a reasonable level of assistance; this may include large labels, non child proof containers or multi-compartment compliance aids (MCCA).

They do not have to provide these for other service user/patient groups and hence may charge some individuals for this service.

Pharmacists may provide MAR charts in certain circumstances when deemed appropriate and some Pharmacists may provide a Medicines Use Review (MUR) service.

### 1.11.10 Nursing Personnel

Will provide nursing and clinical care to individual service users/patients, e.g. caring for wounds, pressure sores and the change of dressings or carry out invasive procedures such as injections and bladder irrigations and matters relating to feeding tubes. During such provision they will also monitor the health status of the individual and report any changes in circumstance to the GP.
1.11.11 **Specialist Nursing**

This includes, for example, respiratory nurses, stoma nurses, palliative care nurses or continence advisors who also provide nursing and clinical care to individual service users and support to their families. These specialist nurses will support and educate the service user/patient in coping with their particular condition and assist them in dealing with stoma equipment or the drug treatments or therapy necessary to their condition.

**Designated Person**  
(Name)  
(Job Title)
2.1 Pre-Admission/Pre-Commencement of Care Package

2.1.1 The overall aim of the Medication Policy is to promote independence through encouraging service users to manage their own medicines as far as they are able.

2.1.2 The service needs to clarify whether the service user is self-medicating, requires a level of support from staff or requires staff to administer their medication. In order to remain as independent as possible, some service users may need assistance to take their prescribed medication as part of their care package.

2.1.3 The category of support required should be assessed by the Care Manager or Manager/delegated individual prior to the commencement of the service and the exact nature of the assistance required will be clearly documented within the service user’s personal plan or other relevant documentation within the particular service.

2.1.4 If the person has been self medicating prior to admission or commencement of care package, but there is some uncertainty as to how well they have been doing this, they should be allowed to continue to do so with the implementation of an agreed risk management plan.

2.1.5 Service users have the right to expect that any assistance offered is carried out in a professional manner by properly trained staff.

2.1.6 Prior to assistance being given the service user must give written consent, wherever possible, at the point of assistance and staff must have read this policy.

2.1.7 Any concern about a service user and their medication, either before or following admission/commencement of service, must be reported to the Manager/Supervisor who will seek appropriate advice from the GP, Pharmacist, District Nurse and/or Social Worker.

2.1.8 Categories of Support

Person is totally independent

Assisted Self-Medication
(Service user directs carers and takes responsibility for their medicines)

Level 0

Level 1

Permitted Tasks
○ Help with ordering and collecting prescriptions
○ Verbal reminder to take medication (known as ‘prompting’)
○ Help with reading labels or patient information leaflet
○ Advising on safe storage of medicines
○ Observing and reporting to the Senior Care Worker any changes in service user’s ability to manage their medicines

Excluded
○ Opening containers to assist service user
○ Administration of medicine (handing a prepared dose to a service user
○ Any invasive, clinical or nursing procedures
○ Specialist tasks (see section 2.21.4) unless a suitable health professional has given additional training and the carer is signed off as competent to provide such care
Supervised or physically assisted self-medication
(Service user directs carers and takes responsibility for their medicines)

Level 2

Permitted Tasks
○ As above (assisted self-medication)
○ Opening containers
○ Pouring liquid doses
○ Preparing inhaler/spacer devices
○ Preparing a compliance device for eye drops
○ Applying topical preparations (e.g. a cream or ointment)

This level of support must be covered by the completion of a Medicines Administration Record sheet

Excluded
○ Invasive, clinical or nursing procedure
○ Opening containers or handing prepared doses without direction from service user
○ Assisting with opening monitored dose devices (Medidos, Dosette or similar) filled by family or friends
○ Specialist tasks (see section 2.21.4) unless a suitable health professional has given additional training and the carer is signed off as competent to provide such care

Complete Medicines Management
(service user is not taking responsibility for selecting which medicines are to be taken)

Level 3

Permitted Tasks
○ As above (assisted & supervised self-medication)
○ Selecting and administering the appropriate medicine by opening the container, handing the prepared dose to the service user and ensuring it is taken correctly

Excluded
○ Invasive, clinical or nursing procedures
○ Specialist tasks (see section 2.21.4) unless a suitable health professional has given additional training and the carer is signed off as competent to provide such care
○ Assisting with administration of medicines stored in monitored dose devices (Medidos, Dosette or similar) filled by family or friends

2.1.9 Self-Medicating

Staff will only provide assistance with medicines if this is specified in the personal plan/support plan. A record of medication assistance will be kept on a self-medication risk assessment and agreement form (Appendix 2)
2.1.10 **Administration by Staff**

Staff will only administer medicines if this is specified in the personal plan/support plan and this has been the category of support required by the person following the completion of the medication risk assessment and agreement form (**Appendix 2**).

2.1.11 **Planned Admission (Short Break and Intermediate Care)**

In accordance with the practice of the service involved, the service user/service user’s representative will be sent a list of minimum requirements regarding medication and prescribed items prior to the commencement of the service. Each service is to add/use their own documents.

See **Appendices 3, 4 and 5** for examples of format/content to use:

1. Short Break – Older Persons
2. Short Break – Younger Persons
3. Intermediate Care

A minimum requirement will be:

- 7 days supply or a sufficient supply of all prescribed medication/items to last the duration of the stay and no longer
- Confirmation from the service users’ GP or other health professional of their current prescribed medication
- Clear instructions regarding variable dose or ‘as required/directed’ medicines
- For those service users who self medicate, medication will be accepted in the containers that are used at home. Assistance with medicines from unlabelled compliance aids filled by family or informal carers will be limited to assisted self-medication only (verbal assistance/prompt)
- For those service users who require their medication to be administered by staff, all medication received must be in the original, suitably labelled containers as dispensed by a pharmacist, such as boxes, bottles or other compliance aids

2.1.12 **Planned Admission to permanent care**

In accordance with the practices of the service involved, all information regarding medication needs will be gathered as part of the assessment process by the relevant professionals and/or responsible person.

Before admission is agreed the manager/responsible person will ensure all assessed needs can be met within the service.

2.1.13 **Planned commencement of care package (Domiciliary Care)**

To be developed
2.1.14 Planned commencement of care package (Day Care – Older Persons)

In order to support Day Centre service users with the correct handling, storage and administration of their medication, the same procedure as detailed in section 2.1.2 will apply, with the exception that only sufficient medication as is required for the duration of the length of stay in the Day Centre will be brought to the service at the commencement of each session.

Staff must always be aware of the need to continually support individuals within the taking of medication in view of a change occurring within their medication regime e.g. short course of antibiotics being prescribed, increase or decrease in dosages.

2.1.15 Emergency Admission/Commencement of Care Package

In the case of emergency admissions or emergency commencement of a care package, particular attention must be given to determining what medication, if any, is currently prescribed. This can be a copy of the most recent prescription or confirmation from a GP of the person’s prescribed medication.

If no information is available through the carer or family etc, the designated person must contact the GP to confirm details of medication prescribed before undertaking any administration.

If the admission/commencement of care package has taken place outside of normal surgery hours and the service are unable to clarify the current prescribed medication from any source, then medication should be withheld until clarification can be sought from the service user’s GP or other health professional. The person should be observed by staff for any signs and symptoms of illness or deterioration, and if concerned request a visit from the out of hours GP service, or send the person to the Accident and Emergency department. If this situation occurs, staff must make detailed recordings of events and action taken.

Following admission or commencement of care package, and as far as is possible, the same procedure as detailed in section 2.1.2 will apply for all emergency situations.
2.2 Medication Assessment

2.2.1 Some service users wish to, and are able to, administer their own medication and keep it themselves. They may choose to do this and people, wherever possible, should be encouraged and supported to administer their own medication to maintain their independence.

2.2.2 Where a service user has been deemed capable of self-medicating, every effort must be made to maintain up-to-date information of medication being taken. All such information must be recorded in the service user’s personal plan. The service would only be required to keep a record when they have an involvement in obtaining the medicines on behalf of a service user.

2.2.3 In all cases of self medication, it is essential that a risk assessment is carried out, preferably at the point of referral, to ascertain the ability of the service user to self medicate and to identify and eliminate any risk to themselves or to others. The record of the risk assessment is to be kept on the service user’s file. This agreement should be completed and agreed with the delegated responsible person within the service and, wherever possible, should involve other professionals and family members/service user’s representative in order to gain a robust assessment of the person’s ability.

2.2.4 If the person has been self-medicating at home but there is some uncertainty as to how well they have been doing this, they should be enabled to continue to do so within the risk management process.

