ADULT SOCIAL CARE & HOUSING

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Adult Social Care & Housing

Handling of Medication in a Bed-Based Reablement Support Setting

Policy & Practice Guidelines

July 2021

1 Document Information

Title:	**Handling of Medication in a Bed-Based Reablement Setting Practice Guidelines**
Status:	**Approved**
Current Version:	**v1.0**
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Approved by:	Adult Social Care Leadership Group
Approval Date:	**December 2019**
Review Frequency:	Annual
Next Review:	July 2022

Version History		
Version	**Date**	**Description**
V0.1	September 2019	Initial draft – one Policy (Clinical Commissioning Group Locality Medicines Optimisation Team)
V1.0	December 2019	FINAL Version – Approved
V2.0	July 2021	Urgent antibiotic pathway, self-medication updated, Staff learning Pathway and variable doses added to policy, Jo Parry Group Manager.

2 Contents

3. Introduction and scope

The Isle of Wight Council's (IWC) Handling of Medication in a Bed-Based Reablement Setting Policy forms an essential part of local health and care systems risk and medicines management strategy. The policy provides guidance to all Bed Based Reablement home workers involved in the care and support of adults living in Bed Based Reablement setting and it will be reviewed on an annual basis. The Practice Guidelines support the Handling of Medication in a Bed Based Reablement Setting Policy and reflects good practice guidance and legal requirements and applies to all individuals being supported and employees working in a Bed Based Reablement setting. Individuals refers to all users of the bed based reablement services (day services, respite and reablement).

The policy is prepared in compliance with the relevant statutory frameworks and relevant guidance. The policy and practice guidelines reflect good practice and ensure that all are aware of their roles and responsibilities in relation to the handling of medication, reducing the risk of any legal action against the Council arising out of improper handling of medication in a Bed Based Reablement setting.

Note: all supporting documentation is located on** Adult Social Care Staff Information Page under 'Handling of Medication in a Bed B**ased Reablement Setting Policy, Guidelines and supporting documentation'.

4. Policy and Practice Guidelines aims

This policy outlines the Isle of Wight Council's (IWC) vision for handling of medication in Adult Social Care. It also describes the Directorate's commitment to best practice, legal compliance, enablement and safeguarding of the wellbeing of individuals, employees, and anyone else that could be affected.

The policy is prepared in compliance with the relevant statutory frameworks and relevant guidance. The policy and practice guidelines reflect good practice and ensures that all are aware of their roles and responsibilities in relation to the handling of medication, reducing the risk of any legal action against the Council arising out of improper handling of medication in a Bed Based Reablement setting.

Medicines play an important part in helping individuals remain independent. It is important that individuals take their medicines, as prescribed, and should always be helped to manage their own medication, where this is possible, and appropriate in order to retain their independence. This will be done through the use of medication assessments within the Bed Based Reablement setting.

The aim of the policy and practice guidelines are to:

- Set out the principles by which medicines are managed in line with Care Quality Commission (CQC), National Institute for Health and Care Excellence (NICE) guidelines and legal requirements

- Ensure all members of staff working within Homes are aware of their roles, responsibilities, and limitations
- Manage the medication risks to individuals and staff
- Ensure that individuals receive appropriate medication safely and effectively
- Provide a clear and structured framework to enable lines of responsibility and leadership in the administration and delivery of medicines to be clear and comprehensible.

To support this policy, a number of guidelines published by the National Institute for Clinical Excellence (NICE) should be considered, these are:

- Managing medicines in care homes [SC1]
- Managing medicines for adults receiving social care in the community [NG67]
- Controlled drugs: safe use and management [NG46]

In addition, there is a range of other resources available from NICE

- **Baseline assessment tools**
  Every NICE guideline is accompanied by a baseline assessment tool, which lists all the recommendations and can be used by services to assess how their current provision compares to what is recommended. This can help identify gaps in provision and be used to inform action plans for improvement work.

  The baseline assessment tool can be downloaded from the relevant guideline 'tools and resources' tab on the NICE guideline webpage.

- **Checklist for updating the medicines policy**
  This is a checklist for health and social care staff developing and updating a care home medicines policy accompanies the NICE guideline on managing medicines in care homes (SC1) Checklist for health and social care staff developing and updating a care home medicines policy

- **NICE social care quick guides**
  NICE has a suite of 'quick guides' relevant to social care and they are short illustrated guides highlighting key elements of different NICE guidelines, such as Social Care Quick Guides for example Giving medicines covertly

5. Responsibilities

This policy applies to council employees, agency staff, and individuals being supported. Where the term 'employee' is used within the policy this refers to all those persons working in any of the aforementioned work settings or roles (including Agency).

It is the responsibility of the Registered Manager to ensure that all staff have read and understood this policy and that any unmet training needs are brought to the attention of the IWC Learning & Development Department so that training is made available in order that correct and safe practice is carried out at all times.

It is the responsibility of each member of staff to be accountable for their actions in relation to the procedures within these practice guidelines. All staff administering medicines must follow the policy and guidelines for managing medication.

6. Staff Training (SWAY Learning Pathway Link)

https://sway.office.com/UHtAXtgIRf4kJy4i?ref=Link

All staff who administer medications will be provided with training delivered by the CCG Medicines Optimisation Team to enable them to perform the tasks safely and efficiently. The Registered Manager will keep a record of this training and review the proficiency of the care staff on an annual basis or more frequently as necessary.

