



lifestyle

by **homecare** services

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Medication Management Policy and Procedure

Overview:

The following policy has been written taking into consideration the guidance issued by the Care Quality Commission (CQC) and Royal Pharmaceutical Society of Great Britain's guidelines published in 'The Handling of Medicines in Social Care' (RPSGB, 2007), it also takes into consideration the local guidance issued by the local PCT and Community Pharmacist.

Homecare Services adheres fully to Regulation 12- Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to the handling of medication. Homecare Services also fully adheres to the Medicines Act 1968, the Misuse of Drugs Act 1971, the Misuse of Drugs (Safe Custody) Regulations 1973 and the Nursing and Midwifery Councils Guidelines for the Administration of Medicines.

As with all our policies, due to the variations of employee's roles, it is the employee's responsibility to report as soon as identified to their manager if they cannot implement the policy. With the information provided a risk assessment and a person-centred approach will be decided and implemented.

Our Policy Statement:

"To ensure we act with dignity, respect, a person-centred approach, within the best interest of the service user when supporting the administration of medicine".

This policy outlines how the team at Homecare Services ensure the administration of medicines is implemented in safe respectful manner in line with all relevant legislation and clear procedures. All transactions involving medicines are regulated by the Medicines Act 1968 and subsidiary regulations made under that Act. The policy and guidelines for Homecare Services embodies the principles of legislation and guidance in appendix A:

How we will implement our aim:

- **Roles and responsibility of employees**

It is the responsibility of all employees to act in accordance with the law and within the guidance of this policy, unless recorded otherwise. For each employee that works directly with service users, to be aware of their individual service users care plan and implement accordingly.

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All procedures (appendix B) must be followed unless alternatives procedures have been identified and implemented. In such cases documentation/risk assessments will need to be confirmed before and actions are carried out by care staff.

Many of the people to whom we provide our services require assistance with either **PROMPTING, REMINDING OR ADMINISTERING** their medication, before we commence a service, we need to know the following:

- The amount of help and support with medicines that the person needs from the care worker
- Which medicines, what dosage and the times that the care worker needs to administer the medication
- How is the medicine dispensed, i.e. original packaging, Monitored Dosage System (MDS)
- Has the care worker had adequate training.

The information will be collected during the assessment of the service user's needs. The amount of involvement that is needed from a care worker regarding a person's medication will be recorded in the individual care/support plan and will be monitored and reviewed regularly.

All care staff will be trained to support the administration of medicines before doing so. Care workers will be appropriately trained in the handling and use of medication and will have their competence assessed.

The training will cover:

The supply, storage, and disposal of medicines

- Safe administration of medicines
- Quality assurance and record-keeping
- Accountability, responsibility, and confidentiality.

It will also consist of giving medicines:

- Into the mouth (tablets, capsules, liquids)
- Ear, nose and eye drops
- Inhalers
- Medicines applied to the skin

This level of training will not cover giving medicines that use invasive techniques such as giving suppositories, enemas, and injections.

Care workers, will **NOT** administer specialist treatments where specialist techniques are used, such as:

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

However, Homecare Services may consider administering using the above-mentioned methods if the care worker has been trained by a health care professional and that the healthcare professional is satisfied and has signed a statement to say that the care worker is competent to perform such procedures.

- **Principles of safe handling of medication**

Everyone involved in the care and support of a service user is responsible for ensuring that his/her medication is managed appropriately. However, the primary responsibility for the prescribing and management of medication rests with the Registered Prescriber in consultation with other members of the primary health care team and the patient.

Prescribed medicines are the property of the person to whom they have been prescribed and dispensed.

Medication must be administered safely and correctly to the person whose name appears on the label and according to the prescriber's instructions. These instructions are indicated on the pharmacy label. At each administration, medication **must be** recorded and signed for by the administrator.

Medicines must be available to service users when they need them. In the event of medication not being available when the service user needs it, advice must be sought immediately from the senior member of staff, the service user's GP or pharmacist, out of hours Doctor services or NHS Direct as appropriate. The senior/supervisor/coordinator must be informed, and the advice documented in the service user's records.

Medicines must be stored and disposed of safely and risk assessments must be in place and accessible to staff.

Administration of medication will be delivered in a way that respects dignity, privacy, independence and cultural and religious beliefs of the service user.

The Care Quality Commission's Regulations must be adhered to.

Staff who administer or support people with their medication must be suitably trained in medication handling and have been assessed as competent.

Domiciliary care staff may refuse to administer or support people with their medication if they have not received suitable training and do not feel competent to do so.

