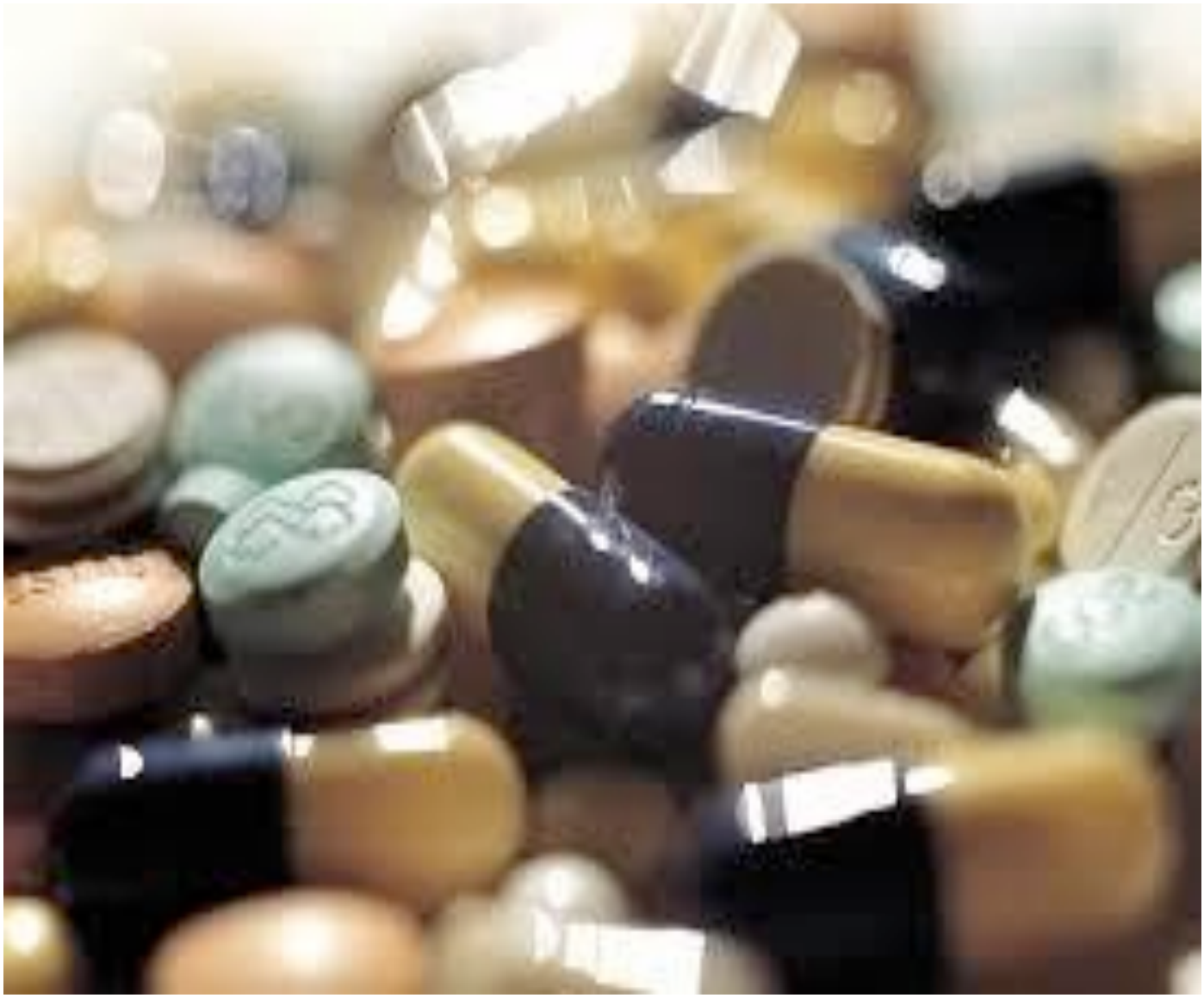
AFFINIA

HEALTHCARE

Medication Policy



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Signed off by	
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Changes History:

Issue number	Date	Author	Principal changes
1.1	November 2008	Syed & Quinn	Original document outlining procedures and practice guidelines for administering medication
1.2	3.10.10	Chinny Kalu	General updating of the document and alignment with multi-agency policies and procedures for Safeguarding Adults at Risk and Care Quality Commission requirements.
1.3	August 2015	Chinny Kalu	Update of document. Ensuring compliance with NICE guidelines issued in March 2014, updating sections on: controlled drugs, consent and capacity, deprivation of liberty safeguards, and medicines reconciliation.
1.4	May 2017	Chinny Kalu	Policy updated to include guidance for infection control during the handling and administration of medication to ensure no cross contamination, adverse reaction to medicines/creams by the person administering. Policy updated to include guidance that covert medication cannot be used unless multi agency agreement and safeguards are in place. Policy updated to include guidance for checking the expiry dates of open medications such as eye drops, ear drops, ointments and creams. Policy updated to clarify review dates for clients in their own homes- Domiciliary Care Policy updated to provide guidance for the review, auditing and recording of MAR charts.

We acknowledge the assistance of Pippa Quinn of Syed and Quinn Consultants as well as Local Colleagues from Adults' Services, local NHS trusts, and pharmaceutical advice from Boots Romford Market Place, local independent Community Pharmacists and the Care Quality Commission.

Contents

1. Principles of this policy

1.1 Affinia Healthcare aims to encourage and support people to self-medicate and independently manage their own medication. Assessments regarding ability to self-medicate will be promoted as best practice. Compliance aids may be required to ensure the person using the service remains independent and free of intervention.

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

1.3 This policy applies to our domiciliary care service and Supported Housing Services.

Where the service user stores their own medicines, Staff should follow the rules that apply to domiciliary care.

Where medicines are stored for and on behalf of the service user, Staff should follow rules that apply to Supported Housing.

1.4 Implementation of this policy is dependent on close collaboration between Health and Social Care Services in partnership with Affinia Healthcare as providers and with agreement of people using our service and or care workers.

1.5 This policy has been developed as best practice and considers the Medicines Act 1968 and subsidiary regulations made under that Act and Article 3 of the Human Rights Act 1998, the right not to be subjected to torture or to inhuman or degrading treatment or punishment.

As its purpose it represents a general working document for all staff of Affinia Healthcare:

- To comply with current legislation and best practice in the administration of medicines, including**:**
- Relevant evidence-based guidance and alerts about medicines management and good practice.
- Published by appropriate expert and professional bodies, including:
- National Client Safety Agency
- National Institute for Health and Clinical Excellence
- Medicines and Healthcare products Regulatory Agency
- Department of Health
- Royal Pharmaceutical Society of Great Britain (RPSGB)
- Social Care Institute for Excellence
- Medical and other clinical royal colleges, faculties and professional associations
- The safe and secure handling of medicines: a team approach (RPSGB, 2005)
- Safer management of controlled drugs: Guidance on strengthened governance arrangements (DH, 2007)
- Safer management of controlled drugs: Guidance on standard operating procedures for controlled drugs (DH, 2007)
- The handling of medicines in social care (RPSGB, 2007)

- Research governance framework for health and social care: Second edition (DH, 2005)
- The Mental Capacity Act 2005
- Mental Capacity Act Code of Practice 2007
- Misuse of Drugs Act 1971
- Health and Social Care Act 2008
- NICE Guidelines – Managing Medicines in Care Homes 2014

Scope

- All **medication**s, drugs.
- All persons delivering care or support, and persons ordering, receiving, managing, administering, disposing and recording medicines.

Policy

This policy must be read in conjunction with Royal Pharmaceutical Society - Handling Medicines in Social Care, which takes precedence over this document, and any specific requirements of the Registration Authority.embodies the principles of the Misuse of Drugs Act 1971 and associated regulations, the NHS Community Care Act 1990 (The Care Act 2014), Care Standards Act 2000 the Health and Social Care Act 2008 and subsequent guidance provided by the Care Quality Commission (CQC) and the National Service Framework for Older People 2001.

1.6 In accepting a contract of employment from Affinia Healthcare, all staff undertake to sign up to, accept and to follow this policy as an example of best practice.

2. Liability insurance

2.1 AFFINIA HEALTHCARE liability insurance covers the personal liability of employees working with medication and related tasks. Affinia Healthcare also indemnifies care staff regardless of the nature of their duties, whilst carrying out official duties, in respect of the financial consequences of negligent acts or omissions committed in the course of their duties. The indemnity does not apply where care staff act outside their contract of employment or authorized duties (e.g. by ignoring instructions or this policy), or where there is fraud, dishonesty, criminal or unlawful acts.

3. Principles regarding managing medicines

3.1 Medicines remain the property of the person using the service to whom they have been prescribed. They should not be shared with others or used on a temporary basis if another person using the service runs out of the same item.

3.2 Care staff involved with medication related tasks should not advise people using the service about medication. They should refer queries to a suitably qualified health professional.

3.3 Whilst in the care of family or friends, care staff should not administer medication to the person using the service until an agreement has been made regarding who will take overall responsibility for medication. This is to reduce the risk of medicines related incidents.