People accessing care and support often require medication in a safe and timely manner and many care workers are involved in the management and administration of medication.

Ensuring that appropriate learning opportunities are provided during induction, and are updated regularly, helps comply with CQC expectations.

We also want to ensure that staff feel confident in their own skills, and managers are able to assess their staff as being competent to provide this important task.

Staff will be observed by their manager a minimum of three times who will assess staff in a range of areas to assess competency using the Staff Competency Audit Sheet

Staff that do not administer medicines may be asked to apply topical preparations as part of personal care. These staff should be assessed as competent to carry out these tasks by a senior member of staff using the Medications Staff Competency Audit Sheet.

Learning activity 4: Request access to undertake an Opus distance learning workbook

This pack is aimed at senior staff and managers in a variety of care settings including care homes, homecare, reablement, extra care housing, supported living and day care. This interactive distance learning workbook provides advice on competency assessment, auditing, and management of medicines incidents in your care setting and provides you with the tools to implement safe processes in your organisation. The accredited distance learning course for senior staff responsible for assessing competence, auditing medicines, and managing medicines errors and incidents.

Course Title: (To be added to the Learning Hub. To request access in the interim, please email learning.development@iow.gov.uk)

1st year in post required training:

Learning activity part 1: Complete the e-learning course

This short course covers the following areas and is a basic introduction to the key areas:

•introduces the basic principles of safe and appropriate handling of medicines
•the importance of being competent and gaining consent
•learn about the safeguards for people's health, wellbeing, and human rights
•learn about responsibilities and the 'rights' of administration
•learn about the different types of medication and prescriptions
•the importance of keeping good records
•how to store and dispose of medicines correctly

Course Title: Managing Medicines e-learning (60 minutes)

Learning activity part 2: Attend the course delivered by our local CCG Medicines Optimisation Team

The training is fully accredited by the Royal College of Nursing and can be used as part of your professional development. The content covers the ordering, storage, administration and disposal of medicines and all legal information surrounding medicines in care settings. There are also some practical exercises for attendees at each session.

Course Title: Medicine Management in Care

Learning activity part 3: (For those working with people with learning disabilities) Complete the e-learning course

This course looks at what the STOMP campaign is trying to achieve, why people have been over medicated, how people should be supported and what to do if you think someone is being over medicated.

Course Title: Stop Over Medication of People (STOMP)

2nd year in post and subsequent years required training:

Dependant on the results from the regular (annually after the first sign-off) competency audit checklist, your manager will direct you to one of the following options:

(N.B. Although a guide is given below to which activity to direct staff to, managers can use their discretion to ensure learning is effective and offers a challenge to staff for refreshing skills)

Typically aimed at staff with no concerns about competency:

Learning activity option 1: Re-complete the e-learning course (as per year 1) - Managing Medicines e-learning (60 minutes)

Typically aimed at staff with some minor concerns about competency:

Learning activity option 2: Re-attend the 'Medicine Management in Care' course (Delivered by the Medicines Optimisation Team, Clinical Commissioning Group (CCG))

The content covers the ordering, storage, administration and disposal of medicines and all legal information surrounding medicines in care settings. There are also some practical exercises for attendees at each session.

Typically aimed at staff who may have been involved in medication errors/ incidents and/or there are multiple concerns about competency:

Learning activity option 3: Undertake the CPD certified online short course (4 hours)

This course covers legislation associated with handling medication, procedures for receiving, administering, handling, storing, and disposing of medication; as well as looking at the most common types of medication that are administered to individuals in a care setting.

Course Title: Course: Understanding the Safe Handling of Medication

Learning Activity: Attend the 'Assessors Refresher for Medicines Handling and Managing Incidents' course

On completion of the course, you will understand how to:

•Identify areas for improvement in competency assessment
•Improve the skills and techniques needed to assess competence and manage incidents
•Identify areas of concerns with medicines and put measures in place to mitigate the risks
•Provide practical solutions to aid incident management of medicines
•Demonstrate competence and confidence in the areas of competency assessment and management of errors
•Create an action plan

Course Title: (Dates to be added to the Learning Hub)

7. Admission to Bed Based Reablement Setting - Individuals utilising day services or individual services

- **Day services** – individuals will bring sufficient medication for the duration of their day service stay. Bed Based Reablement Services are not responsible for day service users' medications. Controlled Drugs will be stored safely for the individual in accordance with the Misuse of Drugs Safe Custody regulations 1973

  (Please also refer to Standard Operating Procedure)

- **Respite services** - individuals will bring sufficient medication for the duration of their respite stay. The individual is responsible for obtaining supplies should they run out of medication or should a new medication be prescribed and will be supported by the

Duty Manager at the Bed Based Reablement service.

(Please also refer to Standard Operating Procedure)

- **Reablement Services** – the hospital will supply 14 days of medication for individuals upon discharge together with a discharge summary. The individual is responsible for obtaining supplies should they run out of medication or should a new medication be prescribed and will be supported by the Duty Manager at the Bed Based Reablement service.

  (Please also refer to Standard Operating Procedure)

8. Supporting the Individual to Obtain Medication

All medication will be ordered either the Individual. This will be supported by the Duty Manager or a suitably trained member of staff.

Staff must ensure that they inform the Duty Manager if any medication appears to be in short supply.