2.2.5 Guidance notes for self-medication risk assessment and agreement

i. All questions should be answered or comment provided where the answer is unclear. The assessor should make an initial decision based on the resources currently available and the service user’s current skills/abilities.

ii. The questions should then be reviewed to include any adjustments or support that can be provided to enable the person to self-medicate and these should be clearly logged onto the assessment form. Adjustments or support can include such things as; staff ordering and/or obtaining the medication, large print labels, reminder cards, easy open bottles, staff decanting medicine from the container into a pot for the service user to take, staff putting medicine into water to dissolve. The local pharmacist should be able to offer advice on aids that are available.

iii. It is important to realise that further adjustments can be made at any review of the assessment and service users may move between levels of self-medicating or having medication administered by staff.

iv. Once the adjustments/support required have been identified, the assessor should make a decision as to whether the service user; can self-medicate totally independent, can self-medicate with verbal or physical assistance or requires their medication to be administered by staff.

v. The support required should include evidence of how staff are to monitor the person’s compliance with self-medication. It is unreasonable and unnecessary to expect a service user to sign that he/she has taken medicines, and an invasion of privacy for staff to check at each administration time that the medicine has been taken. However it is important that staff record details of how self-medication is being supported. A minimum timescale for an audit of the person’s remaining supply of medicines should be agreed and recorded onto the risk assessment and agreement form.
vi. The admitting person must set the first review date on admission of the service user. This may vary from service to service and be dependent on the abilities of the service user.

First Review timescale within this service
__________________________________________

vii. The service user (or their representative), where possible, and the assessor should sign the risk assessment document to confirm their agreement to the assessment outcome, as there may be some risk involved.

viii. The responsible person, on the identified review day, will conduct the review and report the outcome to the Senior Officer on duty at the time, if appropriate.

ix. The assessor must make sure the service user understands that the safe storage of their medication is their responsibility and that this is for their own and other’s safety. Within a registered care home, medication self-administered by service users must be kept in a lockable facility and it is the responsibility of the service to provide this facility for the service users. The service user should be made aware that staff will not access this lockable facility without their permission, but that a master key is held by the service in case of emergencies.

x. Service users should be actively discouraged from carrying medication in handbags or pockets except where medical advice recommends they be available at all times, e.g. in the case of angina tablets or sprays/inhalers for breathlessness.

xi. Staff should be alert to any changes in the ability of the service user to manage their medication and report any concerns to the senior staff/manager.

xii. The service user must be encouraged to report any missed or incorrectly doses to staff as soon as possible.

xiii. As there are risks of interaction between prescribed medicines and medicines purchased over the counter (including herbal and homeopathic remedies), service users should be encouraged to inform the service if they, or a relative, purchases such medication for self-administration.

xiv. It should be noted that people can self-medicate controlled drugs and the guidance issued by CSCI ‘The safe management of controlled drugs in care homes’ should be followed.

xv. The monitoring of the service user complying with self-medicating will be carried out in accordance with the agreed arrangements discussed in the initial risk assessment or in subsequent reviews.

xvi. Following the initial risk assessment, reviews will be carried out at agreed timescales or immediately a concern has been identified about the service user’s compliance with or capability for self-medicating.
2.3 Receipt of Prescribed Medicines

2.3.1 On initial admission

Recording of the receipt of medication can only be undertaken once the self-medication risk assessment and agreement form has been completed and an outcome agreed.

All service users must have a photograph taken which should be stored next to the MAR sheet for that individual.

If a service user is admitted with the same or similar name as an existing service user, a distinctive **ALERT** sticker must be placed at the top of each person’s MAR sheets on admission.

2.3.2 Receipt of Medication administered by staff

All medicines brought into a care home from whatever source, including discharge medicines from hospital, medicines prescribed in an acute situation as well as medicines prescribed on a regular ongoing basis or those brought from another home should be recorded by a designated person.

As a minimum the record should show:

- Date of receipt
- Name, strength and dosage of medicine
- Quantity received
- Service user for whom medication is prescribed or purchased
- Signature of the member of staff receiving the medicines and a witness

Should it be necessary within the service that one person carries out this task, another trained member of staff should carry out a check at the earliest opportunity.

For additional protection and to assist in identifying service users (particularly if there are two or more people with the same name), the service user’s date of birth should also be recorded. It is also good practice to record the name of the service user’s GP, any known allergies, the type of container the medication is received in and where the medication is stored i.e. fridge, controlled drug cupboard, service user’s room.

Any medication that cannot be identified must be either returned home or to the pharmacist, with the service user’s permission, as unidentified medication cannot be recorded or administered.

2.3.3 Receipt of medicines for service users who self-administer

To support good practice and assist in the audit and monitoring of self-medication, a record of all prescribed medicines should be held by the service.

To aid in the possibility of people moving between levels of self-medicating or medication being administered by staff, it would be best practice to record all prescribed medicines onto a MAR sheet.

The medicines received should be checked to ensure they are; the property of the service user, the most current medication dispensed and, where possible, not past their expiry date.

It is sometimes the case that service users/carers buy their own containers or use their own system, which aid the service user to self medicate when at home alone. If that system has been used successfully at home it should be encouraged to continue while in the service and alternatives should be explored if necessary, according to risk assessment outcomes.

An appropriate sticker should be placed on the MAR sheet to indicate either ‘self medicate’, ‘Assisted Self-Medication’, ‘Supervised or physically assisted self-medication or ‘Complete Medicines Management’.
2.4 Storage of Medicines (including Cold Storage)

2.4.1 All medication held in the service must be stored in unmarked cupboards, locked wall-mounted cabinets, locked trolleys sited away from public areas or a lockable facility in each service user’s bedroom. Whichever storage facility is utilised must be used specifically and solely for the purposes of storing medicines.

2.4.2 Cupboards must be sited away from sources of heat, moisture or direct sunlight as any of these elements can cause medicines to deteriorate. The temperature of the designated medicines storage area should be between 16°C and 25°C. Under no circumstances should this exceed 25°C.

2.4.3 Trolleys must be secured to a wall if not stored within a locked cupboard.

2.4.4 Keys for the medicine cupboards should be kept separate from other keys. Copy keys should be retained by the Service Manager or designated person in case of loss. A designated officer should keep the keys and the procedure for handing over keys should be understood by all staff concerned and recorded in the in-house procedure. See Appendix 6 for process applicable to service.

2.4.5 Each service user’s medication must be kept together but separately from other people’s i.e. in individual containers identifying that person.

2.4.6 Wherever possible, oral medicines should be stored separately to non-oral medicines.

2.4.7 Stock should be rotated as it is received and the remains of an old prescription must not be mixed with a freshly supplied prescription. Out of date stock should be disposed of.

2.4.8 For guidance on the storage of Controlled Drugs see section 2.13

2.4.9 A separate lockable refrigerator should be available to be used exclusively for the storage of medicines requiring cold storage. This should be kept locked at all times in accordance with storage of other medicines. A locked tin within a refrigerator may be suitable within a small home environment. This should be subject to a risk assessment and kept under review.

2.4.10 The temperature of the medicines refrigerator should be monitored and recorded daily when in use, using a maximum/minimum thermometer. The refrigerator should be defrosted monthly and a record should be kept on this. Normal range is between 2-8 °C. Temperatures outside of this range should be reported immediately.

2.4.11 Oxygen not in use must be stored in a large airy room with adequate ventilation and no source of ignition. Only the minimum amount required must be stored. Where a service user has oxygen in their room the Oxygen Safety Information (Appendix 7) should be available in the room and must be adhered to by all staff and professionals.

2.4.12 When oxygen is in use within the service the appropriate risk assessments and risk control measures should be completed and adhered to.

2.4.13 Medication must not be left exposed and unattended at any time. If an emergency situation arises when medication is being administered and which requires the attention of the staff member administering the medication, the cupboard/trolley must be locked until the responsible person is able to return.
2.5 Ordering of Medicines

2.5.1 It is recognised by the RPSGB that the rights of service users to choose where their prescriptions are dispensed may be limited. The Society recommends that the person in charge of the service should select one pharmacy where the service obtains medicines on behalf of its service users in order to ensure continuity of care.

2.5.2 It is the responsibility of the manager/designated person to ascertain the current prescribed medication before a further supply is requested, in whichever way is appropriate to the service.

2.5.3 Care should be taken by the designated person to ensure that only current required prescribed medication is ordered, to prevent an overstock.

2.5.4 It is the manager/designated person’s responsibility, wherever possible, to:

- Initiate the order for the FP10/GP10 or other NHS prescription form
- Have sight of the prescription forms before they are sent to the pharmacy as this is the only document signed by the prescriber
- Check the prescription form against the items ordered
- Sign the exemption declaration on the back of the prescription form on behalf of the service user, if the person is unable to do this themselves

2.5.5 Confirmation of current prescribed medication must be obtained before ordering any medication including repeat medication. However it is legally permissible for a pharmacist to supply medicines (not Controlled Drugs) against a faxed or verbal order, if the prescriber provides a written prescription within 72 hours.

2.5.6 It is good practice to track the ordering, prescriptions and receipt of medicines and records should be kept of all stages.

2.5.7 The process for ordering medication will vary from service to service and should include a minimum of:

- Who orders?
- What day?
- By what method?
- By which pharmacy?
- From which GP?
- Records/copies kept
- Where & how evidence is filed

The service specific procedure for the ordering is clearly identified in Appendix 8.
2.6 Changes to Medication

2.6.1 There are occasions when it may be necessary for medication to be changed. Only a qualified practitioner can do this.

2.6.2 All changes to medication should be in written form. Verbal instructions should not be accepted, except in certain circumstances (see section 2.6.6). Wherever possible the GP/prescriber should be asked to amend the MAR sheet when any changes are necessary.