3.4 The 6 Rights of Medication Administration

When supporting Service Users to administer medication, it is critically important you check for following details in every case:

- The Right **Medication**
- To the Right **Person**
- At the Right **Time**
- At the Right **Dose**
- Via the Right **Route of Administration**
- Completing the Right **Documentation**

4. Consent and capacity

4.1 Consent must be obtained and recorded to ensure that people who use the service are in agreement with the identified interventions. This consent should be recorded on the Medication Management Assessment Form – Community (Appendix A) or if they are in hospital, the Medication Management Assessment
– Hospital (Appendix B) and on completion of the care Provider Medication Risk Assessment and Agreement Plan (Appendix C). People using the service who are physically unable to sign may authorise a representative to sign on their
behalf. A person may remove consent at any time.

4.2 A person's mental capacity to give consent must always be considered. For people over 18 years old who are unable to make a decision about their treatment, the prescriber(s) must document through an assessment of the person's mental capacity that it is in the best interests of the person using the service that medication should be prescribed.

4.3 For people over 18 years old who are unable to communicate consent, this is taken to mean that they lack mental capacity. Every possible step should be taken to assist the person to make a decision and to communicate that

decision. This may require the use of other communication tools and methods. If the person still cannot communicate their decision, the prescriber(s) must
document this through an assessment of the person's mental capacity and then establish that the treatment is in the best interests of the person using the service.

4.4 Any advance decision regarding medication, made at a time when the person using the service had mental capacity, need not be in writing - unless it is related to life-saving treatment - and must be taken into account if valid and applicable. The advance decision may already have been recorded in health care notes, following a verbal advance decision: this is because healthcare professionals are encouraged to make such a written record.

4.5 Consent to treatment cannot be provided by third parties unless they have been authorised to do so by the Court of Protection or they hold a registered lasting power of attorney for health and welfare decisions.

4.6 For further information about assessment of mental capacity, making a best interests decision, understanding the role of a Lasting Power of Attorney, and the status of advance decisions to refuse treatment, practitioners must consult the Mental Capacity Act 2005 Code of Practice. Any practitioner who does not follow the guidance in the Code of Practice will be expected to provide good reasons why they have departed from its advice.

5. Assessing and recording what type of support is required

5.1 People using the service will be encouraged to self-medicate and their ability to do so will be assessed using a multi-disciplinary approach, with the Medication Management Assessment Form – Community (Appendix A) or, if they are in hospital, the Medication Management Assessment – Hospital (Appendix B). This will help for example; identify any support the person using the service may require in obtaining medicines from the pharmacy or any difficulties the person using the service experiences in taking their prescribed medicines.

5.2 The Care Manager should provide the care provider with a copy of the completed Medication Management Assessment for all new Referrals. The Responsible field supervisor must complete a Care Provider Medication Risk Management and Agreement Plan (Appendix C) to identify what support is required in aiding the individual to take their medication and to ensure that the person using the service and/or their carers/advocate/next of kin agree with the proposed care arrangements. The care plan must be reviewed regularly (at least annually) and when changes are needed (see also 4.6).

5.3 Completion of Appendix A or B and C will establish what support the person using the service needs for each form/type of medication:

Level 1 ‘General support tasks’: Person using the service takes responsibility for self-medicating (with physical assistance from care staff)

Level 2 ‘Administration by care staff’: Care staff take responsibility for

administering medication

Level 3 'Administration by specialist technique': Care staff administer medication by specialist technique

People's abilities can change so care staff members need to understand these different levels and who to notify if needs change.

	Level 1 General support tasks	**Level 2** Administration by care staff	**Level 3** Administration by specialist technique
Medicines chart	Optional	Required	Required
Training	Medicines training	Medicines training	Specialist training
Competency check	By care provider	By care provider	By registered health care professional
Responsibility for administering medicine	The person using the service	The care worker	The care worker with ongoing supervision from the health professional

5.4 Where both Health Professionals **and Affinia Healthcare** care staff are involved in delivering support with medication there will be an agreed care package between both parties.

5.5 Care staff should report any concerns regarding the individual's ability to self-medicate to their Care Manager. A review of the person using the service's needs may be required.

People using the service who previously self-medicated, but then deteriorate and need care staff to administer their medicines – Domiciliary Care

5.6 For individuals already receiving care from Affinia Healthcare who deteriorate and then require help with medication, the Field care Manager should complete a Care Provider Medication Risk Management and Agreement Form (Appendix C) in consultation with a health care professional if necessary.

5.7 If assistance with medication is needed, then the length of the visit may need to be increased upon agreement with the Care Commissioning Manager (CCM) or the social worker/Care manager..

Medication reviews: Supported Housing

5.8 In line with NICE recommendations 1.8.2-1.8.5 (see below) Supported Housing should have a process for ensuring residents have their medicines reviewed on a regular basis.

5.9 The Key-worker should document in each Tenants's care record:

which health professional is responsible for that resident's planned review (NICE recommendation 1.8.2)

the agreed frequency review (based on their safety and needs). This should be annually as a minimum (NICE recommendation 1.8.4)

5.10 The Key worker should identify residents who may need more frequent review of their medicines and highlight this to the GP; for example, residents:

entering the end-of-life phase

with a recent diagnosis of a long-term condition

needing frequent or complex monitoring

who have been returned to the Scheme (for example, after hospital discharge)

5.11 The Key worker should try to involve the following people in the medication review the resident and/or their family or carers, the pharmacist, community matron or specialist nurse, GP, Team manager, practice nurse, social care practitioner (NICE recommendation 1.8.3)

5.12 The medication review should look at (NICE recommendation 1.8.5):

what concerns, questions, side effects or other problems the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) has with their medicines

All prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for

how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance

any monitoring tests that are needed

Medication Reviews: Domiciliary Care

5.13 Care staff must keep their line managers updated about the needs of the supported person relating to medication and must report any significant changes, any concerns they have, or any difficulties being experienced by the person. This includes changes in the condition, behaviour or abilities of the person receiving support.

Any advice given to the supported person to consult their GP or another healthcare professional should be recorded in the care notes.

Line managers must respond to, and where appropriate, investigate any concerns about medication related issues raised by care staff. This may involve liaising with assessment staff, community pharmacists, general practitioners and other prescribing healthcare professionals as appropriate about a wide range of medication related issues and advising care staff on actions to take.

5.14 All Clients should have a chance to raise questions and highlight problems about their medicines. The medication review seeks to improve or optimise impact of treatment for an individual Client. The review is undertaken in a systematic and comprehensive way, by a competent person. Any changes resulting from the review are agreed with the Client. The review is documented in the Client's notes. The impact of any change is monitored.

Types and Levels of Medication Review:

Level 1: Prescription Review – a technical review of the list of a Client's medicines

Level 2: Treatment Review – a review of medicines with the Client's full notes

Level 3: Clinical Medication Review – a face to face review of medicines and condition (8B3V or 8B3x).

The types of Review are:

Type 1: Prescription review – addresses issues relating to the prescription or medicines; the Client does not need to be present, nor access to full notes.
Type 2: Concordance and compliance review – addresses issues relating to the Client's medicine taking behaviour e.g. a DRUM or MUR (Dispenser's Review of Use of Medicines by dispensing doctors or their staff or Medicines Use Review by community pharmacists).
Type 3: Clinical medication review – addresses issues relating to the Client's use of medicines in the context of their clinical condition.

Who to review:

The National Service Framework for Older People stated: "By 2002: All people over age of 75 should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6-monthly" This is mandatory for NHS organisations.
A Practice Guide ,5 Room for Review and A Guide to Medication Review suggested the following target groups to prioritise medication review:

<u>Clients at risk of medicines-related problems:</u>

- taking four or more medicines every day
- on a complex medication regimen or more than 12 doses in a day
- recently discharged from hospital
- recently transferred to care home
- frequent hospital admissions
- with multiple diseases receiving medicines from more than one source e.g. specialist and GP

- significant changes to the medication regimen in the past 3 months or more than 4 changes in medication in the past 12 months
- taking higher risk medicines - those requiring special monitoring e.g. lithium; those with a wide range of side effects e.g. NSAIDs;
- symptoms suggestive of an adverse drug reaction
- longstanding use of psychotropic medication where non-compliance is suspected or known
- high incidence of self medication

Special needs:

- older people
- residents in care homes
- learning difficulties
- sensory impairment e.g. sight or hearing
- physical problems e.g. arthritis, swallowing difficulties
- mental states such as confusion, depression, anxiety, serious mental illness
- communication difficulties
- literacy or language difficulties
- minority ethnic groups
- refugees and asylum seekers
- living alone or poor carer support
- Housebound
- recent falls identified by a screening tool (appendix 1)

Opportunities to improve care:

- new evidence or guidelines
- newly diagnosed long term condition
- out of date care plan
- newly registered Client

Managers and Care Coordinators should always ensure before a medication review, that the clients are provided with written information about the review including what they can do to prepare for the review.

What should the review cover:

For each drug:

Check that The medication prescribed is appropriate for the Client's needs Following hospital discharge there may be unintentional changes to regular medication or conversely medication may have been introduced that was appropriate in the hospital setting, but is not needed at home e.g. hypnotics, enteral nutrition or nebules. National and local evidence-based guidelines should be considered at this stage. A medication may be time-limited e.g. clopidogrel and aspirin in combination for one year. Drugs of "limited clinical value" are flagged up in the BNF and the STOPP START Toolkit suggests medication that might be inappropriate for older people in certain situations.