If medication needs to be ordered by the Duty Manager:

It should be ordered by:

- Using the repeat prescription form (the white copy) that comes with each prescription and taken to the GP practice concerned or
- Using the GP surgery repeat prescription request form

Verbal requests for medication should be avoided wherever possible unless confirmed in writing.

The supplying Pharmacy for this person is: ……..

The main Pharmacist / Pharmacy contact at this Chemist is ……

Tel: ……..……

The person's GP practice is: ……....

The emergency out of hours procedure is to contact 111 / or 999 depending on nature of query.

8.1 Disposal of Medication

As prescribed medicines are the personal property of an individual, consent should be obtained to dispose of any medication. This can be verbal consent, and is evidenced in the care plan, MAR charts and returns book.

Medicines must be disposed of when:

- The expiry date is reached or on the advice of the pharmacist or medical practitioner

- Equipment such as fridges or other cooling systems have failed to work and there has been a conversation with the local pharmacy who has advised these medicines are not safe to keep

- There is an excess of medication surplus to an individual's requirements

- The individual for whom the medication is prescribed dies – In this case the medication must be kept for seven days after the death as details may be required by the Coroner's Officer.

- When a dose of medication is taken from the dispensed container but not taken by the individual, it must be placed in a separately labelled container , entered into the returns book, and sent for safe disposal

- A course of treatment is completed and there is a surplus to requirements, or the Medical Practitioner stops the medication

- Medication where indicated on packaging or in the *Patient Information Leaflet* that it is to be discarded at a specific time after opening

Medication for disposal must be returned to the supplier e.g. the pharmacy or dispensing surgery

A record of ALL returned medicines must be made and kept in the home at the point of refusal/waste. The record of disposal must include:

- Individual's name
- Name, strength, and quantity of medicines
- Date of return
- Signature of the member of staff returning the medicine
- Signature of the person receiving the medicine (if possible)

All disposed Controlled drugs must be recorded in the Controlled Drug Register and a signature of receipt obtained.

(Please refer to separate Standard Operating Procedure)

8.2 Missing Medication

If on delivery of medications (whether weekly, monthly or any other) you notice items are 'missing' then a process should be followed by the staff involved in the ordering process. The Pharmacy should be contacted initially to check if the prescription has been received. If the prescription has not been received, then the

staff would need to contact the GP practice for information.

A record should be maintained for any items that are 'missing' and strict timings of when the Pharmacy/GP practice is contacted should be adhered to e.g. call immediately, chase up within 24 hours etc.

(Please refer to separate Standard Operating Procedure)

8.3 Receipt of Medication

When new medication arrives at the home it must be checked at the earliest possible opportunity by the Duty Manager to ensure that all details are correct. Any discrepancies must be documented and queried with the Surgery (or hospital in the case of TTO) as soon as possible. The outcome must also be documented in the Medication Handover Book as well as the individual's care plan.

The check will include:

- All of the details on the medication label and on the Medication Administration Record (MAR) chart, these directions must match. (See Medication Seven Rights of Administration)
- Storage conditions
- Expiry dates (see also expiry dates guidance, listed in 9.5)

In addition, any controlled drugs must be recorded in the C*ontrolled Drugs Register* by two people (one to document medication, second person as a witness to check everything matches).

Any discrepancies must be documented and queried with the Surgery or hospital. The outcome must also be documented in the individuals care plan and Medication Handover Book.

(Please refer to separate Standard Operating Procedure)

8.4 Record Keeping

A MAR chart will be maintained for every individual in the home and will contain the following information:

- Individual's name
- Name of home
- Allergies (if known …. Including 'none known' if this is the case) the GP practice should be confirming allergies… These should be highlighted to ensure they stand out
- Name of GP (or GP practice)
- Medication prescribed

- Route of administration
- Time of administration
- A PRN profile should be completed for EVERY 'when required' medication.
- Insert Carried Forward medication on MAR chart.

Every time a medication is administered the MAR chart should be signed by the Duty Manager in the relevant box on the MAR chart. Controlled drugs should be double signed on the MAR chart. This is a legal requirement.

Changes to medication should always be documented in writing by either and email or letter by the prescriber, however if this is not possible a verbal instruction can be given over the telephone. This should be witnessed by two members of staff and recorded in writing on the MAR chart in clear handwriting, using BLOCK CAPITALS, and also written in the care plan or care plan.

The Registered Manager is responsible for making sure that all records relating to medicines are kept correctly and retained for at least 3 years after date of the last entry.

8.5 Audit Trail / Stock Rotation

All medication retained within the home must be accounted for at all times with a paper or robust computerised trail as verification

Daily, weekly, and monthly audits will be carried out to ensure quantities tally and theses audits documented.

For items such as eye drops, ointments, creams, and liquid medicines the date of opening must be recorded on the label and the contents discarded after the specified time has lapsed (see expiry dates guidance, listed in 9.5).

Advice from the supplying pharmacist must be sought if there is any doubt as to the expiry of any medication.

Please note where a medicine has an inner and an outer container, such as liquids, creams and ointments, the pharmacy label and date of opening must be applied to the item instead of, or as well as the outer box.

(Please refer to separate Standard Operating Procedure)

9. Storage Requirements

Individuals will be supported to self-administer at all times. A lockable drawer or cupboard will be provided in their room for this purpose. The individual is responsible for the security of the key. A spare key will be kept securely to use for emergencies.