2.6.3 In all instances the directions on the container relating to that medication should be overlabelled securely with a pre-printed label saying ‘see MAR sheet for directions’. This label must not obscure the details of the person.

2.6.4 Changes of Dose

A Monitored Dosage Systems/Compliance Aids (including Nomad, Manrex etc)

If the change of dose is a decrease or unwanted tablets/capsules need to be removed from a cassette or carrier, then ideally the system should only be altered by the pharmacist. If this is not feasible, but only if the medication can be clearly identified, then the designated member of staff must ensure that they have removed the unwanted tablet or capsule and disposed of it in the appropriate container.

Should the change of dose be an increase e.g. 1 to 2, then the GP/prescriber must provide the extra prescription to obtain the increase required. These can be kept in the original container until the pharmacy re-opens and the medication can be added to the monitored dosage system by the pharmacist if necessary.

B Separate Containers

Where medication is stored in separate containers it is not necessary to remove or add medication when a dose changes. The directions on the label should be amended as soon as possible (as paragraph 3 above).

2.6.5 Warfarin

The current dosage prescribed will be recorded in the patients yellow WARFARIN record book and this is the dosage that should be administered, as this information may not be on the MAR sheet. Clarification of the Warfarin dose can be sought from the Warfarin clinic within normal clinic hours (see WARFARIN record book for contact details).

2.6.6 Verbal Orders

Care homes/services cannot legally accept verbal instructions for the commencement of any NEW treatment with a Prescription Only Medicine. However there may be occasions when a qualified practitioner/prescriber needs to give verbal instructions to the service for changes to medication currently prescribed.

Wherever possible, written confirmation of the change should be requested by fax before the changes are made. Where this is not possible, the prescriber may give verbal instruction for a dose to be changed, but this must be subsequently confirmed in writing as soon as possible, but within a maximum of 24 hours.
In those circumstances the designated staff member should endeavour to obtain confirmation of the prescriber’s request by asking them to repeat the instructions to a colleague. The change must be initially recorded onto a Verbal Changes to Medication form (see Appendix 9) and then both staff members must add and verify the changes to the MAR sheet. These changes on the MAR sheet must be signed and dated by both staff members.

If there is only one member of staff on duty any verbal changes to medication can ONLY be accepted in writing.

2.6.7 New Medication

If new medication is prescribed, it is good practice for this to be recorded in the person’s notes by the GP, wherever possible.

A prescription must be obtained as soon as possible and medication supplied by the pharmacist should be added to the MAR sheet as set out in section 2.18.

If the medication is in addition to a monitored dosage system but initially supplied in a separate container it must be added to the monitored dosage system by the pharmacist at the earliest opportunity.

New short term or PRN medication, such as short courses of treatment, must be kept in its original container with directions on that container intact. Any such medicines should be started as soon as possible, within 24 hours at the latest following the receipt of the prescription.

2.6.8 Discontinued Medication

If a medication is to be discontinued, the pharmacist is the person who should remove any unwanted medicines from a monitored dosage system. However, in situations outside of pharmacy hours and ONLY if the medication can be clearly identified, staff should remove this from the monitored dosage system. This should be clearly recorded onto the MAR sheet.

Discontinued medications not in a monitored dosage system should be either; retrieved from the service user with their consent, or removed from where it is stored and returned to the pharmacist.
2.7 Disposal of Medication

2.7.1 All medicines prescribed and dispensed for a person are the property of that individual. If the person leaves the service their medicines should be given to them, unless the person gives consent for their safe disposal.

2.7.2 Following the death of a person all medication must be kept for a period of seven days before disposal, in case the coroner's office or the court requires them.

2.7.3 No staff within the service can dispose of medication themselves. It must be returned to the supplier, which in the majority of cases will be the pharmacist who dispensed them. The pharmacist is the only person who can and is responsible for the disposal of medication. Disposal of medicines on site through the sewage system is not considered appropriate.

2.7.4 If the pharmacy is not open the medication should be stored in a designated container and kept in a locked cupboard until it can be returned to the pharmacist. Medicines dispensed for individual service users are their own property and should be sent with them on discharge.

2.7.5 Records

It is the responsibility of the designated person to ensure that a complete record of medication going out of the service, by whichever discharge route, is recorded in a medication returns book or directly onto the MAR sheet. This record must be able to provide a full audit trail, and must include:

- The name of the person for whom the medication was prescribed
- The name and strength of the medication
- The quantity being returned.
- Signature of the member of staff who arranges the return of the medication
- Signature of person taking receipt of medication (i/c pharmacy), wherever possible
- Date of return to the person/pharmacy

The person taking receipt of the medication could be the service user themselves, ambulance or hospital personnel, relatives, friends or a representative from the pharmacy etc.

This record must be kept in the service for three years from the date of the last entry.

2.7.6 Discharge of Medication

When a service user is returning home (from Short Break/Intermediate Care Service)

A count must be done of the remaining medicines being held in the service by two members of staff or the service user/their representative and one member of staff if this is appropriate. A record of this count must be recorded onto the MAR sheet and both people responsible for the count should sign to confirm the amount of medicines leaving the service.

Intermediate Care Only

Within the Intermediate Care Centre the person responsible for discharging the service user should ensure that the person has at least 7 days supply of medication to leave with.

2.7.7 Transfer to hospital/another service

Should a person be discharged to hospital from a service then a list of current prescribed medicines should be sent with this person. Where required, all of the person’s current prescribed medication should also be sent with them when they leave. A copy of the current MAR sheet could also be sent.

Receipt of the medication should be obtained from the person receiving the medication i.e. ambulance personnel, relatives, service user, hospital personnel etc.
2.8 Adverse Reactions/Side Effects

2.8.1 There are a range of side effects that people may experience when taking medication and these should be clearly stated in the Patient Information Leaflets (PILS) which should be issued with each medicine. Unfortunately there are occasions when people may suffer a severe or adverse reaction to the medication they are taking. This could be:

- a suspected side effect that is not mentioned in the patient information leaflet that came with the medicine; or
- a suspected side effect that has caused problems severe enough to interfere with everyday activities.

2.8.2 If it is suspected that a medicine or herbal remedy has caused an unwanted side effect then an appropriate health professional should be consulted. NHS Direct can also be contacted for advice on 0845 46 47.

2.8.3 If there are immediate concerns about a suspected side effect, then the person’s GP or other health professional, including a pharmacist should be contacted.

2.8.4 There is a system/process for reporting any suspected adverse drug reactions (ADR) and this is the Yellow Card Scheme (see Appendix 10a & 10b).

2.8.5 The Medicines and Healthcare products Regulatory Agency (MHRA) is the medicines safety watchdog. The Yellow Card scheme collects information on suspected side effects from all types of medicines from health professionals and members of the public. These include prescription medicines, medicines that can be bought without a prescription, and herbal and other complementary remedies.
2.9 Medication required when a person is away from the service

2.9.1 There may be occasions when a service user is away from the service i.e. day centre, outings, holidays, hospital appointments etc. and medication is prescribed to be taken during this time.

2.9.2 The initial step should be to establish whether it is essential the person requires the prescribed medication during the time they are away from the service. Advice can be sought from the GP/prescriber/pharmacist and a record of the advice given should be clearly recorded into the personal plan.

2.9.3 If it is essential that the medication should be taken during the time the person is away from the service then; an individual risk assessment should be completed (Appendix 11a), and the medicine, in its original container, should accompany the service user. This may be in the charge of the service user, a member of staff or another person. This risk assessment should link and relate to the corporate risk assessment (Appendix 11b).

2.9.4 To reduce the risk of adverse effects/reactions, if the person is prescribed a new medication the initial dose should not be administered prior to or whilst the person is away from the service.

2.9.5 A risk assessment should be carried out to establish the risk reduction measures that should be in place to ensure that; the medication is stored and transported safely, is taken by the correct person at the correct time and that the process is within legislative guidelines.

2.9.6 The risk assessment will be appropriate for all occasions medication has to be administered whilst the person is away from the service unless circumstances are drastically different i.e. day leave will be different from a planned holiday. A social leave form may be completed and stored in the person’s personal plan if required (example – Appendix 12).

2.9.7 The risk assessment will be reviewed should anything adverse occur or at a minimum timescale set by the service. Minimum Timescale within this service ________________

2.9.8 If the person is away from the service for any planned leave, for example over 24 hours, then ideally the pharmacist should be contacted in advance to provide a specific supply of medication to cover this period of leave.

2.9.9 A record should be made on the MAR sheet of when medicines were temporarily removed from, and returned to, the service. If a member of staff accompanies the person, the MAR sheet should be taken and completed by that person, wherever possible and appropriate.