The dose prescribed should be reconsidered with advancing age or changing physiology e.g. renal clearance.

It is unlawful for service providers to discriminate on grounds of age however for medication that has clinical benefit only after use for a number of years or is intended to prevent events in the distant future it is appropriate to consider the Client's life expectancy when weighing up the benefits versus risks of a treatment.

The medication is effective for the Client – this may involve objective evidence e.g. change in HbA1c or discussion with the Client.

Any required monitoring has been done or arrangements are in place e.g. blood tests specific to a medication or to monitoring a disease.

Consider:-

- Drug interactions – also consider the impact of withdrawing an interacting drug e.g. simvastatin and warfarin.
- Contraindications to the drug – this status may have changed since the drug was originally prescribed(e.g a change in Client factors such as kidney function or co-morbidities)
- Side effects – adverse reactions are implicated in many hospital admissions; they can also lead to non-compliance and therefore ineffectual treatment. Some drugs may be appropriately prescribed to mitigate side-effects, but in many cases the original need for the original drug can be reconsidered e.g. should a PPI be co-prescribed with an NSAID, or could the NSAID be replaced with a less toxic option?
- Compliance – it is estimated that 50% of medicines are not taken as prescribed. The history of prescription "issues" can indicate non-compliance but cannot be relied upon due to possible hoarding. The Client may have practical issues such as swallowing difficulties or remembering to take medication in a complex regimen. For Clients that struggle to manage ordering repeat medication in time, repeat dispensing and/or the electronic transfer of prescriptions might help. The Client could also be encouraged to see the community pharmacist for an MUR or for provision of large labels, easy-open containers etc.

- Concordance – if the Client understands the rationale behind their treatment, they are more likely to take the medication as prescribed and adopt other non-medical measures. This may be particularly important in the very elderly who may no longer be interested in medication that prolongs life, but be more willing to take medication that allows them to live without pain or discomfort. Client decision aids can be used to inform Clients about the risks and benefits of treatment.

- Over-the-counter and complementary medicines – many potent medicines can now be purchased by the Client; these may have side effects, antagonise or augment prescribed medication or affect the course of the disease. e.g. St John's Wort reducing contraceptive effect or decongestants in cough and cold remedies elevating blood pressure.

- Lifestyle and non-medicinal interventions – the Client may be more willing to adopt a lifestyle change than take medication – or have made a lifestyle change that negates the need for treatment e.g. weight loss to control hypertension. Lifestyle interventions that complement pharmacological therapy should also be promoted as appropriate.

- Unmet need - this is an opportunity to identify and treat new conditions, particularly those that increase in prevalence with age e.g. atrial fibrillation, heart

failure and dementia. Some conditions are frequently under-treated e.g. warfarin could be more widely used to prevent stroke in atrial fibrillation

Documentation:

- Record Information pertinent to any decisions made at the review.

Communication of changes:

- The Client and/or carer must be informed of changes and have the opportunity to discuss or be involved in the decision making. If the Client is resident in a care home, uses a monitored dose system or uses the repeat dispensing service the community pharmacy should also be informed of medication changes.

6. Transferring information about a person's medicines (medicines reconciliation)

6.1 In line with NICE recommendation 1.7.3, when a person moves to a new care setting, the following 'medicines data set' about them and the medicine(s) they use must be sent to the new care provider on the day that they are transferred (to ensure the information is up to date):

- Person's full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents)
- GP's details
- Details of other relevant contacts defined by the person and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- Medicines the person is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- Changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- Other information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine (adherence support)

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

6.2 For Affinia Healthcare, the Team Manager is responsible for providing this medicines data set (for people they discharge) and collating this medicines data set (for people they receive). This should include who is responsible during 'out of hours periods'.

6.3 The Team Manager responsible for collating this medicines data set, should obtain (or verify it) with other care information such as:

An up to date discharge summary
Recently dispensed medicines labels from the pharmacy
A recent repeat slip
Medicines administration records from their previous care service

They will need to verify this information with an authoritive source such as:

The dispensing pharmacist
The prescriber
Another health professional
The person using the service
Their family/carers

6.4 Whenever Changes occur to person's medicines between staff at shift changes, this must be communicated either in care notes or in the medication section' during handover.

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

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

6.7 Care providers should keep (and allow the person using the service access to) the latest copies of the Client Information Leaflets for each medicine supplied by the pharmacy.

Transferring of medicines: Supported Housing and day services

6.8 If a person is going on holiday or leave, either the resident's original dispensed medicines should be sent with them or a separate prescription for the supply of the medicines should be requested for the period of the holiday or leave. Medicines must not be placed in envelopes or other types of temporary containers. Any medicines leaving or entering Supported Housing under these circumstances should be appropriately recorded in the medicines book with a record of the quantities supplied so they can be accounted for. This also applies if medicines are transferred to hospitals with the person using the service.

6.9 Where a person using the service is regularly away from the Supported Housing e.g. in day services or with relatives, the designated Care Manager should ensure the continuity of supply. Where medicines are being transferred

from the home to the day service the Medicines Administration Chart for Day Services (Appendix E) needs to be implemented.

7. Confidentiality and sharing of information

7.1 Information about service users must be treated confidentially and respectfully.

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

7.3 Consent to share this information will have been obtained when the Medication Management Assessment (Appendix A or B) is completed.

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

8. Principles of the levels of support

Level 1: General support tasks

8.1 These are tasks that care staff can carry out to help a person using the service self-medicate and maintain their independence. These would be likely for those with a physical disability or frailty, whose mental capacity is not in doubt.

8.2 The person using the service must have the mental capacity to direct the care staff member and instruct them what to do. For this, the person using the service must be able to:

- Understand how to take their medication
- Understand the consequences of not taking the medication or not
- Following the doctor's instructions
- Identify their medicines i.e. confirm that they have been passed the right drug, dose, strength and form of medicine at the right time
- Make choices and communicate them

8.3 A person's ability to self-medicate should be established with **each** medicine (e.g. they may not be able to use an inhaler device but could self-medicate with a cream). The initial assessment is only the start of the care planning process. Their ability to self-medicate may only become apparent as they establish a relationship with care staff.

8.4 Self-medication should not be seen as an 'all or nothing' ability a person has. Care staff should be clear of the type of support they can provide to a person without it being considered that they are taking responsibility for administering medication.

8.5 Self-medicating individuals must be reminded of the risks to others if medicines are left lying around. The risk to others should be taken into consideration when deciding if a person is able to self-medicate.

8.6 There are medicines that may be better kept by the person using the service (e.g. asthma relievers and glyceryl trinitrate (GTN) sprays for angina). Storing these away from them may delay treatment.

Which tasks are considered general support?

8.7 **Physical assistance:** For example: unscrewing lids, popping tablets out of a blister pack (only if the person using the service tells the care staff which tablets to pop out). These remain general support tasks when the person using the service (not care staff) takes responsibility for confirming that they are taking the right medicine at the right time.

8.8 **Occasional infrequent verbal reminders :** verbal reminders may sometimes be required for a self-medicating person using the service (in the same way any of us may occasionally forget to take a dose). The occasional need for a verbal reminder does not mean a person using the service should be assessed as incapable of self-medicating.

8.9 However, if regular verbal reminders are needed (or if the person using the service becomes reliant on these verbal reminders) then their ability to self-medicate would be in doubt. With regular verbal reminders, care staff are taking responsibility for ensuring the right medicines are taken on time, and are essentially therefore administering medication (level 2) and a medicines chart will be needed.

Level 2: Administration by care staff

8.10 Care staff are considered to be providing level 2 tasks when they are taking responsibility for:

- Providing a regular verbal reminder
- Selecting the right medicine to pass to the person
- Responsible for checking or ensuring that the medicines are taken accurately i.e.**" the 6 R's";** the right person, the right time, the right medicine, the right strength, the right form, the right dose, the right method and the medicine is in date and recorded correctly

8.11 Level 2 tasks may include some or all of the following tasks:

- Frequent observed verbal reminders (verbal reminders) to take medication
  - For domiciliary care settings only: leaving out medication to be taken later when risk assessed as safe (to enable someone's independence).See section 14.7 – 4.9 for more details
- Administration of oral medication including tablets, capsules and liquids
- (including all controlled drugs)
- Measuring out doses of liquid medication (where care staff are responsible for ensuring they have measured out the correct amount)
- Administering inhaler devices
- Applying external medicated creams/ointments/gels/lotions etc
- (including those applied to intimate areas)
- Applying transdermal patches (including controlled drug patches)
- Applying medication to the eye, nose or ear

Level 3: Administration by care staff using a specialist technique

8.12 Level 3 tasks may include some or all of the following tasks:

- Rectal administration, e.g. suppositories, enemas
- Administration into the vagina e.g. pessaries; Injections e.g. Insulin
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Giving oxygen
- Nebulised medication
- Buccal Midazolam

9. Training requirements

Training for general support tasks – Level 1

9.1 Affinia Healthcare require staff to have had medicines administration training even if they are just providing general support tasks (i.e. the training set out in 9.2 – 9.4). This is because people using the service who only require general support tasks can soon deteriorate and require staff to administer their medicines to them.