Other medication not requiring cold storage or controlled drug storage will be kept in the designated robust cabinet secured by lock and key (BS2881). This will provide space for each individual individual to have their medication grouped together and

internal and external medicines stored separately. This cabinet will be used only to store medication.

The keys to this cabinet will be on a separate ring reserved solely for this purpose and be kept by the designated Duty Manager, on their person. A duplicate set of keys will be limited, and any unresolved loss of keys must be followed with a change of locks.

For certain conditions, such as asthma/angina or anaphylaxis, it may be necessary for individuals to carry their medication with them at all times. The GP or hospital will advise the individual when this is the case, and this must be documented on the MAR chart, and a risk assessment should be in place to support the individual.

Non fridge items must be stored according to conditions required by the manufacturer. This is commonly below 25°C however, information pertaining to storage requirements can be found on the packaging or in the Patient Information Leaflet provided with the medication or by accessing www.medicines.org.uk.

9.1 Medicines Requiring Refrigeration

Medicines requiring refrigeration will be stored in either a locked medication fridge or in a locked box within a specified food fridge. The box should be kept at the lowest part of the fridge as far to the back of the fridge as possible.

When medication is in this fridge it must be maintained at a temperature of between 2-8°C. A maximum/minimum thermometer must be used to ensure this. The fridge temperatures are to be checked and the minimum and maximum reading recorded daily. Record temperatures TWICE daily in the summer months. The thermometer must be re-set on each occasion. The fridge must be defrosted at least twice a year and a record of this maintained.

In the event of the thermometers highlighting the fridge not maintaining the correct temperature, advice must be sought from the pharmacist and, if necessary, all stock must be disposed of and a new supply obtained with as little disruption to the continuity of care of any individuals as possible.

9.2 Insulin Storage / Recording

Unopened insulin will be stored in the refrigerator but should be removed for at least one hour prior to administration for better comfort and efficiency. It can be stored safely for up to 28 days or 6 weeks (depending on the manufacturer) out of the refrigerator once it is in use. Date of removal from fridge must be recorded on all insulin kept outside of the fridge.

As with all other medications, it is essential to check the expiry of insulin when it is received into the home and prior to administration.
When records of insulin are made it must be ensured that the wording 'units' rather than abbreviations e.g. 'U' or 'IU' are used.

9.3 Oxygen Storage

Oxygen will be prescribed for each individual individual if the prescriber considers it necessary. Advice on storage and administration may be obtained from the supplier but the following guidelines should also be followed:

- Cylinders must be stored under cover and not subject to extreme temperatures
- The storage area must be clean, dry, well ventilated, and away from highly flammable liquids, combustibles and sources of heat and ignition
- Cylinders must be stored upright and secured by way of a chain to the wall
- Empty cylinders must be stored separately and easily distinguished from full cylinders
- The statutory warning notices must be displayed in any room/area where oxygen is used or stored
- Oxygen therapy must only be discontinued, or the flow rate altered by the direction of the prescriber
- Equipment must be handled by trained staff or under the supervision of trained staff only
- Regular stock checks will be carried out with particular attention paid to expiry dates
- A record should be made on the MAR chart the same as with any other medication

In addition, the Duty Manager must contact the pharmacist or oxygen provider to discuss any further recommendations regarding the use of oxygen.

9.4 Storage of Test Kits

Testing kits for urine and blood are stored in the cupboard used to store external preparations. The expiry dates of these kits should be checked on a regular basis and prior to immediate use.

9.5 Expiry Dates

Dates of opening must be documented on all opened medication by the member of staff who opens it.

Particular attention should be made to the expiry dates for medications. Frequently these are not displayed on the outer packaging of certain items such as eye drops and eye ointments. Most eye drops need to be discarded after four weeks of opening however some expire after two weeks therefore, as with all medications; it is essential that the patient information leaflet is consulted. If in any doubt the supplying pharmacy should be contacted for advice.

10. Administration of Medication

Staff will only be permitted to administer medication to individuals once they have been suitably trained (see Section 6) and deemed competent by the Registered Manager (see S*taff Competency Audit Sheet*) available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'.

Administering staff will familiarise themselves with the Handling of Medication in a Bed Based Reablement Setting Policy, supporting practice guidelines and sign to demonstrate their understanding of the contents of both documents.

Medication must be administered to individuals as prescribed. The prescriber's directions will be on the printed label attached to the medication. Additional information can be found in the Patient Information Leaflet provided with the medication. These are stored in the individual's medication file. If there are any queries regarding the way in which the medication is to be given, the Prescriber should be contacted in the first instance.

Variable doses - where possible this is to be avoided however where it can't be it needs to be clearly documented within the individuals care plan and how the decision is made as to what dose is given.

To avoid errors with the administration of medication, the following MUST be adhered to:

- Medication must only be administered when prescribed and not left in pots on the side/tables/trays etc.
- When not in use the medication cupboard must be locked, and the key held by the Duty Manager

- Any medicines which appear to be in short supply must be reported to the Duty Manager and Registered Manager immediately, and also recorded in the Medication handover book and individual's care plan.