Confidentiality must be observed regarding the customer's medical history and medication. Staff responsible for medication must follow the correct procedure for advice and guidance. Medication must not be transferred from one container to another and should not be removed from the original container / packaging until the time of administration.

Medication that needs to be taken with a service user e.g. to the day service, should ideally be dispensed by the Pharmacist in a separate container / package and this must be risk assessed. If there is any query or concern regarding a service user's medication, then that medication should **not be given**, and the GP must be consulted immediately. The care worker **must contact a senior/supervisor/coordinator** who is then responsible for consulting with the relevant GP, or the care worker must contact the service user's GP, OOHDOC or NHS Direct for advice and inform the senior of this.

Health and Safety risk assessments and close supervision will be undertaken for any medication that is unsafe to handle e.g. cytotoxic preparations (medication for cancer treatments). Advice on the medicine label, patient information leaflets and from the pharmacy must be followed to ensure safe handling of this type of medication.

If for any reason a service user's medication cannot be administered at the prescribed time, action must be taken as detailed in the individual's support plan to prevent this impacting on the service user's medication regime. Care staff should contact their senior or on call team when out of hours for advice.

Staff must not disguise medication (covert administration) in food or drink. In exceptional circumstances this may be agreed on the written request of a clinical team, following an MCA and Best Interest Decision and consultation with the prescriber. Full documentation would be needed to support this exception, including a risk assessment. Some service users (usually with profound needs) take medication with food on a spoon to aid swallowing; this does not constitute covert administration but must be agreed with the prescriber or pharmacist.

Tablets must not be crushed or split and capsules must not be opened unless specifically designed for the purpose.

PRN (Pro Re Nata = when required) medication must be given in accordance with the prescriber's instructions, details of which should be recorded in the service user's support plan. A protocol detailing how and when the medication should be given, the time interval between doses and the maximum in 24 hours must be drawn up in conjunction with the prescriber and recorded in the support plan. Any increase in the use of PRN medication must be reported to senior or on call team when out of hours for advice.

Advice on medication issues, policies and procedures should be sought from a pharmacist or GP by the appropriate person (house manager, care-co-ordinator).

Medication reviews will be performed by the GP or Pharmacist and staff must be aware of potential changes to a service user's medication regime.

- **Choice and Consent**

Safe administration of medicines means that medicines are given in a way that avoids causing harm to a person. Homecare Services considers this to be a key element of good practice and has direct link to the principles of:

- At Homecare Services we prompt, remind and administer when supporting service users to take medication, the service user will always have choice (be asked) and where possible give consent
- Each service user regardless of their ability should be asked/request consent before supporting the administration of medicines
- Observe, if nonverbal, a person-centred approach is always upheld and each care worker should be able to make a judgment on whether or not the person wants to take the medicine. Such observation should always be recorded
- Only give medicines to the person they were prescribed for
- People should receive the right medicine at the right time and in the right way.

Every effort must be made to preserve the dignity and privacy of individuals in relation to medicine taking this means by being tactful and sensitive, it is a key indicator in the quality of the relationship between care worker and the person being cared for.

- **Mental Health Capacity (best interest)**

Care staff need to be aware of the Mental Capacity Act 2005 and its Code of Practice and the Deprivation of Liberty Safeguards (DoLS) to protect both the person and them. People should not be given medicines without their knowledge if they have the mental capacity to make decisions about their treatment and care.

If there are concerns about the person's ability to give informed consent to take their medicines, a mental capacity assessment will be carried out. Care staff are required to speak with their manager for advice if they feel a mental capacity assessment may be needed.

Covert Administration refers to medicines being disguised when administering; i.e crushed into food. Homecare Services does not condone the practise of 'Covert Administration' of medication unless the practise has been specifically authorised in writing and signed by the persons Doctor. If a member of staff observes this practice is needed, in the best interest of the service user they **must** record their observations and speak with a manager immediate so that medicines can be administrated in accordance with the individuals needs with a least restrictive approach.

- **Administration**

Care workers may administer medication to service user's when clearly identified on their support plan, as per the assessment of needs. The social worker/home manager will determine if medication support is required, and the Registered Manager or Senior Care Worker/Coordinator will assess how much help a service user will need to take their prescribed medication.

The level of support should be agreed and documented as follows:

General Support (**Level 1 Prompting**) - this may include:

- An occasional reminder or verbal prompt*
- Requesting repeat prescriptions from the GP
- Collecting medicines from the pharmacy
- Returning unwanted medicines to the pharmacy
- Manipulation of a container e.g. opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the service user and when the care worker has not been required to select the medication.
- Service user's may be assessed as Level 1 for some of their medication and Level 2 or 3 for others.