Training for administering medication – Level 2

9.2 All care staff must receive medicines training and be signed off as competent afterwards by the care provider before they can administer medication. This training must cover the learning outcomes as advised by Skills for Care in the Care Certificate (those outcomes relevant to the type of care setting they are working in).

9.3 The training for level 2 tasks (where care staff are administering medication) should be delivered by a suitably competent person (e.g. someone knowledgeable in the subject with relevant, current experience of handling medicines). AFFINIA HEALTHCARE requires the trainer should have a minimum qualification equal to that of the Level 3 Diploma Support Use of Medication in Social Care Settings unit (or have equivalent occupational competence) and suitable experience in delivering training.

9.4 All Care staff should undertake training updates at least 2 yearly and have a yearly competence check.

9.5 Affinia Healthcare collects and maintains data to support our quality assurance framework. These will include:

- lists of care staff who have received training (and when)
- records of the initials of care staff who will record on administration record charts (Appendix O) and receipt of medicine into home or Supported Housing (Appendix Q)
- central system for recording medication incidents (refer to section 19 for further details on medication incidents)

Competency Check

9.6 Managers carry out frequent competency checks either on a spot check basis or at supervision to assess care staff competency when administering medication. This is recorded in the care staff training file. At each observation or check, the care staff is observed as they give medication and carry out key tasks linked to the medication policy.

Training for Administration using a Specialist Technique – Level 3

9.7 These types of medicines will normally be administered by a health care professional. However, if appropriate a health care professional may delegate these tasks to care staff provided they agree this with the Care Manager and that they are satisfied that the staff member(s) have received the appropriate training (that assesses competence or has a system in place to ensure that competence is assessed after the training).

9.8 Ongoing support for care staff is required from the health professional as ultimately responsibility for these tasks remains with the health professional.

9.9 Where a Healthcare Professional has delegated the administration of medication by specialist Technique to a Care worker employed by Affinia Healthcare, the Care worker has a right to refuse to administer medications via specialist techniques if they do not feel confident in their own competence.

10. Record Keeping

Record keeping for general support tasks – Level 1

10.1 Care staff must record details of general support tasks in the person using the service's care record notes. There is no requirement for care staff to record general support tasks on a medicines chart. This is because care staff are enabling a person using the service to remain independent and self- medicate. If the person using the service has a medicines chart (because other items are being administered by care staff) then care staff should write 'self-medicating' next to those items that the person using the service self-medicates.

Record keeping for administering medication - Levels 2 and 3

10.2 An appropriate medication record chart must be used to record when medication is given to a person using the service by care staff:

Where medicines are provided in their original packaging a Medication Administration Record (MAR) chart obtained from the person using the service's dispensing pharmacist will need to be used. Day Centres will need to use the Medication Record for Day Services (Appendix E).

If administering medication from a Monitored Dosage System (MDS) a Medication Record for Monitored dosage system form should be used (Appendix F).

A MAR chart may also be needed to record items not in the Monitored Dosage System (e.g. liquids, eye drops etc).

10.3 Once Medication record charts have been prepared prior to use, they should each be checked and signed by a Team Manager/Registered Manager certifying that they have been prepared correctly and accurately.

Auditing MAR Charts: Domicililary Care and Supported Housing

10.4 Care staff must use printed MAR charts from a pharmacy for all clients of Affinia Healthcare. The MAR chart must include all prescribed medicines and should be used to record all medicines administered including non prescribed medication such as 'bought medicines'.

The MAR chart must show:-

- The name, DOB and address of the person
- Start date and day of the MAR chart
- GP Name
- Any known allergy
- Name, form and strength of the medication
- The dose to be given
- Frequency and time of administration of each dose
- Date of receipt of each medicine and quantity received
- Date of discontinuation of medicines where appropriate
- Any special instructions, for example, 'swallow whole'

- Where a MAR chart is supplied by the pharmacy/dispensing GP this should be the document used.
- Where a MAR chart is not provided by the pharmacy a MAR chart must be written by a trained and competent member of staff. Line managers must ensure that a supply of blank MAR charts are available to staff. See Appendix 7.
- Where more than one agency is involved in the administration of the person's medicines one MAR chart should be used and this should be shared and completed by all agencies involved. Other carers, including relatives, who assist the person receiving support (for example, at weekends) should be encouraged by the assessor or manager to complete the MAR chart to ensure that records are complete.
- It is essential that the MAR chart is completed at the visit by the member of staff responsible for the administration of medication. Care staff must not sign the MAR chart for medication administered by others. Managers must carry out visual checks of MAR charts at each spot check.
- It is acceptable for care staff to add a code to the MAR chart at the next visit to indicate, for example, that the medication was not given on a previous occasion as the person was in hospital or on holiday.
- There must be no gaps on the MAR chart for regular medication. If care staff identify any such gaps they must contact their line manager to report this. The reason for the gap should be investigated to establish if the medication has not been given or whether the MAR chart has not been completed. Advice should be sought from the GP/pharmacist regarding actions to take if it is established that the dose has been missed.
- If care staff forget to sign the MAR chart they should contact the line manager as soon as they realise so that this can be recorded.
- If a medication is discontinued or changed, a trained and competent member of staff

must update the MAR chart. The original entry should be cancelled by drawing a diagonal line through it and any remaining signature spaces should be ruled through. A note should be added to the entry saying the medication had been discontinued/changed and the name of the healthcare professional authorising this. The member of staff making the change should sign and date the entry. A corresponding entry should be made in the person's care plan. Where necessary, care plans should also be reviewed and updated to reflect the changes.

- Where a new medication or new dose of current medication is prescribed, a new entry should be made in the next available space on the MAR (or a new MAR chart created, if necessary) to reflect any change in dose or new medication. All changes to the MAR must be signed and dated by the member of staff making them and checked by a second competent member of staff (wherever possible) who should also sign the record.
- Managers must keep a record of signatures/initials of staff involved with administering medication to people receiving support at Level 5 or 6. See Appendix 6.
- Completed MAR charts must be returned to the offices of the service for archiving. These forms must be kept with the person's file. If more than one agency is involved the opportunity to obtain a photocopy of the completed MAR Chart should be offered to the second agency.

Following the introduction of the new CQC guidance on 1st April, further advice is being sought on the retention of documents. The policy will be updated as soon as possible.

- Line managers must ensure care staff complete MAR charts to an acceptable standard by carrying out a regular audit of the charts. (See separate audit tool.)
- Any reminders, omissions, missed doses and any advice given to the person to consult their GP or another healthcare professional should be recorded in the contact sheets.

Preparing a temporary medication record AS94a: Domiciliary Care

10.5 In certain circumstances it may be necessary to use a Temporary Medication Record (Appendix D). This form may be used where it is not possible to obtain a MAR chart and the person using the service would be at risk if a medication was not administered by care staff, for example an antibiotic prescribed and left by the GP out of hours.

10.6 As an alternative, care workers can add any new medicine onto the existing MAR chart if the person using the service already has a MAR chart.

10.7 Care must be taken to ensure that this written record is printed in capitals using indelible ink. The information that is printed on the label of the packet of medication must be copied directly to the recording chart.

10.8 Once a Temporary Medication Record (Appendix D) has been prepared, it should be signed by the care staff who entered the information and the next care staff to administer the medication must check that the record has been completed correctly and countersign.

10.9 Care staff must contact the Registered Manager to inform them that a Temporary Medication Record has been used. The Registered Manager will

need to put measures in place to obtain a MAR chart from the pharmacist as soon as practically possible.

10.10 Team Managers and field supervisors must countersign all changes to ensure that changes made to MAR charts are only undertaken and checked by competent care staff.

11. Recording changes to the MAR chart

Verbal orders:

11.1 Verbal orders to stop, add or amend medicines should only be accepted in an emergency, when the person using the service's health would be put at risk if the order was not acted upon immediately.

11.2 When the prescriber needs to give a verbal order for a person in their own home, they should do this by ringing the office of Affinia Healthcare Tel:- 01708281158
Out of Hours - 07960202639

11.3 When taking a verbal order, care staff should make a written record of their name, the time and date of the call, the name of the prescriber they are speaking to, and the new instructions. They should repeat the instructions back to the prescriber to confirm that they have heard them correctly, spelling out any drug names if they are unsure. It is best practice that a witness be present to confirm the information. Written confirmation (via fax, email or a letter) should be obtained within 24 hours from the prescriber (or within 72 hours at weekends or bank holidays).

11.4 In domiciliary care, it is accepted that a witness might not be available to overhear the verbal order.

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

11.6 Text messages from telephones can be used as written confirmation in exceptional circumstances. They should check that the sender is a prescriber for the person and the message is received from their designated number. Staff must record the details of any text message received, including the content of the text message, telephone number it was sent from (it should
be a pre-agreed designated number), the time sent, any response given. The recipient of the text should then sign and date this record. They should then delete the text from the phone.

11.7 Verbal orders to change warfarin will not be accepted due to the risk of mistakes occurring. Warfarin doses can only be altered with written instructions.

11.8 The prescriber is encouraged to amend the MAR chart themselves, if this is not possible then a competent member of staff can make the change following the guidance below.