2.9.10 Alternatively and ONLY when a risk assessment has established that it is inappropriate to send the medicine in its original container, the following procedure should be followed:

   i. The correct procedure should be taken by staff to identify the medication that is to be taken out of the service and administered by staff or self-administered

   ii. The designated member of staff should place each medicine in a suitable separate container. As an additional safeguard it may be considered advisable to involve a second designated staff member in these circumstances

   iii. Each medicine container should be labelled with the name of the person, the description of the medicine, dosage, quantity, time to be taken and the name of the service (NOTE – the advice and assistance of a community pharmacist should be sought with regards to appropriate types of containers and labelling requirements)
2.10 Missing Medication

2.10.1 If it is discovered that medication is missing, after the initial receipt of medication into the service then the following actions should be taken:

i. Person in charge informed

ii. A complete audit of all storage and documentation should be carried out

iii. Further investigation into events (if appropriate)

iv. Regulation 37 notification completed and sent to CSCI (if required and appropriate to service)

v. Police and Senior Management informed (if theft or misappropriation is suspected following investigation)

vi. Incident form completed which details the full record of actions taken and outcome of events
2.11 Over the Counter/Homely Medication

2.11.1 Non-prescription medicine is another name for homely or household remedies, which refer to medicines available over the counter in community pharmacies. This also applies to homeopathic and herbal remedies.

2.11.2 Should a service user choose to use a homely remedy, advice and direction for use should be gained either from the pharmacist (preferably from the pharmacist who is familiar with the person), NHS Direct Service, out of hours GP service, the 24/7 or Urgent Care teams. This will ensure that the homely remedy is compatible with other medicines being taken.

2.11.3 Service users, their relatives or representatives must be asked to advise the staff of any over the counter medicine/homely remedy, which they have purchased, or been asked to purchase on behalf of a person. Where relatives/residents do not co-operate with this policy, this must be documented within the service user’s personal plan.

2.11.4 As soon as possible following admission, a Homely Remedies Authorisation Form (Appendix 13) should be completed by the person’s GP or other appropriate health professional i.e. Nurse Prescriber. This only applies to service users receiving level 3 support from staff.

2.11.5 If a service user is taking homely medicines then these should be recorded onto the MAR sheet and signed for, if appropriate. An individual record of administration of these medicines should be kept (Appendix 14a)

2.11.6 If the service hold a stock supply of homely medicines; i.e.

- Paracetamol
- Simple Linctus
- Calamine Lotion

then a separate central record should be held which clearly shows the receipt, administration, stock balance and disposal of these medicines (Appendix 14b).

2.11.7 Should there be evidence that a service user is taking regular doses of a homely medicine such as Paracetamol or simple linctus (i.e for the relief of pain, indigestion, cough etc), then the person should be supported to contact their GP, where possible, if this exceeds a maximum of 48 hours. If necessary then staff can seek medical advice on behalf of the person, taking into consideration any issues of consent (see section 1.9).

2.11.8 It is recognised that there will be occasions when service users are unable to inform staff that they are experiencing any symptoms of a minor nature e.g. toothache, stomach ache etc and staff are required to make use of their knowledge and experience of the person to establish whether a homely remedy may be necessary. Ideally this should have been discussed and agreed with the GP prior to any such medication being required. Staff have a recognised duty of care to make an appropriate response to such symptoms of a minor nature, however they should recognise that the person’s capacity to consent must be considered at all stages (see section 1.9) before a decision to administer an over the counter or homely remedy is made. Where the service user is not able to fully participate in the decision to take these medicines, then the reasons for making this decision should be clearly recorded in the person’s personal plan.

2.11.9 Staff must not offer any advice regarding prescribed or ‘over the counter’ medication and must not purchase ‘over the counter’ medication or homely remedies without the permission of their line manager and without advice from either the service user’s pharmacist or GP.
### 2.12 Administration of Medication by Staff

#### 2.12.1 Medication can only be administered by staff appropriately trained (see section 2.20). The person allocated responsibility for administering medication during any shift should be identified and not delegate this responsibility to other staff.

#### 2.12.2 Staff should only administer medication to one person at a time and recognising the importance of administering medication, staff should be focused and aim not to be distracted.

#### 2.12.3 All medication should be recorded on the MAR sheet or appropriate record as per procedure.

#### 2.12.4 Staff should:

i. Handle medicines with good hygiene

ii. Always wash their hands before and after administering medication

iii. Keep everything as clean as possible

iv. Always explain the procedure to the person so they know what to expect

v. Check the label of the container against the MAR sheet and ensure that it is the right dosage of the right medication for the right person, at the right time, by the right route and that the medication has not already been taken

vi. Contact the senior person on duty for advice and support if there is any discrepancy, queries or concerns, or they are unsure about any aspect of giving medicines

vii. Check that the service user is not due any other medicine from any other containers, particularly if the medication is stored in a monitored dosage system

viii. Check all containers for expiry dates and security before and after use

ix. When administering oral medication, ensure the service user is sitting in a well-supported position, where appropriate, and has sufficient fluid or food with which to swallow the medication

x. Avoid handling the tablet/capsule by emptying from the container into a clean medicine cup. The specific needs of the service user should be taken into consideration

xi. Give the service user the tablet(s), capsule(s), liquid

xii. Encourage the service user to take the drink/food and ensure wherever possible that the service user has swallowed the medication and is left comfortable

xiii. Never leave medication unattended, this has not been administered until the person takes it

xiv. Follow instructions on all medication, particularly those that are soluble, dispersible or effervescent
xv. Sign for the administration or non-administration of medication in black ink in the appropriate places on the MAR sheet, or appropriate records, immediately afterwards.

xvi. Record onto the MAR sheet if a prescribed medication is not taken, together with the reason why and using the appropriate code. Staff should consider whether refusal of that medication compromises the service user’s condition or the effect of other medications. Assess the situation and contact the GP if necessary.

xvii. Store the remaining medication away again as per policy after medication has been taken.

xviii. Observe the service user for any untoward effect of their medication and inform the GP of any adverse reaction (see section 2.8).

2.12.5 Liquid Medication

When administering liquid medication the following steps should also be followed:

i. Check the cap is tight and shake the bottle.

ii. Measure out into a clean 5ml spoon, medicine measure or oral syringe.

iii. When pouring the medicine, tip the bottle with the instruction label facing upwards so that if any of the medicine dribbles down the bottle it will not mark the instruction label.

iv. Measure the liquid out at eye level.

v. The neck of the bottle may require to be wiped with a clean tissue before replacing the lid/cap. Ensure the medicine container has been closed properly.

2.12.6 Other Prescribed Medications

Where service users are prescribed medication by the following routes:

- eye or ear drops
- nasal sprays or inhalers
- topical creams/ointments
- oxygen and/or nebulisers
- PEG
- Rectal or vaginal

and staff are expected to administer any of the medications, they should be competent to do so and have received appropriate training (see section 2.20).

2.12.7 Eye Drops/Ointment

The original packaging should be retained, particularly if this contains the instructions for use.

The date that the actual bottle/tube is first opened should be written directly onto the bottle/tube, as eye drops should not be used for more than four weeks after they have been first opened. The Patient Information leaflet should provide any additional detail regarding the life span of the medicine.

Wherever possible this procedure should be carried out in private.
### 2.13 Controlled Drugs

2.13.1 For the purposes of all aspects of managing controlled drugs (CD’s) and to minimise the potential for errors, these procedures should be carried out by an authorised and trained member of staff and witnessed by another designated appropriately trained member of staff. However, it is recognised that this may not always be a practical reality and a service user ‘should not be deprived of prescribed medicine because there is only one member of staff on duty when he or she needs it’.

2.13.2 When controlled drugs are prescribed for a service user the receipt, administration and disposal of these medicines should be carried out and recorded according to the steps in section 2.3, 2.12 and 2.7. The additional steps below must also be carried out:

2.13.3 **Ordering/Collection**

Service users or their representatives may need to supply evidence of their identity when collecting Controlled Drugs medication. If the medication is a Schedule 2 Controlled Drug and the person collecting the prescription is a health care professional acting in his/her professional capacity on behalf of the service user, the pharmacist/dispenser will request proof of their identity and their name and address.

2.13.4 **Receipt:**

The receipt, administration and disposal of controlled drugs must be recorded in a ‘register’. This can be in a bound book or register with numbered pages.

The ‘register’ must include the balance remaining for each product with a separate record page being maintained for each service user. The balance of controlled drugs should be checked at each administration and also on a monthly basis.

When an opened bottle of liquid medication is received into the service, an estimate of the amount remaining in the bottle should be recorded.

2.13.5 **Storage:**

The secure storage of controlled drugs is specified in the Misuse of Drugs (Safe Custody) Regulations 1973. In brief, the requirements for controlled drug storage are:

- Metal cupboard of specified gauge
- Specified locking mechanism
- Fixed to a solid wall or a wall that has a steel plate mounted behind it
- Fixed with either Rawl or Rag bolts

For those services where controlled drugs are not prescribed regularly, it is not necessary to comply with the above guidance, however a secure, double locked cupboard should be in use.

For safe practice the controlled drug cupboards should only be used for the storage of controlled drugs. Items of value such as jewellery or money should not be placed here. Only those with authorised access should hold keys to the controlled drug cupboard. Where the controlled drug is held in a monitored dosage system, the entire container must be stored according to Controlled Drug legislation, unless the person is totally self-medicating (see section 2.13.8).

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1 CSCI guidance ‘Safe Management of Controlled Drugs in Care Homes’ January 2007
2 NPC A guide to good practice in the management of controlled drugs in primary care (England) February 2007
2.13.6 Disposal

When controlled drugs have passed their expiry date, the need for the prescription has ceased, or the service user has died, the controlled drugs should be returned to the relevant pharmacist or dispensing doctor at the earliest opportunity for appropriate destruction. Even when still in date, such drugs should not be reused for other service users.