- A record must be made on the MAR chart directly after the medication has been taken. If for any reason medication is not given or refused, the reason for this must be marked clearly on the MAR chart. Any refusal should also be documented in the individual's Care plan and the Duty Manager and Registered Manager informed. A key at the bottom of the MAR chart shows the correct symbol to use. Regular refusals must be reported to the individual's GP by the Duty Manager or nominated member of the care team to ensure vital medications are not missed.

- Administering staff must confirm the identity of the individual that is to have the medication. This can be done by checking the Care plan or MAR chart where a photograph is held, asking the individual to confirm their name, to confirm the identity. Under no circumstances should medication be given if there is uncertainty as to the individual's identity.

- The MAR chart should be used to check the individuals' name, medication, its dose and frequency against the name, medication, its dose, and frequency on the medication label. The two must match. If there is any discrepancy, clarification must be sought from the prescriber before medication is administered.

- All staff should note how each medication that they deal with is given e.g. oral, inhaled etc.

- It must be ensured that the correct device used for the process, e.g. British Standard stamped measuring spoons/oral syringes. If the manufacturer states these to be used for single use only, this must be adhered to.

- Where there are several drugs in one slot of a monitored dosage system, staff should ensure that the correct number is in each slot before and after administering and report any discrepancies immediately to Duty Manager prior to administering the medication.

- Any discrepancies will be dealt with by the Duty Manager who will liaise with the appropriate authorities e.g. GP, Pharmacist.

- Controlled drugs must be administered by two members of staff, one to administer and one as a witness. A record must be made on the MAR chart and in the Controlled Drug Register.

- If a medication error should occur it must be reported to the Duty Manager and Registered Manager/on-call manager immediately.

- It is the responsibility of all staff to ensure that they are familiar with the policy, guidelines, and the system of medication administration.

- Time critical medicines (e.g. Epilepsy or Parkinson's medicines) must be administered at set times as there is only a small window of opportunity to ensure that the patient's condition does not deteriorate.

- Provisions must be made for PRN and homely remedies medications to be administered at times outside of the usual medication round times.

- Staff should be aware of the medication they are administering to individuals, monitor the condition of the individual following administration and call in the GP if there is concern about any change in condition that may be a result of medication.

- Staff should record outcomes for all (as required) medicines to ensure individuals are reviewed, as necessary, if these medicines are ineffective.

- Medication reviews by a GP and/or multidisciplinary team must be prompted on an annual basis or more frequently when advised by the prescriber.

10.1 Procedure for Administration

Assemble all equipment before starting the round and follow Standard Operating Procedure for full guidance

10.2 As Required Medication

In the case of Medication prescribed to be taken 'when necessary' or 'when required' (PRN) the indication must be made clear on the medication label, on the MAR chart and in the Care plan. In addition, the maximum dosage in twenty-four hours and the necessary time interval between dosages must be annotated on the MAR chart. Clear instruction must be obtained from the prescriber as to the indications for the medication and under what circumstances it may be administered. How the medication is requested and/or offered must be documented in a PRN protocol.

It is recommended that any PRN medication must not be supplied in a Monitored Dosage System (MDS) but supplied by the pharmacy in its original packaging. Current, surplus PRN medication which is still within its expiry date should be carried forward to the next month. It must be ensured that a record of the medication carried forward in this way is made on the MAR chart to complete the audit trail. Outcomes must be recorded for all as required medicines.

10.3 Administration using Specialised Techniques

Support staff in the home must not undertake any tasks which properly fall within the responsibilities of the Community Nursing Services (District Nurses) e.g. the administration of injections and enemas and the insertion of catheters.

10.4 The Use of Measuring Devices

It must be ensured that any measuring device is accurate and that if it displays the symbol for single use only, this must be adhered to. Generally oral syringes supplied with medication are for single patient use and not single use, but if there is any doubt the supplier must be contacted for advice.

It is essential to use the correct type of syringe for the route of administration. An appropriate oral/enteral syringe should be used to measure oral liquid medicine. An intravenous syringe must not be used to administer oral liquid medicine and enteral feeds.

10.5 Anticoagulant Medication

Additional information will be provided when this type of medication is prescribed and regular INR (blood clotting) monitoring will take place. It may be necessary for individuals requiring dental or foot treatment to have a blood test prior to treatment, therefore the healthcare professional e.g. dentist/chiropodist or other should be notified of the medication as soon as possible and at least three days prior to treatment. The literature provided with the medication must be consulted for additional guidance and the prescriber/supplier contacted for further advice.

It is essential that the guidelines for taking verbal orders and amending MAR charts should be followed when changes to the dose of Warfarin are made. Advice **must** be sought as to the interval for testing and monitoring and any changes actioned. Written confirmation of dose changes must to be obtained immediately.

Support staff must be assessed as competent to administer this medication and **must** understand when to contact relevant healthcare professionals and seek specific training in this area if needed.

10.6 Antipsychotic Medication

These types of medication may need more frequent monitoring and it must be ensured that the Arthur Webster Clinic is consulted when necessary. There are serious concerns over the widespread prescribing of antipsychotic medication over long periods of time for people with a learning disability and dementia. The Healthcare professional should prompt a review annually.

It is a requirement of the Mental Capacity Act that the individual and those involved in the care and support of the individual should be available to discuss the situation, such as the risks and benefits of the medication. Directions must be full and complete and care staff must understand when it is necessary to administer the medication (e.g. Lorazepam PRN), based on the individual. Dementia training and positive behavioural support training must be available to all the support staff.