Altering MAR charts: Domiciliary care and Supported Housing

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

11.10 **Changing doses (only when authorised by the prescriber and written confirmation obtained): Supported Housing only**

First cancel the item on the MAR (as set out above) then add the item with the revised details as a new entry (ref: CQC professional advice: Medicine administration records in Supported Housing and domiciliary care). Once an item has been added to the existing MAR, it should be signed and a colleague should check that it has been prepared correctly and countersigned. The date the new item was added to the MAR should be written on the MAR.

11.11 Care must be taken to ensure that this written record is printed in capitals using indelible ink. The information that is printed on the medication label must be copied directly to the recording chart. There should be a reference in the person using the service's notes or on the back of the MAR explaining why the item was changed and the written confirmation must be attached to the MAR.

12. Ordering and collecting/receiving medicines into the care setting

12.1 **Ordering prescriptions:** Care staff can help self-medicating individuals order prescriptions. It should be recorded who is responsible for ordering prescriptions, especially if more than one care provider provides support.

12.2 Whilst the choice of the pharmacy should be down to the person using the service, it is acknowledged that pharmacists offer different services. Ideally the same pharmacy should be used. This ensures that the pharmacist's computer records for that person using the service are complete, up to date and promote continuity.

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

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

12.5 **Supported Housing:** Staff should have protected time for ordering and checking medicines delivered to the home (NICE recommendation 1.10.2)

12.6 **Supported Housing:** The Supported Housing should have at least 2 members of staff who are competent to order medicines, although at any one time ordering can be carried out by 1 member of staff (NICE recommendation 1.10.3)

12.7 **Supported Housing:** Supported Housing should keep a record of which medicines they have ordered (for example, a copy of the prescription, stock order or requisition note) so that they can check off the medicines received from this record

12.8 **Supported Housing:** Supported Housing should have a formal means (electronic or paper) of notifying the pharmacy of any medicines that are started, stopped or changed

12.9 **Supported Housing:** Supported Housing should have a process for ensuring they have enough stock of anticipatory medicines (for example, those used in end-of- life care) when these are used by a Supported Housing.

Collecting or receiving medicines from the pharmacy (including controlled drugs)

12.10 Whenever care staff order medicines, then they must retain a copy of that order so that they can check it against the medicines when they are received.

12.11 When collecting or receiving medicines, care staff will record on Collecting or Receiving Medicines Record Form (Appendix Q):

1. The name of the medicine
2. The strength
3. The form/type of medicine e.g. tablet or liquid
4. The person using the service's name
5. The quantity received/collected
6. The care staff member's initials or signature
7. The date that the medicine was collected or received

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

12.13 For domiciliary care, sections 12.10 to 12.12 are not legal requirements, but are good practice recommendations made to enable the medicines to be accounted for and avoid any disputes in case medication goes missing.

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

13. Storage and security of medicines

Storage and security of medicines: domiciliary care

13.1 Medicines should be stored in the container supplied by the dispensing pharmacist. This will be correctly labeled and suitable to keep the medicine in a good condition.

13.2 The person using the service should be advised to store medicines in accordance with the pharmacist or label on the medicine and manufacturer's instructions.

Medicines should always be kept out of the reach and sight of children (bear in mind older people may have grandchildren who visit).

13.3 **Storing medicines away from a person using the service**: If there is a risk identified that a person using the service would be in danger by accessing their medicines, of causing themselves harm, then a decision may be needed to store medication securely away from them (for example, in a locked box). This is an important and sensitive decision, which could deny a person their rights. Therefore this decision should only be made after consultation and discussion with the GP or community nurse and involved carers/relatives. The decision should be documented on the risk assessment. The decision must be reviewed at least annually and if the risk changes.

Storage and security of medicines: Supported Housing and day services

General storage principles – Supported Housing and day services

13.4 Where medicines are stored on behalf of people using the service, a suitable lockable cupboard will be used. This should preferably be in a room where access is only available to those administering medication. Medicines must be stored in accordance with the manufacturer's storage requirements. If a trolley is used, it should be secured to an immovable object (if it's stored outside of the locked room). It is essential that the cupboard or trolley in which medicines are stored should only be used exclusively for this purpose and should be kept locked except when medicines are being issued or received. When the cupboard and trolley are unlocked, they should never be left unattended.

13.5 If there is a constant need to refrigerate medicines, a separate and secure refrigerator should be used. If not a domestic fridge can be used. Medicines should be locked in a separate container to minimise access from other people using the service and avoid contamination by food. In any case, the refrigerator temperature must be monitored and recorded on a daily basis, using a minimum/maximum temperature monitoring device to ensure temperatures are maintained within the accepted temperature range +2 to +8 degrees Centigrade. Care must be taken to ensure the device is reset after each reading and care staff must immediately report temperature readings outside of the accepted range to ensure verbal reminder remedial action is taken and the pharmacist is contacted to discuss if the medicines need to be replaced.

13.6 Care must be taken to ensure that the keys are properly controlled. Only staff that are trained and authorised to handle and administer medicines should be able to access medicines. Keys should be kept by the Care Manager (or designated officer) and a procedure for handing over keys should be clearly understood by all care staff. Medicine storage keys should be kept on a separate key ring from other keys and the number of duplicate keys available should be restricted.

Storage principles for self-medicating individuals: Supported Housing and day services

13.7 Self-medicating individuals should be advised to keep medication safe and not accessible to any other people using the service

13.8 Residents within a Supported Housing should be provided with a personal lockable drawer or cupboard that only they and designated care staff have access to, with the permission of the resident.

Expiry Dates

13.9 **Particula**r attention should be made to the expiry times of medications. Frequently, these are not displayed on the outer packaging of certain items such as eye drops, ear drops and eye ointments. Most eye drops need to be discarded after four weeks of opening, however some expire after two weeks. It is therefore, essential that for all medications, the Client information leaflet is consulted and the directions for expiry strictly followed.

14. Administering medicines at level 2 and 3

14.1 Care staff are considered to be administering medication when they are taking responsibility for confirming they have selected the correct medication i.e. confirming that they have:

The **right medicine, for the right person, have selected the right dose, at the right time and given via the right route or method.**

14.2 Errors are minimised by reducing the number of steps in the administration process. This is best achieved by administering medicines from their original containers (with the pharmacy label attached) directly to the person using the service. A medicines pot or other suitable container may be used to transfer medicines from the pharmacy container to the person using the service for immediate administration. The administration record must be completed immediately after the dose has been administered.

Infection control and safe Handling of Medicines – All Services

Staff should always use sanitary techniques when handling or preparing oral medications. This is not only for the safety of the residents, but also for the safety of the staff who is administering medications.

Oral medications are not to be touched or handled by the employee's hands to prevent contamination of bacteria or viruses from employee's hands onto the medications. Meds should be transferred from the blister packs or bottle directly into an appropriate container or cup given to the resident. Tablets or capsules should not be placed directly into residents' hands.

Meds should be administered as soon as possible after doses are prepared Meds should NOT be preset! Staff must clean hands before and after administering medications to each resident (either through washing hands or using antibacterial hand sanitizer). Documentation in the MAR should be completed by the staff member who administered the dose immediately after staff witnesses ingestion of medication by individual client.

Some medications may be harmful to staff if directly touched by the staff member's hands. With these medications, it is especially imperative that staff do not directly touch medications.

When you are giving some types of medications, it is necessary to wear gloves. Change your gloves as soon as you have finished administering medications to the individual. Never re-use gloves for more than one individual and always

wash your hands again after you take off your gloves. Wearing gloves does not take away the need for handwashing: Always wash your hands as soon as you take your gloves off. And, only wear a pair of gloves to complete a specific task for a specific individual. Never wear the same pair of gloves for another task or with another individual

Alpha Reductase Inhibitors
Examples are: finasteride (Proscar®), dutasteride (Avodart®), Jalyn®
Pregnancy Category X – Women of child bearing age should not directly handle tablets.

Chemotherapy or other cancer medications
Examples are: methotrexate, mercaptopurine, fluorouracil, tamoxifen
Teratogenic – Women of child bearing age should not directly handle.

If a medication is dropped, DO NOT administer that contaminated dosage to the resident. Discard and order replacement.

Crushing tablets and/or opening capsules

14.3 There may be occasions where tablets or capsules may need to be crushed or opened to enable the person using the service to take their medication:

This should only be done when both the pharmacist and the prescriber have given authorization (this can be provided verbally and recorded in the person using the service's notes).
This should only be carried out with the consent of the person using the service.

Splitting tablets

14.4 It is always preferable for solid dose forms (tablets or capsules) to be administered as single or multiple units (e.g. one or two tablets) per dose. Occasionally it may be necessary to split a tablet to achieve the required dose. In such cases tablets may be split if they are scored by the manufacturer. Non-scored tablets should only be split after confirming with the pharmacist that splitting is safe. Alternatively it may be possible for the medicine to be requested to be prescribed in a liquid form by which the correct dose can be easily and accurately measured using an oral syringe.

Administering from monitored dosage systems (MDS)

14.5 If it is appropriate for medicines to be administered from a monitored dosage system (MDS) (sometimes called a blister pack) this must be a sealed, tamper-proof MDS that has been prepared by a pharmacy. Care staff cannot administer medicines from dossette trays or boxes that have been filled by relatives, neighbours etc. This is because there would be no pharmacy label fixed with details of the medication and the accuracy of the process for filling the dossette tray or box cannot be guaranteed.