*If a prompt is required more than 2-3 times per week, a review should be undertaken as a persistent need for reminders may indicate that the service user does not have the ability to take responsibility for their own medicines and full administration of medicines by staff may be required. At this point consideration should be given to whether the service user could remain at Level 1 with the use of assistive technology e.g. from Carelink.

The nature of the general support with medication should be identified on the service user's support plan and in Risk Assessments if applicable.

Administering Medication (**Level 2 Administration**) –this may include:

- When the care worker selects and prepares medicines for immediate administration, including selection from a monitored dosage system or compliance aid.
- When the care worker selects and measures a dose of liquid medication for the service user to take.
- When the support worker applies a medicated cream/ ointment; inserts drops to ear, nose or eye; and administers inhaled medication.

A record must be made on the medication administration record sheet including:

- Date
- Time
- Medication – name, form, strength
- Appropriate codes used for refusal, absence, sleeping and other reasons such as medication unavailable, spillage, dropped tablets etc. Where the code “O” (for other) is used, an explanation is required on the medication record sheet and customer’s notes.

Examples of codes which might be used are: *note these codes will be used in recording of administration of medicine section below.

R= Refused **A**= Absent **S**= Sleeping **O**= Other **P**= Prepared

Specialist tasks (**Level 3 Administration**) –this may include:

- Administration of insulin
- Rectal Diazepam
- Adrenaline injection (Epipen)
- PEG feeds
- Oxygen administration
- Nebuliser

These tasks require specialist training and **must not be carried out** by care staff unless they have undertaken this training.

In Domiciliary support, any changes or additions to the existing medication record sheet should be confirmed in writing either using a letter confirming current medication, by fax/email or by direct entry on the communication sheet by the GP or Registered Prescriber.

A Domiciliary care senior will transfer this information to the medication administration record kept in the customer’s file. A suitably trained member of staff must then check the MAR sheet entry for accuracy. If Electronic MAR Charts are in use, the care manager/coordinator/supervisor must be notified and will then update accordingly.

When staff accompany customers to medical appointments, any changes to medication will have been communicated directly (verbally) by the prescriber and a prescription issued for the medication. Staff **must** ensure that the MAR sheet is amended accordingly.

Where a care worker is required to administer Warfarin, the current dose should be followed according to the yellow anticoagulant record book or patient record card issued by the hospital or clinic. If there is no yellow record book available, the line manager must be contacted for advice. The prescriber or duty doctor will then be contacted for clarification of the dose to administer, and the advice given by the medical professional must be documented. In this event, the dose of Warfarin **must not be** administered until advice is given.

Care workers should inform their line manager if they are unable to administer medication because the customer persistently refuses is asleep, absent or the medication is unavailable.

To ensure effective communication if other agencies are involved in the service user’s care and support, a communication record should be used. If a member of care staff needs to pass any information on, this should be documented in the relevant communication record and the senior/coordinator informed. The management team or support worker will then contact the agency. If the agency needs to pass information on, then they too may write in the communication record.

Any information provided by the agency must be forwarded to the office to ensure effective inter-agency working. Care supervisors/coordinators should audit the content of the communication record in line with observational monitoring.

Non-medical preparations can be distinguished from medicines as they do not have a product licence e.g. baby oil / hand lotion / sun creams / cosmetic moisturisers. Medicines do have a product licence and this can be seen displayed on the packaging i.e. PL.....(followed by numbers) e.g. E45 cream. In exceptional circumstances, assistance with the use of non-medical skin care preparations is acceptable provided that the District Nurse or Registered Prescriber has confirmed that there are no skin or tissue viability issues and as long as any change to the condition of the skin is reported immediately to the District Nurse or Registered Prescriber via the senior and a record is made in the service user's support plan. Care staff would need written confirmation of these instructions before they can administer non-medical preparations and this must be recorded on a MAR chart, or care plan where appropriate.

Care staff are not allowed to administer any non-medical preparations or medication purchased under the General Sales List (Medication) (GSL) at the request of the family or next of kin, if this is requested it must be reported to the senior or on call team when out of hours for advice.

Care staff are not permitted to administer medicated dressings, only dry dressings, which are used for protection. If a medicated dressing becomes detached, advice must be sought from the District Nurse. All communications to be recorded.