The IWC supports stopping over medication of people (STOMP) with a learning disability, autism, or both with psychotropic medications to manage behaviours. Our aim is to improve the quality of life of people to ensure individuals only receive

psychotropic medication for the right reasons and in the right amount with regular reviews.

Several 'Key Therapeutic Topics' published by NICE summarise the evidence base on this topic and should be read in conjunction with this policy:

- Antipsychotics in people living with dementia Key therapeutic topic [KTT7]
- Psychotropic medicines in people with learning disabilities whose behaviour challenges Key therapeutic topic [KTT19]
- Antipsychotic medicines for treating agitation, aggression and distress in people living with dementia (**Patient Decision Aid** to help people living with dementia, their family members and carers and their healthcare professionals discuss the options)

11. Adverse Drug Reactions

Medication is chosen to produce a specific effect; however unwanted side effects may also occur. In the event of an adverse reaction to medication the Duty Manager must be notified, and advice sought from the appropriate source e.g.

- Individual's GP
- Community Pharmacy
- 111 (out of hours only)

Healthcare professional advice must be followed, and the individual's progress monitored. The event must be documented on the MAR chart and in the individual's care plan.

12. Alterations to a Medication

Direction by a GP to alter a dose or stop medication may occur either during a GP visit or via a telephone conversation. Written confirmation of the change must be requested whenever possible.

Prescribers may telephone through instructions to vary doses. 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. The instructions should be repeated back to the prescriber to confirm that they have been heard 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, secure NHS.Net email or a letter) should be obtained within 24 hours from the prescriber. If this written confirmation is not obtained within this time frame, the Duty Manager should chase up and record in communication book/handover book/care plans.

Where possible a conference/speaker facility on the telephone in a private room should be used to enable two support workers to verify the direction. In any case, to limit the possibility of misinterpretation a second member of staff must be asked to repeat the direction back to the GP.

Where the GP refuses to confirm the alteration or discontinuation in writing or by adding a signature to the MAR chart following a visit or telephone conversation, the procedure must be witnessed by two members of the team, documented and signed by both on the individual's MAR chart and care plan stating the alteration, instructing GP, time and date.

Although the label on the corresponding medicine container must not be altered, an identifying mark can be placed on the container to indicate that a change in dosage has occurred.

A new medication must not be initiated without a prescription (e.g. no borrowing from another person's medication whilst awaiting a supply).

Interim medication requests from GP i.e. Antibiotics or any medicine that needs to be started urgently will need to be notified to the pharmacy so they are aware and can ensure it is delivered that day.

12.1 Cancelling medication on the MAR

When an item of medication is stopped, a cross through of the item should be made on the MAR chart to make it clear that it has been stopped. The former record should still be legible. The cancellation must be signed and dated, and a reference made in the Individual's notes or on the back of the MAR explaining:

- why the item was stopped,
- who it was stopped by
- and the member of staff that crossed it out on the MAR chart:

Both the MAR and the Care Plan should be double signed.

12.2 Adding a medication to a MAR

This must only be done when authorised by the prescriber and written confirmation obtained

Care must be taken to ensure that the record is printed in **CAPITAL LETTERS**. The information that is printed on the medication label must be copied directly on to the MAR chart. There must be a reference in the individual's notes or on the back of the MAR detailing the date, time and prescriber and explaining why the item was added. Do not start the medication until written confirmation has been received (this could be the new MAR chart, the right-hand side of the prescription, a spare label from the chemist, or an email from the GP). Any handwritten entries must be signed by <u>two</u> members of staff.

13. Additional Requirements for Controlled Drugs

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. Examples include Morphine, pethidine, methadone.

Stricter legal controls apply to controlled medicines to prevent them being misused, obtained illegally, or causing harm.

Designated and trained staff (following the guidelines in section 6 of this policy), must administer Controlled Drugs. A second, appropriately trained (as above) designated member of staff must witness the administration of Controlled Drugs.

Controlled Drugs administered by staff must be stored in a metal cupboard which complies with the Misuse of Drugs (Safe Custody) Regulations 1973. This includes the use of a heavy gauge metal cabinet with a double locking mechanism (BS3621).

Receipt, administration, and disposal of Controlled Drugs must be recorded in a (bound book) Controlled Drug Register. A running balance, checked by another Support worker, must be maintained. There must not be any cancellations, obliterations, or alterations. Corrections must be made by a signed and dated entry in the margin or at the bottom of the page. See Completed CD Register Example.

Controlled Drugs for disposal must be recorded in the Controlled Drug Register and a signature of receipt obtained.

The balance of Controlled Drugs will be checked on each administration and **also** on a weekly basis by the Registered Manager.

If there is any doubt as to whether or not a medication within the home is a Controlled Drug, advice must be sought from the pharmacist or prescriber.

If an individual is self-medicating a controlled drug medication, care will be taken to ensure that this medication is stored safely at all times.

14. Self-Administration

There is a legal requirement for any self-medicating individuals to be provided with lockable storage for their medicines to be stored appropriately.

We support self-medicating How we do this can be found in the standard operating procedure attached to this policy

When individuals come into bed based reablement setting they should be supported to self-administer their medicines wherever possible if they wish to and it does not put them at risk. A risk assessment must be carried out in this circumstance. This will help them to keep control of their own lives; it is important for all individuals and particularly important for those in respite care.