Care homes should record the forms and quantities of controlled drugs they are returning, and the pharmacist /dispensing doctor should sign for them on receipt. If pharmacy staff collect the controlled drugs they should sign for them in the controlled drug register at the time of collection.

Relevant details of any such transfer for disposal should be entered into the controlled drug register and signed by the authorised member of staff, returning the drug.

2.13.7 Audit

Routine checks of all controlled drugs held, and the recorded running balances, should be carried out by two authorised members of staff, on a regular basis, e.g. monthly, and a record kept.

Where a discrepancy is found, it should be reported immediately to the registered manager who should investigate promptly.

If the discrepancy cannot be resolved, the advice of the local pharmacist should be sought and, if the service is registered with CSCI, the CSCI local office informed. CSCI will then share information as needed with the accountable officer.

If the discrepancy is found to be an error of subtraction or addition in the calculation of stock balance, the following procedure should be followed:

- Do not change the balance column or use correction fluid. Under the last entry, details of the following should be made:
  - the date
  - the error in subtraction / addition (indicated with an asterisk)
  - the correct balance
  - the signature of the member of staff and the witnessing member of staff.

If the above discrepancy cannot be identified, the pharmacist who is providing a service to the home should be contacted to establish whether there were any unrecorded returns of controlled drugs. If confirmed by the pharmacist, full details of such returns should be entered into the controlled drug register, together with the signature of the person who returned the drugs and that of the pharmacist who received them. The correct date and the words ‘entered in retrospect’ should also be added.

If the reason for the discrepancy cannot be found, and the controlled drugs appear to have gone missing, then the procedure for medication errors (section 2.20) should be followed.
2.13.8 Self-Medicating Service Users

Service users can keep and take controlled drugs themselves. This would be following the assessment identified within section 2.1 and only if it is indicated that the person is aware of the particular responsibilities of holding and managing controlled drugs.

Service users can hold controlled drugs in their own bedroom within a lockable cupboard or drawer. A specific controlled drug cupboard is not required.

When the service user does not arrange the supply and collection of controlled drugs but relies on the care workers to do so, there should be clear records of receipt from the pharmacist, supply to the service user and any subsequent disposal of unwanted controlled drugs. These records can be made on the Medicine Administration Record chart (MAR) however, for the purposes of good practice, entries can also be made in the controlled drug register.

Whilst it is not necessary to keep a record of the receipt, administration and disposal of controlled drugs within the controlled drug register when a service user is wholly independent, it is considered good practice to do so.

2.13.9 Non-Prescribed Controlled Drugs

Under section 8 of the Misuse of Drugs Act 1971, it is an offence for a manager/employer to knowingly permit the use, production or supply of any non-prescribed controlled drugs taking place on their premises. This includes car parks, gardens and adjoining areas. It is also an offence to ignore such occurrences.

The use of illicit or non-prescribed controlled drugs will not be tolerated within the care service. If anyone is known or believed to be in possession of a controlled drug, they will be informed that they are committing an offence under the Misuse of Drugs Act (1971) and will be advised of the legal risks that this carries.

Any member of staff who suspects that a service user has in their possession or is using illicit drugs must report their suspicions or findings to their Line Manager who will then inform the appropriate Care Manager.

Any member of staff who visits a service user, whether in a care home or their own home, and who appears to be under the influence of illicit substances, has the right to leave the service user’s home if they feel threatened. It is essential that they then inform their Line Manager immediately.

2.13.10 Self Assessment and Controlled Drug Declaration Statement

All health care organisations providing clinical services and relevant social care organisations will need to complete a periodic declaration (at least every two years) on whether or not their organisation keeps stocks of controlled drugs and whether there are any special circumstances that might explain any seemingly unusual patterns of prescribing or supply.

○ The declaration and self-assessment questionnaire will be sent to organisations by the relevant agency, and may be included in other assessments or planning tools.

○ The relevant agency can determine the frequency of self-assessment.
○ Organisations should return their declaration and self-assessment to the agency responsible for monitoring their use of controlled drugs (CSCI in the case of registered care homes)

○ These assessments will inform inspections on a risk-assessed basis to provide an additional check that CDs are managed safely.

2.13.11 **Controlled Drugs review by nominated people/liaison officers**

The Health Act 2006 has created a power of entry and inspection for the police and other nominated people to enter premises to inspect stocks and records of controlled drugs. Prior to the Health Act 2000, the Police only had right of entry to pharmacies (but not to GP surgeries) to inspect controlled drugs and controlled drugs registers, except if there was evidence that an offence might have been committed. Nominated people/agencies include PCT’s, RPSGB, Healthcare Commission and CSCI.

○ Information from the declaration and self-assessment, routine monitoring and other sources will be reviewed to decide whether any further action is needed

○ The review will assess the organisations clinical standards in the prescribing, supply, administration, storage, record keeping and disposal of controlled drugs and assure compliance with the Misuse of Drugs Act 2001 and associated regulations, medicines legislation and any relevant professional codes of practice.

○ Primary Care Trust accountable offices are responsible for arranging periodic inspections of premises which are used in connections with management or use of controlled drugs and not subject to inspection by the Healthcare Commission, CSCI or the RPSGB Inspectors. Advanced notification of inspection does not have to be provided.

2.13.12 **Common Controlled Drugs**

For an index of the most common controlled drugs see Appendix 15.

2.13.13 **Domiciliary Care**

There are no special requirements for controlled drugs schedule 2 or 3 in a domiciliary setting. They should be treated as any other medicine.
2.14 Refusal of Medication

2.14.1 An adult who has mental capacity has the legal right to refuse treatments, even if a refusal will adversely affect their health or shorten their life.

2.14.2 When a service user has mental capacity, staff must respect a service user's refusal to take medicines. Failure to do so is unlawful in both civil and criminal law, and is a breach of the service user's human rights. The exception to this principal concerns treatment under relevant mental health legislation.

2.14.3 Service users may temporarily refuse medication and should be given another opportunity to take it if possible. The individual needs of the person should be clearly identified in their personal plan and taken into consideration when administering medication.

2.14.4 If the service user refuses to take their medication it should be explained that the medication has been prescribed to maintain their health. If the person still refuses to take the medication this must be recorded on the MAR sheet and senior staff and the GP surgery informed immediately. Outside of normal working hours the senior staff should be informed immediately and the GP surgery informed at the earliest opportunity. If staff have immediate concerns about the person’s health due to the medication not being taken, advice can be sought from NHS Direct, the 24/7 team or the Urgent Care Team.

2.14.5 If a service user refuses to take prescribed medicines then the reason for the refusal must be recorded on the back of the MAR sheet and in the service user's personal plan.

2.14.6 Regular and consistent refusal of medicines should be reported to the person’s GP and appropriate steps put in place.

2.14.7 Should the covert administration of medicines be considered then this should only be carried out according to the procedure in section 2.16.
2.15 Crushing Medication

2.15.1 Many people are unable to swallow their tablets or capsules whole and the crushing or opening of capsules by staff may be considered as a method used to administer such medication.

2.15.2 If a decision to crush or open medication is made the staff must be aware of the following:

- The opening of capsules or crushing of tablets in the majority of cases makes its use "unlicensed", may affect the chemical uptake and alter the action of the medication.
- Consequently the manufacturer assumes no liability for any harm that may occur to the patient or the person administering the medication.
- Under the Medicines Act of 1968 only medical and dental practitioners can authorise the use of unlicensed medicines in humans.
- It is therefore strictly illegal to open a capsule or crush tablets prior to administration without the prescriber’s authorisation.
- Even when a medicine is authorised for administration as "unlicensed" by the prescriber, a percentage of liability of any harm that may arise will lie with the person giving the medication.
- The balance of this liability would be assessed in a court of law on an individual case basis.

2.15.3 Chewing medication prior to swallowing must also be carefully considered because this practice can have the same effect as crushing tablets or opening capsules. Where service users are unable to swallow tablets or capsules, staff should discuss this with the authorised prescriber and appropriate pharmacist. An alternative, such as a liquid, should be prescribed instead, if available.

2.15.4 Additionally, staff should consider whether the person administering the medication might have sensitivity to it. In such cases even minimal contact with the medication could result in a serious reaction.

2.15.5 If there is no option but to crush the medication, it must be done with the knowledge and agreement of the authorised prescriber and pharmacist and the consent of the service user.

2.15.6 If the service user lacks the capacity to consent, then the guidance in section 1.9 should be considered and followed.

2.15.7 The reasons why medication is being administered this way must be clearly documented in the person’s personal plan.

2.15.8 The crushing of medication should be monitored and evaluated and any adverse effects should be reported to the prescriber immediately.
2.16 Covert Administration

2.16.1 Covert administration (hiding medication in food, drink etc) is not to be carried out at any time unless under the direction of a health professional e.g. GP, Psychiatrist, who may deem it necessary for the person’s health and well being or for the safety of others.

2.16.2 Covert administration of medicines is only likely to be necessary or appropriate when someone is actively refusing medication but who is judged not to have the capacity to understand the consequences of their refusal.