14.6 If administering medication from an MDS a Medication Record for Monitored Dosage System form should be used (Appendix F). A pharmacy printed MAR chart or Medication Record for Day Services (Appendix E) may also be needed to record items not in the Monitored Dosage System (e.g. liquids, eye drops etc.).

Leaving medication out to be taken later: domiciliary care

14.7 In certain circumstances person using the services may need doses of medication to be left out by care staff in order to enable a person using the service's independence (not just to save a visit). An example would be a person using the service who takes a sleeping tablet before bed. This can only be done for medication that should be taken at or around the time of the visit. It is not acceptable to leave medicines out to be taken at other times of day for example; morning medicines must not be prepared and left out by care staff the night before for the person using the service to then take in the morning.

14.8 Medication should not be left out in open, unlabelled containers. In exceptional circumstances where medication may be required to be left out when care staff are not present, a risk assessment needs to be carried out. This should assess and document any risks involved, both to the person themselves and to other people who may visit or live with the person, e.g. family members or friends, and the person using the service's capacity to remember to take the medication, and also document the actions to be taken to reduce the risk.

14.9 Care staff must record on the MAR chart what medication has been left out for the person using the services to take themselves. They can't record its actual administration because they will not have witnessed it. Instead they should use a code, for example an 'X' and provide additional information to support the code used on the MAR chart.

Administering 'when required' medication

14.10 Medication with a 'when required' dose is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly but occasionally. In such circumstances the person using the service may not need the tablets every day.

14.11 To ensure the medication is given as intended, a specific plan for administration must be recorded on the Protocol for administering 'when required' medicines (Appendix I) and ideally kept with the MAR charts. The Care Manager should obtain information from the prescriber on why the medication has been prescribed and how to give it. The plan should be written taking into account knowledge about the individual person using the service's needs.

14.12 A record does not have to be made each time the medication has been offered to the person using the service. However the Protocol for administering 'when required' medicines (Appendix I) should identify what the medicine is for and that an assessment has taken place on whether the person using the service requires the medication. Care staff who are supporting a person using the service who requires medication must be able to demonstrate that they know what the medicine is for, how frequently it should be offered, awareness that they need to consult the MAR and circumstances for which they should be offering the medication. It may be appropriate to administer the medicine only once all other planned non- medical interventions have been attempted.

14.13 When required medication should not only be offered or given at the times listed on the MAR chart or at specific medication rounds. As it is for occasional use the person using the service should be offered the medication at the times they are experiencing the symptoms either by telling a member of care staff or by care staff identifying the person's need as outlined in the care plan.

14.14 If when required medication is needed regularly then a referral to the prescriber should be considered for a review of the person using the service's medication, as their medical condition may have changed and the treatment required may need altering. Similarly if the medication is not having the expected effects the prescriber should be contacted. In both cases the response to the medication should be clearly recorded.

14.15 When required medication that is still in use and in date should be carried over from one month to the next and not disposed of. A record of the quantity carried over should be recorded on the new MAR so there is an accurate record of the quantity in stock and to help when performing audits.

14.16 When required medication is best supplied in an original box rather than a monitored dosage system (MDS). This allows for a check on the expiry date and reduces waste.

Administering non-prescribed medication

14.18 People using the services may wish to take medication obtained without a prescription, for example to treat colds or headaches. Such treatments may include complementary or alternative medicines. If a person using the service wishes care staff to administer a non-prescribed medicine to them, then care staff must seek advice from the pharmacist who supplies the person using the service's prescribed medication. Care staff should complete the 'Confirmation of advice to administer non-prescribed medication form' (Appendix J). If a pharmacist cannot be contacted, then care staff may seek advice from a nurse or doctor when completing the form.

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

14.20 If following discussion with the pharmacist the advice is not to give the non-prescribed medication, care staff should record this on the 'Confirmation of advice to administer non-prescribed medication form' (Appendix J), discuss with the person using the service and inform the Care Manager.

14.21 Once advice has been sought, the non-prescribed medication must be added to the Temporary Medication Administration Record (Appendix D).

14.22 It is not necessary to seek advice to administer non-medicated creams and ointments (e.g. moisturisers) such as E45, aqueous cream, Diprobase, Doublebase, Oilatum (this is not a complete list of moisturisers, check with a pharmacist to see if a cream/ointment is considered a moisturiser).

15. Controlled drugs

15.1 In line with legal and national best practice guidelines, the controls outlined in this section only apply to the following controlled drugs:

a) All schedule 2 controlled drugs (CDs)
b) Just these schedule 3 CDs: Temazepam, Buprenorphine, Flunitrazepam and Diethylproprion
c) Just this schedule 5 CD: Oramorph 10mg/5ml solution

Hence when using the term 'controlled drugs' (or 'CDs' for short), we are only referring to these drugs in 15.1 a) b) and c).

However, the government might re-classify controlled drugs at any time, hence care staff should check with a pharmacist to see if any other drugs are added to the schedule 3 CDs which have extra controls placed on them (i.e. 15.1, b).

15.2 Care staff may wish to apply controls to CDs not listed in 15.1 if they feel that there is a risk these CDs would go missing, or be more safely stored or accounted for.

15.3 **Storage of controlled drugs: Supported Housing and day services**

CDs should be stored in a special lockable metal cupboard. For Supported Housing, this must comply with the Misuse of Drugs (Safe Custody) Regulations 1973, whilst day services can use a locked non-portable container to store controlled drugs in. CDs requiring this special storage are usually handed separately to the care service by the pharmacist. Once received, they must be immediately secured in the controlled drugs cupboard.

15.4 Individuals who self-medicate may retain independence with CDs but they should follow the same storage requirements as for other medicines in their room (i.e. kept in a locked drawer or locked cupboard).

15.5 A record of the receipt, administration and disposal of controlled drugs must be kept in a CD register (this should be a bound book with numbered pages). This is in addition to usual recording of the administration of the controlled drug on the Medication Administration Record. Each person using the service should have a separate page for each CD prescribed. The quantity left should be recorded on the sheet following each dose administered and checked with the actual amount of controlled drug remaining. Each record should be countersigned by another witnessing designated member of care staff.

15.6 CDs that are no longer required or have expired must be promptly disposed of by returning them to the pharmacy. This must be recorded in the register and witnessed. A receipt of their return to the pharmacy must also be obtained. CDs that are returned to the person using the service when they leave the service or when they transfer to hospital must also be recorded in the register. CD skin patches that have been removed will still contain quantities of controlled drug and so must be folded in half to render the contents irretrievable and returned to the pharmacy.

15.7 Although it is not a legal requirement it is best practice that the booking in and out and administration of the CDs in 15.1 are witnessed by a second (medicines trained) care staff member. This prevents discrepancies from happening. As this is best practice (not a legal requirement) person using the services should not go without their CDs because there isn't a suitable witness available.

15.8 **Liquids**: When measuring liquid CDs in 15.1 (e.g. Oxynorm liquid) it is likely that modest but inevitable errors will occur which can apparently distort the calculated balance of the remaining liquid. For example if a bottle of 200ml of liquid is dispensed and the prescription requires a 5ml dose to be given twice daily, the bottle should theoretically last for 20 days and (say) at the start of the 20th day there should be 10ml remaining. It is possible that there would actually be none remaining due to the cumulative effect of the small inaccuracies that arise in each and every dose measurement. When this is the case, an adjustment to the balance in the CD record book should be made by care staff and witnessed by a more senior member of care staff. Errors in balance should not be carried over from one bottle to the next, as a larger and less explicable error will ultimately be noted.

15.9 The CDs in 15.1 must be entered into a controlled drugs register. The CDs in 15.1 must be booked out of the CD register each time they are given, as well as being recorded on the MAR chart. The balance of the CD remaining in the cabinet should be recorded and checked each time.

15.10 If an error is made in the register it must not be deleted but instead marked ‘’error’’ and a brief explanation recorded at the foot of the page. A correct entry must be made on the following line.

15.11 An audit of the controlled drugs should be undertaken and recorded by the Care Manager at least every month. Controlled drug discrepancies should be immediately reported to the Care Manager to undertake a full investigation and where appropriate inform the local CD Local Intelligence Network accountable officer and/or the police.

Storage and administration of controlled drugs in domiciliary care

15.12 There are no specific legal requirements that apply to controlled drugs in a person’s own home. However if a risk has been identified, then the care provider should consider putting in place systems to ensure that controlled drugs are managed safely.

15.13 Such systems may include: locking controlled drugs away (either with consent of the person using the service or with a best interest’s decision); using a countdown sheet; keeping a receipt of controlled drugs received and disposed of (by taking back to the pharmacy).

15.14 Any concerns should be referred to the Care Manager and if necessary brought to the attention of a relevant health professional for agreed action.

16. Administering warfarin

16.1 Person using the service who are prescribed an anti-coagulant drug such as Warfarin must have an ‘Oral Anticoagulant Therapy Pack’ (sometimes called ‘the yellow book’). This is used by the Anticoagulant Therapy Clinic to record blood tests (called an INR (International Normalized Ratio) test) and dosage directions after each test.