On arrival of a new individual it must be reasonably assessed as to whether they have the capacity to administer their own medication. This could be wholly or partially such as with the use of some inhalers. Where self-administration shows to be a possibility a risk assessment must be carried out and recorded.

Documentation must be made in individual's Care plan and on the MAR chart that they are self-administering.

Individuals' ability to administer their own medicines must be reviewed at least every three months unless there are any changing needs or concerns. For those who already self- administering this will be achieved by way of verification of amounts of medication and discussions with the individual.

15. Individuals' Rights & Preferences

It is the right of the individual receiving care and support to achieve maximum benefit from their medicines. To facilitate this right, support staff, prescribing doctor, pharmacist, community nurses and any other person involved in their care, must communicate and work together. The Mental Capacity Act (2005) must be considered with all aspects of handling of medication.

Individuals may have a preference in the way in which they take or are given their medicines, or who gives medicine to them and when. This may be due to religion or a number of other reasons. The individual's choices and preferences must be identified and considered within a risk management framework. A record of the preference must be kept and documented in their Care plan.

The person-centred care and care plan must be updated when the needs and requirements of the individual's change.

15.1 Individual Consent

Individuals have the right to refuse to take their medication. They must also give their consent for medication to be administered to them by support staff and for medication to be disposed of when it becomes out of use for any reason. A record of the discussion and the way in which the individual has given consent must be made prior to any of these occurrences and reviewed regularly where necessary. If the individual chooses not to take their medication, support staff must not insist but must record the refusal as in Administration of Medication. It is the responsibility of the person administering the medication to reasonably assess the person's capacity to consent.

Consent may be described as being the voluntary permission of the individual to receive a particular treatment or medicine, based on an adequate knowledge of the purpose, nature, likely effect and risks of that treatment or medicine.

Permission given under any unfair or undue pressure is not consent; neither can consent be implied by the individuals' behaviour

15.2 When an Individual Cannot Give Consent

There may be times when an individual is unable to give or refuse consent because they lack the mental capacity to do so. Capacity is issue, decision, and time specific so the individual's ability to give consent must always be time specific. If the individual cannot:

- understand the information relating to the medication
- retain that information long enough to make a decision
- use and weigh it to arrive at a decision and
- communicate their decision

Where the person lacks capacity to give consent, medication can only be given where it is in the individual's best interests. Each decision must be made in line with the Mental Capacity Act (MCA) and the Best Interest process followed and recorded.

On such occasions a Deprivation of Liberty Safeguards (DoLS) must be in place. If the medication could be seen as 'serious medical treatment' and the person has no one else appropriate to consult with about the decision, then a referral must be made to an Independent Mental Capacity Advocate (IMCA). See the MCA Code of Practice.

Please refer to the Isle of Wight Council's Deprivation of Liberty Safeguards (DoLS) Policy.

15.3 Emergency Medication

Emergency medication should only never be provided under the guidance of a healthcare professional.

15.4 Covert Medication

Medication must not be administered covertly (the administration of any medicine in disguised form) for individuals who have capacity. If an individual is refusing their medication it must be brought to the attention of the Registered Manager. Every effort will then be made to explain information and support the individual in the reason for taking their medication (See 13.1). If the individual still refuses to take their medication the decision must be documented, and the GP informed.

Administering medication to individuals who cannot give consent would require a full assessment of their mental capacity following MCA's Code of Practice and the Nursing Midwifery Council's (NMC) Standards for Medicines Management. A full report would be produced, and a best interest decision made for each medication prescribed. This will be clearly documented in the care and care plan. A care plan and risk assessment would need to outline how the medication would be given covertly e.g. in food. The GP, individual's family (or IMCA), Social Worker and Community Psychiatric Nurse may also need to be consulted. In addition, the pharmacist would need to be involved to ensure that crushing a medication or mixing it with certain food or drink would prove non-detrimental. It is good practice to record any response to a medication administered in this way.

Relatives will be consulted and kept informed about any decision to give medication covertly, but they cannot give consent for this unless there is a signed and registered Health and Welfare Lasting Power of Attorney in place.

Administering medication covertly could potentially lead to a Deprivation of Liberty. This should be considered and if applicable an application must be made to the appropriate body.

16. Crushing Tablets

It must not be assumed that it is safe to crush or cut tablets or to disguise medication in any other way. Where an individual has difficulty in taking a particular medication e.g. a large tablet, advice must be sought from the pharmacist who may be able to suggest an alternative formulation of the medication e.g. a dispersible tablet to the prescriber or if cutting the tablet safely using a tablet cutter to half the tablet is appropriate. If an alternative is not available, the Pharmacist may be able to suggest other methods appropriate to that medication.

17. Disposal

As prescribed medicines are the personal property of an individual, consent should be obtained to dispose of any medication.

(Please refer to separate Standard Operating Procedure)

17.1 Medical Device / Medicine Alerts

It is the responsibility of the Registered Manager to ensure that any alerts received by the home are acted on as they are received according to the instruction provided and a record maintained within the home.

Click here to report an MHRA drug alert or:
https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/email-signup

17.2 Individual's Purchased Medication (Patient's Own Medicines)

The home appreciates that individuals with capacity have the right to purchase their own medicines and foods or to have these brought in for them by friends and family members, however, occasionally other medicines or certain foods may interact with prescribed medicines or have other detrimental consequences e.g. chocolate for a diabetic individual.