2.16.3 The decision to administer a medication covertly should not be considered routine and should be a contingency measure based on the individual needs of a particular service user.

2.16.4 Any decision to administer medicines covertly must be taken within a multi-disciplinary process which may include but is not limited to GP, Psychiatrist, Registered Nurse, Pharmacist, CPN and Psychologist and should include carers, relatives/representatives and/or advocates of the service user.

2.16.5 All health professionals involved in the multi-disciplinary meeting to discuss covert administration should have a framework for open multi-disciplinary discussion and access to legal advice about the covert administration of medicines. These discussions and any possible resulting actions must be documented in the service user’s current personal plan and be reviewed at appropriate intervals.

2.16.6 Every agreement regarding covert administration is a limitation of an individual’s rights and should be recorded as such in the personal plan.

2.16.7 Medicines should never be administered in a covert way merely for the convenience of staff at the home. Any abuse of the procedure will be viewed as a serious disciplinary matter.
2.17 PRN Medication

2.17.1 PRN or ‘as required’ medications are those to which no specific dose can be attached, e.g. 2 tablets 4 times a day is required or 1 or 2 tablets at night. In these cases the medication is dispensed in boxes or bottles and should not be dispensed in a monitored dosage system which has been set up by a Pharmacist.

2.17.2 A risk assessment on admission should establish whether the service user is able to request this medication when needed or if they need to be asked/prompted if they require it.

2.17.3 Staff should ensure that the prescriber has written full and precise instructions on the prescription for all medication and should ensure that the use of instructions such as ‘as before’ or ‘as directed’ is not used. Any prescriptions or dispensed medication that contain these ambiguous instructions should be raised with the prescriber.

2.17.4 The indication for use of an ‘as required’ medication should be presented clearly and should include the dose, frequency and dosage intervals including the maximum daily dose.

2.17.5 The full instructions for use should be transferred onto the MAR sheet, as detailed in section 2.4.

2.17.6 When administering PRN medication staff should indicate the amount of medication given i.e. 1 or 2 tablets/capsules and should only sign the MAR sheet when the medication has been given.

2.17.7 Refer to MAR sheet recording guidance in section 2.17.4 for the recording of this type of medication.

2.17.8 PRN medication can be prescribed for people who are not in mental or physical health well-being. There may be occasions when a person:

- displays challenging behaviours
- experiences hallucinations
- experiences a delirium/psychotic incident
- experiences epileptic seizures
- is unable to let staff know when they are suffering pain, general malaise, upset stomach etc

and may be prescribed ‘PRN’ or ‘as required’ medication. Social care staff cannot under any circumstances make a medical decision as to whether the administration of any medication to treat medical conditions is required. This decision is the responsibility of the health professionals involved with this person and as such a clear protocol for the administration of such medication should be developed within a multi-disciplinary process. This protocol, including clear guidance for the administration of such medication, should be documented in the person’s current personal plan and be kept under review.
2.18 Recording and Documentation

2.18.1 There is a statutory requirement set out in Regulation 17 (1) (a) Schedule 3(l) and 17 (3) (4) of the Care Homes Regulations 2001 which are supported by NMS 9 in Care Homes for Older People and NMS 20 in Care Homes for Younger Adults, for a system of recording all medicines in care homes registered under the Care Standards Act 2000. Within this policy the following system has been described:

- **Stock Control** - a record of all medicines ordered and received, and details of the disposal of unused medicines should be kept. The record should show the date of ordering/receipt or disposal; name and strength of medicine; quantity ordered/received or disposed of; name of person for whom medicines have been prescribed and the signature of the member of staff/person ordering/receiving or disposing of the medicines.

- **Medication profile and administration record** – an individual record for each service user containing details of the person’s name and date of birth and any known drug allergies. The Medication Administration record (MAR chart) is the working document which is signed to record administration of medicines. It should include all details of the prescribed medicines – name, form and strength of medicine, the dose, the route of administration, the frequency and time for administering each dose, the date of dispensing and where appropriate the date of cancellation of the treatment. Details of any homely remedies should also be included. Whilst looking similar to ‘prescription’ charts used in hospitals, MAR charts are only a record of medicines which have been administered to service users by care staff and are **NOT** a chart for prescribing medicines. **Appendices 17a and 17b** are examples/templates of MAR charts that can be used if required.

- **Administration Record for Monitored Dosage Systems** - an individual record for each service user containing details of the person’s name and date of birth. The MDS MAR chart is the working document for staff to sign to record administration of the contents of a section/compartment of the monitored dosage system. It can be used to record the prompting of self-medicating service users if required. This administration record should include details of the contents of the MDS as supplied by the Pharmacist and be kept up to date to reflect any changes to the contents of the MDS. **Appendix 17c** is an example of an administration record for monitored dosage systems that can be used if required.

- **Controlled Drugs register** – although it is not required by law, it is recommended that a separate record is kept of the receipt and disposal of controlled drugs and that a balance, checked by another designated and trained member of staff is maintained.

2.18.2 A record should be maintained of all staff responsible for administering medication to identify which members of staff have signed the MAR sheets (**Appendix 16**). This should be held at the front of the medication file and should be updated when new staff have commenced employment and have successfully completed the appropriate training and have been deemed competent to administer medication.

2.18.3 Responsibility for providing medication records lies with the care provider. The pharmacist or dispensing GP are not responsible.
2.18.4 Community Pharmacists may however provide printed MAR sheets as part of their role in providing a pharmacy service to the care service and these can be used. These charts should be correct at the time they are printed and supplied, however should any changes be made to prescribed medication, it is the responsibility of the care provider to ensure these records are up to date.

2.18.5 A GP/prescriber does not have to sign any documents produced by a care provider for medicine administration, however there are occasions when it would be appropriate to ask the GP/prescriber to sign the MAR chart (see section 2.6 Changes to Medication).

2.18.6 Pharmacists should not provide duplicate medicine labels for care providers to stick onto MAR charts as this could lead to errors should a label be attached to the wrong person’s chart.

2.18.7 Medication records are official records and as such can be used in evidence in court cases.

2.18.8 All records must be written in black ink, be legible, accurate, current, dated and signed.

2.18.9 Corrective fluid should not be used under any circumstances.

2.18.10 Should there be any changes to a person’s prescribed medication the MAR charts must be altered in the following way:

- the original direction/instructions must be cancelled by a single line drawn through
- the new directions/instructions must be written legibly and in black ink on a new line of the MAR chart
- the name of the doctor or prescriber who gave the new instructions should be recorded onto the MAR chart
- both the old and the new entry should be dated and signed by the person making the alterations (including a witness when this is possible)

See Appendix 17d for examples of correct and unacceptable amendments to MAR sheets.

2.18.11 Medication records must be completed and stored in accordance with the Data Protection Act 1998 and the organisation’s Data Protection procedures and staff should ensure they maintain the confidentiality of the information held within these records.

2.18.12 It is a legal requirement for medication records to be retained within a care service, which is registered under the Care Standards Act 2000, for a minimum of three years from the date of the last entry. However other legislation may also apply for specific services (i.e. Mental Health Act, The Records Management, NHS Code of Practice) and the organisation’s document retention policy should be followed in all instances.

2.18.13 If the record is held jointly between health and social care professionals, the record should be retained for the longest period for that type of record i.e. if social care is 3 years and health 5 years then the records should be retained for 5 years.
2.19 Audit of Medication Processes

2.19.1 The manager or delegated person should undertake a regular audit of medication records and systems to ensure the processes continue to comply with regulations, standards and legislation. A minimum of monthly would be seen as appropriate, however this should be risk assessed and may be carried out more frequently depending on several factors such as:

- size and type of service
- skills, experience and consistency of staff team
- frequency, type and seriousness of any medication errors

2.19.2 An audit is necessary to ensure that a complete audit trail of medication is evident.

2.19.3 The audit checklists attached (Appendix 18 individual service user medication records and Appendix 19 systems audit) include the minimum areas that must be audited and are examples of an audit format that can be used if the service do not currently have a system in place.

2.19.4 The audit should include a spot check of service users’ individual medication records (minimum of 1 or 10% of service users) and the entire system/processes in place.
2.20 Training

As part of Departmental Policies and Procedures and in accordance with the requirements of the Commission for Social Care Inspection’s national minimum standards\(^3\), all staff working in registered services are expected to undertake appropriate accredited training in relation to the administration of medication. It would be seen as good practice for staff working in non-registered services to receive the equivalent level of training as described within this policy.

Before being able to provide assistance at any level with medicines, care workers should:

- be fully aware of this policy as part of their induction and ongoing training
- have completed a suitable training course approved by the department
- have undergone a formal standard competency assessment

The training must include the underpinning knowledge for the safe handling, management and administration of medicines (equivalent to awarding bodies’ categorisation at Level 2) but practice should be assessed at advanced level i.e. NVQ Level 3 unit of competence or equivalent, before a Carer is allowed to administer medication unsupervised.

Within the services that are affected by this procedure, this training will be undertaken in a minimum of two parts: - Level One and Level Two. Level Three will be additional training for senior staff who are expected to assess the competence in practice of other staff and further training will be required for staff who are to undertake advanced or specialised techniques. The start and completion dates of this training should be recorded onto the Medication Assessment Record (Appendix 21).