16.2 INR blood testing is essential to the safe use of warfarin. The frequency of INR blood testing varies for individual person using the services and is determined by clinical factors but the date of the next test is usually scheduled at the time of the most recent test. All care staff should ensure that person using the services are supported to have their blood test and are aware of where the person using the service’s ‘Oral Anticoagulant Therapy Pack’ is stored.

Administering warfarin: domiciliary care

16.3 Due to the risks of administering a preparation of variable dosage, it is advised that the responsibility of supporting person using the services with the administration of Warfarin should remain with health care professionals.

16.4 However, if a system is identified with a health professional that can ensure the person using the service, receives the appropriate prescribed dosage of Warfarin the care provider may take on the task of administering as part of the person's care.

16.5 A 'level of risk' assessment needs to be carried out to determine potential risk to the person using the service receiving the wrong dose and the actions

taken to mitigate the risk(s) including the implications of the person using the service receiving the incorrect dose and the actions to be taken should this happen. This must be clearly recorded. The MAR chart must be updated by a health professional with clear directions on the dose of Warfarin to be administered to enable the care provider to take on the task of administering Warfarin as part of the person's care.

Administering warfarin: Supported Housing

16.6 In order for care staff to be involved in the safe administration of Warfarin, it is essential that a health care professional has lead responsibility.

16.7 The guidelines for taking verbal orders (8.1) and amending MAR charts (8.8-8.10) should be followed when changes to the dose of Warfarin are made.

16.8 The Care Manager will need to know the interval for testing and action any changes. Written confirmation (as printed instructions or email) of the dose change needs to be obtained immediately following the tests. The Care Manager needs to sign the confirmation to identify it has been actioned and a copy attached to the person using the service's MAR chart.

Medication Errors and Near Misses

16.9 It is recognised that, despite high standards of good practice and care, mistakes may occasionally happen for various reasons. The mistake must not be hidden or ignored. If a member of staff is found to have hidden or ignored the mistake this will be considered gross misconduct and disciplinary action will be taken.

In the event that medication has been incorrectly administered

- Make sure the person is somewhere safe and being observed.
- Contact the GP/out of hours service immediately, outline what has happened, confirm any instructions given by the GP and follow them. Establish if ongoing monitoring is required.
- Contact your line manager/duty manager to explain what has happened and the advice given by the GP. The line manager/duty manager should make arrangements for ongoing monitoring if necessary.
- Record all the advice given and actions taken in the person's care notes, including who you spoke to and the time and date the conversation took place.
- Monitor the condition of the supported person throughout the process.

Medication omitted by mistake

- If you forget to give a medication contact your line manager as soon as you remember to inform them of the situation. A decision will need to be made as to the actions to take, for example, do you need to go back to administer the medication, can it be given at the next scheduled visit, will the dose need to be missed? The advice of the GP or pharmacist should be sought and documented including the name and professional title of the healthcare professional contacted, the advice given and the consequences of missing the dose, if appropriate.

For all errors/incidents

- Explain to the person, in a manner appropriate to them, the medication error and any possible effects (as advised by the healthcare professional contacted), reassure at all times and apologise for the error.
- If the person has capacity, offer to contact family or friends if they would like you to do so. If the person does not wish you discuss the incident with family or friends then this must be respected. Document who you have informed and consent given.
- Where a person has been assessed as lacking capacity, the person with legal authority to act on their behalf (for example, a person with lasting power of attorney for health and welfare) must be informed. This should be done as soon as possible following the incident and an apology should be offered. If there is no person with legal authority to act on behalf of the person then a best interests decision, in line with the Mental Capacity Act and the known wishes of the person, should be made as to whether information should be shared with family or friends. A record should be kept of who was contacted and the information given.
- Complete the incident form including a record of the healthcare professional's instructions, and the information given to the person or their representatives.
- Consideration should be given as to whether the incident should be reported as a safeguarding incident with the local authority.
- CQC must be informed if the error/incident could or has resulted in significant harm to the individual or the incident has been reported to the police. CQC must be notified using the forms available on their website. If the incident requires reporting to CQC then a safeguarding alert should also be raised.
- If you are unsure whether a notification to CQC and/or a safeguarding alert is needed you must seek advice from your manager.
- Where appropriate in line with the duty of candour, a written record of the incident must be given to the person (or to the person legally acting on their behalf for a person without capacity). The written record should include an apology for the incident, the information already given verbally, what actions have been taken, any enquires made and their results. Support should be offered to the person (or their legal representative) regarding the incident. A copy of any information given must be kept in the person's records as should any further communications regarding the incident.

Errors should be dealt with in a constructive manner and line managers are responsible for investigating them, with the aim of learning the underlying reasons for the incident and preventing its recurrence.

During an investigation the manager will need to differentiate between those cases where there was a genuine mistake, or where reckless/unsafe practice was undertaken. A thorough and careful investigation should be conducted before any action is taken.

The line manager must consider the need for further action in relation to supporting the member of staff who made the error. This could include retraining, reassessment of their competence, whether there is a need to stop the member of staff from undertaking medication duties and/or suspend them from all duties. This must be done within the bounds of relevant employment law.

A medication incident log should be kept and reviewed on a regular basis to identify any trends if they exist and to learn from the incidents to prevent recurrence wherever possible.

17. Refusals

Refusal of medication in a person using the service with adequate mental capacity

17.1 Where a person with mental capacity refuses any medication, this must be respected. A note should be made on the MAR chart using the appropriate code, for example an 'X', to show which medication has been refused. In addition, a note should be made explaining why the person has refused their medication as there may be different reasons for different medicines. This should be recorded on the reverse of the MAR chart or Medication Notes for variable dose, when required or refusal document (Appendix G). This should be reported to the Care Manager who should then inform the prescriber as soon as is practical (within 48 hours in any case but sooner if the risks are greater).

17.2 If you suspect that medicines are not being taken on a regular basis, for example not being swallowed, you should record this in the notes and inform the Care Manager, who in turn will inform the prescriber. If a person using the service with adequate mental capacity does this, they should be reminded that whilst it is their right to refuse medication, there are risks to their health and welfare.

Refusal of medication in a person using the service who lacks mental capacity

17.3 In line with the Mental Capacity Act 2005 Code of Practice and guidelines from the Nursing and Midwifery Council, a decision MAY be taken to give medicines covertly (e.g. hidden in food or drink) subject to a multi agency agreement and safeguards.

All service users have the right to refuse to take medicine if they wish to do so, and it is important that this right is recognized. There may be occasions when clients lack the capacity to take medicines or to understand the consequences of refusing to take medicines. In these circumstances, it may be necessary for healthcare professionals to follow a formal process to allow them to act in the best interests of the Client. The administration of any drug or medical treatment to a Client without their knowledge, in a disguised or deceptive form, is known as covert administration. Implementation of covert administration requires a complex, multidisciplinary assessment.

Covert administration is not simply the mixing of a medicine with food or drink to make it more palatable to a Client at their request. **By its definition, a medicine**

is given covertly to a Client in a disguised form without their knowledge but in their best interests.

This must be for a person using the client's best interests when they lack mental capacity and are unable to properly understand the consequences of not taking their medication. An assessment of whether the person using the service has adequate mental capacity to understand if taking the medicine is in their best interests and that the medicine is essential for their wellbeing must be carried out. If it is established that the person using the service lacks adequate mental capacity, the assessor must consult with their healthcare professionals and obtain the views of everyone involved in the person using the service's care (e.g. CPN, care staff, relatives, legal advocates). This may lead to a decision to covertly administer the person using the service's medicines in their best interests. Further guidance should be obtained from AFFINIA HEALTHCARE Best Interest Meetings (Mental Capacity Act) guidance.

17.4 The assessment, consultation and decision must be documented in the person using the service's notes and reviewed regularly as mental capacity can sometimes fluctuate. It may also be necessary to refer to section 14.3 regarding the crushing of tablets. A care plan will be needed to set out clearly how the medicines will be administered covertly to the person using the service and safeguards identified in the support plan. The Mental Capacity Act Code of Practice sets out that it must be assumed person using the service's have mental capacity. Therefore care staff administering medicines must reasonably believe that the person using the service lacks mental capacity each time and the action they are taking when giving them their medicines covertly is in their best interests.

Guidance for appropriate use of covert administration is well documented in regulations from the Care Quality Commission (CQC), the UK regulator of all health and social care providers, and guidelines from the National Institute of Health and Care Excellence (NICE), England's health technology assessment body. The CQC states: "When it is agreed to be in a person's best interests, the arrangements for giving medicines covertly must be in accordance with the Mental Capacity Act 2005".
Covert medication should not be used unless there has been a multi agency agreement to do so and safeguards in place. To use covert medication outside of this is considered assault.

18. Adverse effects

18.1 Care staff should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional (such as the supplying pharmacist). They should also inform the person's relatives.

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

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

19. Medicines-related incidents

19.1 Medicines-related incidents include any actual errors, errors that do not cause any harm and near misses with medicines. They might be identified by staff involved in the medicines-related incident or subsequently by other

people not involved in the incident. They may also come to light after audits.

19.2 If an incident occurs regarding medication, care staff must immediately report this to the Care Manager. This also applies to errors that care staff identify, but have not made themselves – e.g. errors made by prescribers, pharmacists and other care staff.