Therefore, in the interest of the care and safety of the individual visitors will be encouraged to notify the Duty Manager on these occasions and a record of this made in their care and care plan.

Medicines Purchased by the individual or their representative must be clearly labelled with the individuals name and a record of these medicines maintained and if administered by staff must be included on the MAR chart

18. New Individuals / Individuals Leaving

Communication on these occasions is essential to ensure the continuity of care for the individuals. It must be ensured that processes are in place so that medication is available at the time it is needed. On arrival the medication is given to the shift leader and checked with the relative and/or advocate. The same process is followed on discharge.

19. Out of Hours

For medical treatment or advice outside of normal working hours, 111 should be contacted. If it is an emergency, then dial 999.

When contacting the out of hour's services such as 111 or 999 you must ensure you have all the relevant information to hand:

- Individual's date of birth
- Individual's name (remember to use the name that the individual is registered

at the GP with)
- Care home address (including postcode)
- Individual's home address if the individual is a respite patient
- Individual's GP
- Individual's GP address
- Reason for call - include details such as condition and temperature (please make this as succinct as possible).

20. Medication Error / Incident

Should an error occur it must be recorded and then reported to the Duty Manager or the Registered Manager within 24 hours. It is necessary to contact the individual's GP or the out of hour's service 111, ensuring all the information regarding the error is available.

Details of the error must be recorded on the *Medicines Incident Error Reporting Form* using the *Medication Incident Decision Pathway* for guidance (and individual's notes and where appropriate, family will be contacted. If the individual has a serious adverse reaction then ring 999 and request an ambulance, again ensuring the information regarding the error is available. Both documents are available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'.

If an individual's medicine balance is short of any medication, then staff must inform the person in charge or their senior immediately. Details of the error must be recorded on the *Medicines Incident Error Reporting Form* available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'. The GP and pharmacist and manager will be contacted, and advice sought regarding the possibility of a one-off prescription to cover the loss. The error must be documented in the individuals' notes and the MAR chart completed as per code at bottom of sheet.

If in any doubt do not give the medication until clarification has been obtained. Complete the *Medicines Incident Error Reporting Form* available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'.

If a person has been placed at risk of harm or the error involves a controlled drug it must be reported to the Care Quality Commission (CQC), safeguarding and the CD Accountable officer. To report please click here or: https://www.cdreporting.co.uk

21. Misuse / theft

Any suspected misuse or theft of medicine must be reported immediately to the Registered Manager who will complete an Incident Form and report to the CQC who may decide to contact the CCG Medicines Optimisation Team. The incident must be documented and recorded within the home in all cases. Incidents involving Controlled Drugs must be reported to the police.

Under the Health and Social Care Act 2008, the CQC must be notified about specific incidents. The law requires these notifications to be submitted within certain timescales.
Further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications. The notification must be made in writing and the CQC provide template forms to simplify the notification process. Further information and guidance is available on the 'Notifications' section of CQCs website.

The CCG's Medicines Optimisation Team can be contacted on 01983 534271
email: iow.medicinemanagement@nhs.net

22. Medication Administered Away from the Care Setting

When an individual spends time temporarily away from the home efforts must be made to ensure the continuation of supply of medication.

Secondary dispensing or the use of unsuitable containers such as envelopes must not take place.

A record of medication leaving the premises with the individual and a record of medication returning with the individual (even if this is zero) must be made.

(Please refer to separate Standard Operating Procedure)
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23. Admission to Hospital

If an individual is admitted to hospital, then the remaining supply of medicines is taken with them or an alternative quantity following liaison with the hospital. This will be documented on the MAR chart as well the amount of medicines returned with the individual. The way in which communication will take place following admission to hospital must be established by the Registered Manager in advance to ensure any changes made to an individual's medication are acted on promptly.

Any information which may be relevant to the care or treatment of the individual must be communicated to the hospital (e.g. when the last patch was applied). The Registered Manager or senior person must request that any changes made to the individual's medication are communicated directly to the home in written format on discharge and not at a later date so that any alterations can be acted on immediately.

(Please refer to separate Standard Operating Procedure)

24. Application of Topical Preparations

Support staff should be trained (as in section 6 of this policy) and assessed as competent to administer medication in the topical form. See *Medical Staff Competency Audit Sheet* available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'.
It may be appropriate to store certain preparations (moisturisers, shampoos etc) in the individual's room in a lockable container, following a risk assessment.

The site of application should be clearly indicated using a body map included in the individual's MAR Chart folder. A *body map* is available on Adult Social Care Staff Information Page under '*Handling of Medication in a Bed Based Reablement Setting Policy, Guidelines and supporting documentation*'. These items should be reviewed on a monthly basis.

25. Use of Nutritional Supplements

The home will take great care to provide nutritious meals for the individuals as a priority. Individuals requiring nutritional supplements will be monitored following an assessment by the Dietician.

26. Use of Wound Care

Individual individual's dressings must only be requested on an individual patient basis following an assessment by the District Nurses, and not ordered for one patient to be used as stock for others. Staff will attend training in this area wherever possible.

27. Authorised Inspection

Every location where medication is stored is open to inspection by an authorised CQC inspector. Medication, records of their receipt, administration and disposal and any other relevant documentation must be readily available on request of the authorised inspector.