2.20.1 Level One Training

This will commence a minimum of two weeks after the date of commencement of employment and will form part of induction training\(^4\). Staff will receive basic information relating to the types of medications that are common to the service user group, details of what they are used for and common side effects. This basic information pack will detail how medication is managed within the workplace, including who is responsible for the administration, ordering and storage of medication and indicates what staff CANNOT do at this stage (Appendix 22). The Skills for Care Knowledge sets (Medication) can be used to map & record underpinning knowledge and understanding.

2.20.2 Level Two Training

This is in two parts and will commence at the earliest opportunity and at a minimum of six weeks after the date of commencement of employment. The first part is for staff to successfully demonstrate their knowledge and understanding of medication processes by completing a Level 2 qualification or equivalent. Examples of underpinning knowledge based qualifications include: NCFE Level 2 ‘Safe Handling of Medicines’ or ASET Level 2 ‘Certificate in Managing and Safe Handling of Medicines’).

The successful completion of this award does NOT give staff a licence to administer medication and the Carer’s practice MUST be assessed as competent to NVQ Level 3 or equivalent prior to them undertaking this task unsupervised.

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\(^3\) National Minimum Standards, Care Homes for Older People Standard 9 and Care Homes for Adults (18 – 65) Standard 20
\(^4\) Common Induction Standards or Learning Disability Qualifications Programme (LDQ)
Whilst completing level two, staff will not be able to administer medication, however they may observe competent trained staff administering medication and dealing with other aspects of medication processes.

Once staff have successfully completed the underpinning knowledge qualification and confirmation has been received from the awarding body/college, they can then begin to undertake an NVQ Level 3 unit of competence (NVQ Unit HSC 375 or the equivalent). This will include undertaking practical assessments within the workplace in relation to the administration of medication, questioning, observation of practice and evidence of attainment of relevant skills and knowledge. The ‘Assessment of Practical Competency Record’ (Appendix 20) may be utilised as a means of recording a testimony of practice by an expert witness within the NVQ assessment process.

Once the member of staff has been competent in practice to administer medication, they can then commence the administration of medication unsupervised.

If a new member of staff is not successful at either the underpinning knowledge qualification or the Level 3 unit of competency, a probationary review will be held and steps will be taken to identify and address any training and development needs. These will then be recorded in the probationary report action plan.

Members of staff not in the probationary period will be managed through the council’s capability and disciplinary procedures.

2.20.3 Level Three Training

Currently there is no additional training available for the senior staff that are expected to assess the competence of other staff with medication processes. Should this training become available before the review of this document, senior staff will be supported to access this training. This will be recorded on the Medication Assessment record (Appendix 21). In the interim, senior staff expected to assess the competence of other staff will have undertaken the minimum of Level 2 training, be given the opportunity to undertake the NVQ HSC375 unit of competency and be experienced in medication processes.

2.20.4 Advanced/Specialised Training

The above levels of training do not extend to the administration of medicines by specialised techniques including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure).
- Insulin by injection.
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG).

Certain care processes and procedures do not involve the use of medication but require varying degrees of precaution and training, such as the taking of blood glucose levels (BM test), simple dressings, pressure area monitoring or the changing of stoma bags.

Approval by the unit manager and instruction by an appropriately qualified health professional is required for all staff required to carry out any task involving unfamiliar procedures, complex equipment, intimate care or contact with bodily fluids. This should be supported with a written protocol outlining the tasks and precautions to be undertaken and be recorded onto the Medication Assessment Record (Appendix 21).
Any other invasive treatments can only be carried out by medical personnel and this is outlined in the Public Sector – Health Care Extension – Decision Tree (Appendix 23 not available). This document has been agreed between Social Services Directorate, the appropriate Health Authorities and Insurers for the Public Sector. Any decisions required around the administration of medication or treatments should be made in line with the treatment risk decision tree (Appendix 23 not available).

Should the policy be adopted by an agency/service other than a local authority provision then the organisation should make their own liability insurance arrangements.

### 2.20.5 Continuity of Competency to Practice

It is the manager’s responsibility to have a system in place that:

- ensures that staff retain the ongoing competence in practice to safely handle medication
- enables them to identify the need for staff to receive refresher training if necessary and which
- provides staff with receive regular updates to ensure they are kept fully aware of the medicine policy and any subsequent reviews or amendments to legislation and guidance

This should be carried out within a risk management process taking into account errors, absences, personal and organisational training needs and outcomes from audits.

Monitoring of practice should also be an inclusive part of the supervision and appraisal process and appropriate observations of practice should take place at least once a year post qualification. Appendix 20 ‘Medication Assessment Record of Practical Competence’ can be used as evidence of continuing competence to practice and a record of this ongoing assessment should be recorded onto Appendix 21 ‘Medication Assessment Record’.
2.21 Medication Errors/Incidents/Near Miss

2.21.1 Positive Outcomes

Reporting errors is only the first step in the process of reducing errors and quality improvement. Staff should be encouraged to report all errors, incidents or near misses, with regards to medication, as soon as possible. This should be in the context of a no-blame culture as often a range of circumstances have occurred in the lead up to the incident and blaming an individual does not address the underlying risk factors or system flaws.

An error, incident or near miss, however serious, is rarely caused wilfully. It is not, in itself, evidence of carelessness, neglect or a failure to carry out a duty of care. Errors are often caused by a number of factors including process problems, human error, individual behaviour and lack of knowledge or skills. Learning from such incidents can only take place when they are reported and investigated in a positive, open and structured way.

Determining safe practice is an important part of successful risk management. Moving away from punishing errors to learning from them will promote a fair and open culture and safe practice throughout organisations. This will enable the organisation to identify trends and take positive action to prevent the error or adverse incident from happening again.

To promote a fair and open culture and encourage the reporting of incidents, the disciplinary policy and procedure will not be used for the investigation of adverse incidents unless there is clear evidence of wrongdoing, a complete disregard for the safety of others, intent to harm, theft or fraud. This may include:

- **Gross professional or gross personal misconduct**
- **Repeated breaches of acceptable behaviour or protocol**
- **An incident that results in a police investigation.**

Incidents will be investigated for the purposes of learning and change.

Staff remain accountable to users, carers, the organisation and their professional bodies for their actions and a member of staff who makes repeated medication errors must be given the opportunity to undertake further training and be assessed for competence for whichever part of the medicines pathway they are involved in (see section 2.20 and Appendix 20).

2.21.2 Definitions

A medication error/incident can be described as:

‘any preventable event that may cause or lead to inappropriate medication use or service user harm while the medication is in the control of the social/health care professional, service user or consumer. Such events may be related to professional practice, health care products, procedures and systems including; prescribing; order communication; product labelling; packaging; dispensing; distribution; administration; education/knowledge; monitoring and use.”

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5 Adapted from City Hospitals Sunderland NHS Foundation Trust Incident Procedure
A medication near miss\textsuperscript{2} can be described as:

“a medication error that has the potential to cause an injury but does not because either the error was discovered before reaching the service user or the medication was corrected before being dispensed/administered”.

When a medication error/incident/near miss occurs it is important to determine a minimum of 3 things within the analysis of the circumstances:

- What happened
- Why it happened
- What can be done to reduce the likelihood of a reoccurrence

This analysis of all events, regardless of the impact or outcome, provides an understanding of the conditions that produced an actual error or the risk of error as well as contributing factors.

2.21.3 Tool

A tool has been developed which is currently being piloted within Sunderland Adult directly Provided services. When the pilot has been completed and the tool adopted/ratified by TPCT and SMT it will be made available to Independent Sector managers with full instructions for its use.

Until the tool is fully developed and adopted, managers must continue to report and manage any errors or near misses according to current guidelines, ensuring that appropriate action is taken and stakeholder agencies (such as CSCI) are informed as required.
3.1 Practice Guidance