19.3 The Care Manager will need to ascertain if the person using the service has been harmed, or might have been harmed, or of the person has significant concerns. If this is the case they should seek advice from the GP or pharmacist. If this occurs out of hours, then the NHS 111 service can be contacted if, in the view of the Care Manager, they cannot wait to tell the GP or pharmacist the day after. Details of the incident should be fully documented using the medicines incident report form in Appendix K.

19.4 A central record of all errors should be kept. This log can be used for monitoring of patterns and to inform training sessions.

19.5 All medicines-related incidents (including near misses) should be investigated to reveal any root causes, be these systems errors or human

error. These root causes should be recorded as well as which actions are taken as a result of lessons learnt.

19.6 Any training needs should be identified and appropriate training should be provided if needed.

Who to notify when a medicines-related incident is identified

19.7 For registered services, CQC and the local authority should be notified when any medicines-related incident has caused either:

- **Harm or potential harm** to a person using the service. By harm we also include significant distress.
- **Intent**: If the staff member intended the adverse consequences to occur as a result of the incident.

Services not registered with CQC need only notify the local authority (not CQC) for the type of medicines-related incidents above.

19.8 If there is any doubt regarding whether a concern should be raised under these procedures this should always be discussed with the local authority.

19.9 Poor practice can result in harm when risks are not identified and no action is taken to prevent further incidents occurring or the concern escalating. Incident logs should always be checked for patterns by those recording incidents and those responsible for monitoring the effective implementation of that organisation's incident policy.

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

19.11 For further information refer to the Havering Safeguarding Adults Policy and Procedures - http://panlondonadultssafeguarding.proceduresonline.com/index.htm

Any incidents where controlled drugs go missing or any suspected abuse of controlled drugs (both by care staff or person using the services)

19.12 Contact must be made with:

Affinia Healthcare Management (as a Safeguarding Adults concern).

The Care Quality Commission.

Controlled Drug Local Intelligence Network Accountable Officer for Outer North East London by telephone on 08446001201. Where a criminal offence has occurred and a delay in reporting could lead to the loss of evidence, ring your local police station.

Staff can also contact the Local GP, or the dispensing pharmacist to seek immediate advice to prevent further harm. For out of Hours, Staff can contact the NHS helpline for immediate assistance.

In all circumstances, the Local authority and CQC must be notified.

20. Disposal of medicines

20.1 If a person using the service self-medicates, then responsibility for disposing of medication rests with them or their non-professional carer/relative. However, care staff can dispose of medication appropriately if consent is recorded on the 'consent for destruction of unwanted or discontinued medicines' form (Appendix L, form AS109). Unwanted medication should not be used for anyone else. Ensure unwanted/out of date medicines are clearly marked and segregated from the rest of the person using the service's medicine.

20.2 Controlled drugs that are no longer required or have expired must be promptly disposed of by returning them to the pharmacy. A receipt of their return to the pharmacy must also be obtained. For Supported Housing and day services, controlled drugs that are returned to the person using the service when they leave the service or when they transfer to hospital must also be recorded in the register. Controlled drug skin patches that have been removed will still contain quantities of controlled drug and so must be folded in half to render the contents irretrievable and returned to the pharmacy.

20.3 When returning medicines Controlled Drugs and methotrexate must be kept separate from any other medicines that are being returned. Sharps must also be kept separate although these should not be routinely returned to the pharmacist.

20.4 Medication will be returned to (or collected by) a pharmacy regularly according to demand (ideally the supplying pharmacy). Care staff will need to complete the 'Your Consent for us to destroy your unwanted or discontinued medicines' form AS109 (Appendix L) which records the person using the service's name; the name, strength and quantity of the medicine(s); the date of return; the signature of the care staff member returning them and the signature of the person receiving them.

20.5 If care staff cannot easily work out any quantities returned, an estimation of the quantity will be adequate (except in the case of controlled drugs). The pharmacy will be asked for a written receipt, or to sign and 'stamp' any disposal forms (Appendix L) used. This covers care staff in cases where consent for disposal has been disputed or allegations are made that medicines have not been disposed of correctly.

20.6 In the event of the death of the person using the service, medicines become the property of the estate and therefore are the responsibility of the executors to dispose of safely. However it is recommended the medicines should be retained for seven days following the death, in case the Coroner's office or courts require them.

20.7 Under no circumstances may unused medicines be disposed of in the refuse bin or by any other means. Medicines should not be flushed down the toilet or sink.

20.8 Where syringes and needles are used by GPs or other health professionals, they should be safely disposed of by the person using them. Syringes and needles should be placed in rigid sharps boxes and disposed of in accordance with local clinical waste disposal arrangements.

When residents leave the Supported Housing: Supported Housing

20.9 Medicines that have been dispensed for individual residents are their property and should be given to the resident on discharge. If the medication is no longer appropriate, or no longer needed, then consent must be obtained from the resident, prior to the removal and appropriate disposal of medication.

Disposing of single tablets/capsules: domiciliary care

20.10 It may be impractical to expect care staff to visit a pharmacy each time to return single tablets or capsules (for example if a person using the service refuses a dose). In these circumstances, care staff can ask pharmacy staff if they would be willing to supply them with an empty tablet bottle to keep wasted doses in. This bottle should be labelled by the care staff with 'waste medicines' stored safely and then returned to a pharmacy on the next available occasion.

21. Complaints

21.1 The service intends that medication should be handled and administered safely and respectfully. However, if a person or their representative has a concern or complaint this must be taken seriously and investigated.

- Any member of staff who is approached with a complaint about medication handling or administration should inform the registered manager who should establish the details of what has happened.
- The investigation should be documented in the person's care plan along with any actions taken to prevent reoccurrence. Where necessary, procedures should be updated and all staff should be made aware of this.
- The person and/or their nominated representative should be given information on what action has been taken. Care should be exercised to ensure that the confidentiality of the staff is not breached when providing information to the individual and/or nominated representative.
- If the complaint or concern is about the medication itself this should be referred to the person's GP.
- The person and/or their nominated representatives should be encouraged to report concerns or complaints regarding the handling or administration of medicines to the registered manager, or another member of staff if they feel more comfortable.
- A copy of the complaints procedure must be given to the person and/or their nominated representative when the person starts using the service and following any updates to the procedure. They should also be informed that they can raise their concern with CQC directly should they wish to do so.
- A record of the complaints must be kept by the service, including the actions taken, and complaints should be reviewed regularly to identify trends if they exist. CQC may request a copy of this record of complaints.

Glossary

Administration by care staff (level 2)	When the person using the service is dependent upon care staff to select and/or measure and/or give the appropriate medication from a Monitored Dosage System (MDS) or individual pharmacy labeled container, at the time the medication is due. Care staff are responsible for ensuring it is taken/ applied as prescribed.
Administration by care staff using a specialist technique (level 3)	These types of tasks will normally be administered by a health professional and include tasks such as giving medicines via nebulizer or injections.
Supported Housing	Means all Supported Housing (also known as housing with care and support) operated in Havering
Care package	A combination of services designed to meet a person's assessed needs.
Care plan	A document produced by the Care Manager following assessment of the needs of the person using the service, outlining how these needs shall be met.
Care provider	The service that will provide care to the person using the service to meet their assessed needs.
Care Quality Commission	The independent regulator of health and adult social care in England.
Carer/s	People who are supporting a relative, child, partner or friend who is frail or has physical or mental illness or disability or is affected by substance misuse or HIV/Aids. Carers are not paid to be carers and they do not always live with the person cared for.
Care staff	A person who is supporting a person using the service who is frail or has physical or mental illness or disability or is affected by substance misuse or HIV/Aids. Care Workers are paid for the care they provide and may or may not live with the person cared for.
Controlled drug accountable officer	A named person leading the controlled drug local intelligence network (CDLIN) with an oversight on controlled drug issues within the locality

Local Authority	Means Local Council (London Borough of Havering).
Day services	Means all day services operated in Havering
Domiciliary care	Care provided in an individual's own home.
General support tasks (level 1)	Tasks that care staff can carry out to help a person using the service self-medicate and maintain their independence.
Emergency medication treatment plan	Is an individual plan for person using the services with specific health needs, written by the person who prescribed the medication or currently responsible physician.
Multi-disciplinary	Multidisciplinary denotes an approach to care that involves more than one discipline. For example, this include GP's, Nurses, Community Pharmacists etc
Medication administration record (MAR chart)	Is a recording sheet produced by the pharmacist at the time of dispensing the prescribed medication.
Medication record chart	Is a pre printed recording sheet that requires medication to be written on.
Medication record sheet for monitored dosage system	Is a pre printed recording sheet to be used when medication is dispensed in a Monitored Dosage System.
Verbal reminder	Care staff are required to remind a service user to take their medication. There is **no** physical administration by the care staff.
Care manager	Refers to the Manager of the service who is registered with the Care Quality Commission or for day services, the manager of the Day Service (as Day Services are not registered with the Care Quality Commission.
Risk assessment	Collection and interpretation of data to determine the potential risks to person using the services and staff associated with delivering the care package, before the care staff commences work and is updated annually or more frequently if necessary.
Shared lives	Shared Lives Scheme is a service that recruits individuals, couples or families who can provide family-based accommodation or support for vulnerable people.

Staff	Means all staff employed by AFFINIA HEALTHCARE or employees/self employees of an independent agency who are providing a service under contract to Affinia Healthcare.