On occasions, domiciliary care staff may be requested to leave doses of medication out for the customer to take later. If a request of this sort is made by the customer or their family or representative, this **must be forwarded immediately to the line manager**. On completion of a risk assessment, this task may or may not be undertaken as appropriate. Advice must be sought from the line manager and input from the GP and /or family may be necessary. If agreed, the medication would be listed on a Medication Administration Record (MAR) or Electronic Medication Record (E-MAR) however, as the care worker may not see the service user take the medication they should not sign the MAR/E-MAR, the correct procedure in this instance is to select the appropriate code 'O' from the mar chart, for example, and then justify the reason for not signing in the comments section.

For medication supplied in a dosette box or professionally filled and sealed compliance aid, this must be repackaged if a dose change is ordered by the prescriber.

Staff may assist with surgical stockings if the stockings have been prescribed, correctly fitted and issued with instructions from the District Nurse.

• Controlled Drugs

Once a controlled drug is in the person's home, it should be treated the same way as any other medication.

Service users should be encouraged to keep all medication safely and securely. All medication, including controlled drugs must be kept away from children and vulnerable people.

Where there is an identified need for care staff to administer controlled drugs, the consent of the service user must be documented. If the service user is unable to communicate informed consent,

the prescriber must indicate formally that the treatment is in the best interest of the individual and comply with the Mental Capacity Act.

Controlled drugs, as with all other medication, must only be administered by designated, appropriately trained members of staff.

When administering medication, including controlled drugs, care staff should always follow the guidance set out in this policy and medication training sessions. They must always:

- check that the medication is documented on the Medication Administration Record (MAR) or Electronic Medication Record (E-MAR)
- only administer medication from the original bottle or packaging
- know the therapeutic use of the medication administered, its normal dose, side effects, precautions and contra-indications. They should monitor the individual for a period of time after administration, this is of particular importance with controlled drugs
- ensure that, where a service user is taking a controlled drug, they follow any specific protocol agreed in the person's care plan
- correctly sign the MAR or E-MAR along with any relevant controlled drug sheets/stock records
- store controlled drugs within a locked box/unit or out of reach of service users and any other vulnerable person who may enter the person's home

If a risk is identified during the assessment process, safeguards will be put into place to ensure that controlled drugs are managed safely. This may include locking drugs away, either with the consent of the service user or with a best interests' decision.

There is no legal requirement for a second member of staff to witness and sign for the administration or support of controlled drugs in a person's own home, however, Homecare Services will implement any relevant safeguards that they feel may be required to monitor administration practices, this includes stock checks, controlled drug records and second staff member support to staff who request this while they develop confidence in this area. Refusal or non-administration of prescribed controlled drugs and the reason for this must be recorded on the MAR/E-MAR/CD Record and in the service users notes, this must then be escalated to the manager/supervisor/coordinator immediately.

Any mistake or error with controlled medication must be reported to the manager/supervisor/coordinator without delay and medical assistance should be considered if required.

Any adverse effects, incidents, errors and near misses involving controlled drugs will be thoroughly investigated and the appropriate action taken.

Care workers **must not** administer injections of Controlled Drugs.

There is no additional requirement (other than what is outlined above) for Controlled Drugs used in the domiciliary setting (including the use of Controlled Drug patches). However, a risk assessment should be carried out to assess any potential problems with regard to storage, liquid dose measurement, build-up of stock and accessibility by the customer. Advice should be sought from the GP, pharmacist, or District Nurse if necessary.

- **Supply, store and dispose of medication**

It is important that staff are aware of the Misuse of Drugs Act 1971, and associated regulations. Care homes within our organisation working within the guidelines of legislation and regulations (appendix A).

When storing medicines within our care settings/service user's residence we:

- Know how and where medicines are stored, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by the service user themselves, controlled drugs, medicines to be stored in the refrigerator, skin creams, oral nutritional supplements and appliances.
- Secure storage with only authorised care staff having access.
- Ensure the temperatures for storing medicines and how the storage conditions should be monitored.
- Assess each service users needs for storing their medicines and provide storage that meets the resident's needs, choices, risk assessment and type of medicines system they are using.
- Ensure before disposing of a medicine that the medication is still being prescribed for a service user and find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.
- Dispose of medicines and remove medicines classed as clinical waste, we will speak with the service users family or next of kin who will in the first instance, need to arrange for the prompt disposal of: medicines that exceed requirements, unwanted medicines (including medicines of any resident who has died), expired medicines (including controlled drugs).
- Keep records of medicines (including controlled drugs) that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamperproof container within a cupboard until they are collected or taken to the pharmacy.

- **Recording of administration**

For verbal prompts of medication (level 1), the date and time of the prompt must be noted on the service user's care plan, medication that is prompted does not require a MAR/E-MAR.