To be added
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Accountable Officer</td>
<td>The person within a healthcare organisation who takes formal responsibility for all controlled drug handling and governance issues in their organisation</td>
</tr>
<tr>
<td>Administer</td>
<td>To give a medicine by either introduction into the body (e.g. orally) or by external application (e.g. cream or ointment)</td>
</tr>
<tr>
<td>Administration</td>
<td>To select, measure and give a medicine to a service user</td>
</tr>
<tr>
<td>Audit</td>
<td>Official examination of management of medication records</td>
</tr>
<tr>
<td>BNF - British National Formulary</td>
<td>A list of medicines published jointly by the BMA and the Royal Pharmaceutical Society of Great Britain</td>
</tr>
<tr>
<td>Care (or support) worker</td>
<td>A person employed to provide a care service which meets the identified needs of a service user</td>
</tr>
<tr>
<td>Care Home</td>
<td>Any home which provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol. Must be registered with CSCI</td>
</tr>
<tr>
<td>Carer</td>
<td>An unpaid person, normally a friend, partner, neighbour or relative who provides care and/or support to the service user and may or may not be living with or related to them</td>
</tr>
<tr>
<td>Care Manager</td>
<td>Applies to the lead professional involved in the case. This can be a Social Worker, Community Psychiatric Nurse or Community Nurse, Occupational Therapist, Physiotherapist</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>Includes district nurses, community nurses, community psychiatric nurses, health visitors, other specialist nurses</td>
</tr>
<tr>
<td>Competence based Assessment</td>
<td>Assessed as having adequate knowledge, skills and ability</td>
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<tr>
<td>Competent</td>
<td>Assessed as able to do a particular task</td>
</tr>
<tr>
<td>Container</td>
<td>For example – blister pack, bottle or any other container</td>
</tr>
<tr>
<td>Controlled Drugs</td>
<td>Drugs controlled under the provision of the Misuse of Drugs Act 1971 and listed in Schedule 1,2,3 or 4 of the Misuse of Drugs Regulations 2001</td>
</tr>
<tr>
<td>Controlled Drugs Register</td>
<td>Bound book with numbered pages, which will include the balance remaining for each product with a separate record page being maintained for each Service user</td>
</tr>
<tr>
<td>Covert Administration</td>
<td>The practice of disguising medicines in a person’s food or drink</td>
</tr>
<tr>
<td>CSCI</td>
<td>Commission for Social Care Inspection</td>
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<tr>
<td><strong>Day Care</strong></td>
<td>Centre that provides care for the service users only during the day</td>
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<tr>
<td><strong>Designated Person</strong></td>
<td>A suitably trained member of staff</td>
</tr>
<tr>
<td><strong>Dispense</strong></td>
<td>To prepare a clinically appropriate medicine for a person to self-administer or for administration by another. This function must be performed under the supervision of a pharmacist or dispensing doctor</td>
</tr>
<tr>
<td><strong>Document Control</strong></td>
<td>A system for recording of any amendments to the policy, ensuring all stakeholders are using the same version</td>
</tr>
<tr>
<td><strong>Drug</strong></td>
<td>Any substance used in the treatment &amp; prevention of disease</td>
</tr>
<tr>
<td><strong>Healthcare Plan</strong></td>
<td>A document or instructions written by a healthcare professional specifying the treatment required</td>
</tr>
<tr>
<td><strong>Home care or Domiciliary Care</strong></td>
<td>care provided in an individual’s home, normally of a personal nature</td>
</tr>
<tr>
<td><strong>Indemnity Statement</strong></td>
<td>A contractual statement made by the City Council stating that they will take on the obligation to pay for any loss or damage that has been or might be incurred by an employee in the course of their duty, subject to the exceptions identified within the indemnity statement itself</td>
</tr>
<tr>
<td><strong>Invasive Procedure</strong></td>
<td>Any clinical procedure which punctures the skin surface (e.g. injections) or which requires the administration to or within intimate areas of the body (e.g. rectal diazepam)</td>
</tr>
<tr>
<td><strong>Legislative Requirements</strong></td>
<td>Government legislation that services are required to adhere to</td>
</tr>
<tr>
<td><strong>MAR - Medication Administration Record</strong></td>
<td>The form which has been agreed by management to record the administration of medicines</td>
</tr>
<tr>
<td><strong>Medication Group</strong></td>
<td>A member of the Social Care Governance Team and several Registered Managers from social care establishments</td>
</tr>
<tr>
<td><strong>Medication/Medicine</strong></td>
<td>Any substance used in the treatment &amp; prevention of disease</td>
</tr>
<tr>
<td><strong>Monitored Dosage System (MDS)</strong></td>
<td>A method of storing prescribed medicines and tablets. It enables the user to take medicines at regular intervals or enables a carer to make sure that person they are caring for takes the right medicines at the right times</td>
</tr>
<tr>
<td><strong>Multi-agency Team</strong></td>
<td>This consists of all social work services and health care professionals involved in a persons care</td>
</tr>
<tr>
<td><strong>NHS</strong></td>
<td>National Health service</td>
</tr>
<tr>
<td><strong>Over the Counter (OTC) and homely remedies</strong></td>
<td>Non-prescribed medication for minor complaints. OTC remedies include cough syrups, painkillers, antacids etc. Homely remedies often make use of common ingredients such as olive oil, herbs or salt</td>
</tr>
<tr>
<td><strong>Pharmacist</strong></td>
<td>Qualified professional who advises and dispenses medicines. Can be hospital or community based</td>
</tr>
<tr>
<td><strong>Practitioner</strong></td>
<td>A generic term for a registered medical practitioner, registered nurse,</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td>Prescribe</td>
<td>To authorise in writing the supply or administration of a medicine</td>
</tr>
<tr>
<td>Prescriber</td>
<td>A UK registered doctor, a dentist prescribing from the Dental Formulary, or nurse prescriber prescribing within the appropriate section of the Nurse Prescribers’ Formulary or Extended Formulary for Nurse Prescribers</td>
</tr>
<tr>
<td>PRN</td>
<td>Abbreviation for as required medication</td>
</tr>
<tr>
<td>Registered Manager</td>
<td>Person registered by the Commission for Social Care Inspection to manage the Care Home</td>
</tr>
<tr>
<td>Review</td>
<td>Reassessment of needs and service outcomes with a view to revising the care and support plan at specific intervals</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>A systematic examination of all aspects of the work undertaken which includes individuals and environment to consider what could cause injury, harm or loss, whether the hazards could be eliminated and if not, what preventative or protective measures are, or need to be in place, to control the risks to acceptable levels</td>
</tr>
<tr>
<td>Secondary Dispensing or redispensing</td>
<td>The process of decanting/transferring medication from the original container into which it was originally dispensed by the pharmacist to a secondary smaller container with the intention of being given later or by another person</td>
</tr>
<tr>
<td>Self Medication</td>
<td>When a person takes part or whole responsibility of and management for their own medication</td>
</tr>
<tr>
<td>Service user</td>
<td>Any person who receives a service</td>
</tr>
<tr>
<td>Service user plan</td>
<td>The support plan agreed with the Social Worker/Care Manager, service user and service – where appropriate</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Qualified professional who is responsible for the assessment of needs</td>
</tr>
<tr>
<td>Unlicensed Medication</td>
<td>Lack of product licence for the medicine which consequently means the manufacturer may not assume liability for any ensuing harm that may come to the recipient</td>
</tr>
<tr>
<td>Unregistered services</td>
<td>Services which do not provide personal care and therefore are not required to register with CSCI</td>
</tr>
</tbody>
</table>
3.3 Key References/Bibliography

The Misuse of Drugs Act 1971
The Misuse of Drugs (Safe Custody) Regulations 1973
The Medicines Act 1968
The Mental Capacity Act 2005
Data Protection Act 1998
Human Rights Act 1998
Disability Discrimination Act 1995 as amended
National Health Service and Community Care Act 1990
The Shipman Inquiry

The Royal Pharmaceutical Society of Great Britain www.rpsgb.org.uk

‘The Handling of Medicines in Social Care’ October 2007

CSCI guidance/professional advice www.csci.gov.uk

The Care Standards Act 2000
‘Safe Management of Controlled Drugs in Care Homes’ January 2007
‘Professional Advice Medicine administration records in care homes and domiciliary care’ Jun 08
‘Referring medication issues to a CSCI pharmacist inspector’ August 2006
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‘A guide to good practice in the management of controlled drugs in primary care (England)’ Feb 2007

Skills for Care www.skillsforcare.org.uk

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AirLiquide (formerly Linde Gas)

Oxygen & Gases Safety information

Durham and Tees Valley Social Care Medication Strategy Group www.skillsforcare.org.uk

Strategy for the Safe Handling and Administration of Medication by Carers across the North East of England

Model of Good Practice for the Development of Policy for the Safe Handling, Management and Administration of Medication by Carers within Domiciliary Care across the North East of England
3.4 Acknowledgements

This document has been prepared on behalf of Sunderland Adult Services by a working group (Medication Group) comprising:

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Rob Rogers  St Paul Travelers Insurance Company Ltd

Mo Bagnell  Nurse Practitioner, Farmborough Court Intermediate Care Centre

Phillip Foster  Team Manager, Sunderland Adult Services
### Appendices

1. Document Control Amendment Checklist
2. Medication risk assessment and agreement Jan 07 DRAFT 2
3. Kentmere letter for confirmation re short break
4. Grindon Lane Short Break confirmation letter
5. Intermediate Care referral response – YES
6. Service Specific Protocol re Management of Medication Keys
7a. Oxygen Safety Information
7b. Oxygen Safety Sign
8. Service Specific Procedure for ordering of Medication
9. Verbal Changes to Medication Record
10a. MHRA Side Effects leaflet
10b. Patient Yellow Card
11a. Individual Risk Assessment person away from service
11b. Corporate Risk Assessment Admin of medicines outside of services
12. Social Leave Medication Form
13. Consent for admin of OTC or homely remedies
14a. Individual Record of Administration of Over the Counter homely meds
14b. Central Record of Administration of Over the Counter homely meds
15. Controlled Drugs Schedules Information
16. Signatures of Staff trained and competent to administer medication
17a. MAR Chart templates
17b. MAR Chart templates
17c. Medication Record for Monitored Dosage System
17d. Amendments to Medication Administration Records
18. Audit of Individual Service User Medication records
19. Audit of Medication Systems and Processes
20. Medication Administration Assessment of Practical Competence Record
21. Assessment Record for Staff
22. Guidance for Staff on Medicines used to Treat Common Conditions