For administration of medicines (level 2) a record must be made on the medication record sheet including:

- Date
- Time
- Medication – name, form, strength
- Initials of support worker if medication is administered
- Appropriate codes used for refusal, absence, sleeping and other reasons such as medication unavailable, spillage, dropped tablets etc.

Where the code “O” is used, an explanation is required on the medication record sheet. For example, if a medication is left out for the service user to take at a later time, this would be documented in the care plan.

The medication record sheet should be kept in the service user's folder. When these records are full, they must be taken to the office for archiving.

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The care worker will ensure a new medication administration record sheet is issued each month if needed. If a MAR is not available, the care worker must complete one, recording all prescribed medication on this, they must advise the manager/senior/coordinator that this has been completed. Used medication charts should remain in the service user's folder for the current month before being returned to the office. Domiciliary support seniors will be responsible for ensuring that the used medication charts are collected and returned.

Where E-MAR (Electronic Medication Administration Record) are used, the care worker will send the service users medication to the co-ordinator/senior/manager who will add this to the operating system, paper MAR's will need to be completed until all information has been recorded on the E-MAR.

A blank medication administration record should be available in all service users' folders ready for written entries and authorisation to be made by the prescriber at the time of a home visit. Other organisational policies to which this policy relates:

Appendix A: Legislations and guidance linked to the administration of medicines this policy applies to are;

- Medicines Act 1968
- Human Medicines Regulations 2012
- Misuse of Drugs Act 1971
- Misuse of Drugs (Safe Custody) Regulations 1973
- NHS and Community Care Act 1990
- Health & Safety Care Act 2008 and the Care Quality Commission (Registration) Regulations 2009
- Royal Pharmaceutical Society (RPSGB) guidance "The Handling of Medicines in Social care" 2007
- Care Quality Commission (CQC) Professional Guidance
- National Service Framework for Older People 2001
- Mental Capacity Act 2005
- Lifestyle by Homecare Services Medication Policy.

Appendix B: Procedures

Ordering and collecting Prescriptions

Ordering of repeat prescription is usually completed by the GP Surgery or pharmacy, it is also managed by family members. However, if the commissioning local authority authorises this as part of the service provision, then care workers are allowed to collect medication from the pharmacy on behalf of the service user, the care worker must always clarify this with the manager prior to collection. It is also important to state the importance of storing the medication safely during transportation to the service users address.

Administration of medication

Care workers providers should consider including the following in a medicine's administration process:

The 7 R's of administration:

1. right person
2. right medicine

V3:

3. right route/form
4. right dose
5. right time
6. ~~resident's~~ right to refuse
7. right response

The care worker must also understand the following:

- Making a record of the administration as soon as possible
- What to do if the resident is having a meal
- What to do if the resident is asleep
- How to administer specific medicines such as patches, creams, inhalers, eye drops and liquids
- Using the correct equipment depending on the formulation (for example, using oral syringes for small doses of liquid medicines)
- How to record and report administration errors and reactions to medicines
- How to record and report a resident's refusal to take a medicine(s)
- How to manage medicines that are prescribed 'when required'
- How to manage medicines when the resident is away from the care home for a short time (for example, visiting relatives)
- Monitoring and evaluating the effects of medicines, including reactions to medicines.

“PRN” (Pro re nata) – As Required

PRN medication is ‘as required’ by the service user, these medications are prescribed to the service user or seen as a homely remedy, they are intended for intermittent or short-term use. PRN medication will still be recorded on a MAR sheet, and it is important to remember that when completing these there is a difference between a service user refusing medication and not requiring it. For example, a service user is asked if they are in pain and would like some paracetamol, they reply that they are not in pain and do not require them, this should be recorded on the MAR sheet as not required, the service user has not refused medication. PRN medication exceeding 3 days required review from a healthcare professional.

Disposing of medication (out of date, unwanted)

As detailed above, all medication that is due to be disposed of for any reason will be returned to the pharmacy, this could be the responsibility of the service provider or family members. Should medication be found on the floor or refused, it should be placed in a sealed envelope with the name of the medication (if known), the client's name along with the name of the person who found it, signed and dated. This would then be stored either within a locked medicine box or cupboard out

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of reach of the service user with a view to being returned to the pharmacy for disposal. It is important to consider the impact on the service user should they continue to refuse or dispose of medication and a review should always be considered if this continues.

Appendix C:

Additional advice and guidelines for care workers/setting can be found here;

<https://www.nice.org.uk/guidance/sc1>