PROCEDURAL GUIDANCE TO SUPPORT THE MEDICATION POLICY(SL/ACH003)

Appendix 1

The flowchart should be read alongside the detailed guidance notes which all support staff are required to follow.

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1.0 SUPPORT ASSESSMENT AND PLANNING

1.1 An Assessment of support needs relating to medication is completed by a competent manager with input from a relevant professional (pharmacist / psychiatrist / GP) where required. This should include assessing the individual's capacity for understanding the assessment. The outcome of the assessment will indicate the type and level of support required for example -

1.1.1 The person supported is self-medicating
1.1.2 The person supported requires full support with the administration of medication
1.1.3 The person supported requires support with the administration of Covert drugs (Appendix 2 Medication Assessment)
1.1.4 The person supported is not on any prescribed medications but may on occasion require medications no longer supplied on prescription through the NHS

1.2 A support plan will be developed with the person and include the level of support required and specific responsibilities according to assessed need, and agreed with the prescribing GP or other relevant prescribing professionals responsible for the persons medical care (Appendix 3 Medication Support Plan)

1.3 The Medication Support Plan must be reviewed annually by the team leader or following any significant changes to the health and medication support for the person supported or following safeguarding events relating to the maladministration of medication. Review may also be triggered on the advice of a health professional or from the "what's working/ not working" part of the person-centred review or during the progress meeting.

1.4 The person undertaking the assessment must provide sufficient information in the resulting support plan to allow staff to carry out their duties safely. This information must include:

1.4.1 Relevant information about the person including cultural or religious beliefs and specific wishes the person may have in relation to the administration of medication.

1.4.2 Details of all medication that the person is taking (prescribed and bought medication and any supplements)

1.4.3 Level of support required, including any specific tasks which may need to be undertaken.

1.4.4 Whether medication needs to be stored securely.

1.4.5 Relevant health and medication details as advised by an appropriate healthcare professional (for example, is the medication for Parkinson's and is timing critical?)

1.4.6 Medication risk assessment by a healthcare professional (if appropriate)

1.4.7 Name and contact details of the person's doctor

1.4.8 Name and contact details of any other relevant healthcare teams involved (for example, speech and language team)

1.4.9 Name and contact details of the person's preferred pharmacy

1.4.10 A copy of the person's current medication support plan

1.4.11 When assessing the level of support required the assessor must be clear about the difference between assisting a person to take their medication and administering the medication. The following should be taken into consideration.

1.4.12 When support workers **assist** someone with their medicine, the person supported must indicate to the support workers what actions they are to take on each occasion.

1.4.13 If the person is not able to do this or support workers give any medicines without being requested (by the person) to do so, this activity must be interpreted as **administering** medicine.

1.5 '**Prompting'** is a very occasional verbal reminder for a person to take their medicines themselves.

1.6 **Support workers must not offer any assistance with medication unless an assessment has been carried out, the level of support required is clearly documented and a medication support plan is in place and accessible within the person's home**.

1.7 If the GP has prescribed medicines "to be taken as required" they should be made aware that support workers are unable to administer these unless a clear 'as required' protocol is in place for the person; the GP should provide the protocol for as required medication.

1.8 The cultural and religious beliefs of the person may significantly impact on their prescribed medicines and the team leader should ensure specialist advice is sought where this may occur (for example, Muslims may be unable to take their prescribed medicines in the daytime hours during the month of Ramadan).

2.0 STAFF COMPETENCY TO ADMINISTER MEDICATION

2.1 All staff whose job role involves the administration of medication, or the assessment of others will -

2.1.1 Attend support essentials as part of mandatory training which includes specific guidance on their roles responsibilities, accountability and management function including guidance on policy implementation. The support essentials training will incorporate the **6 rights of the person being supported** in the administration of medication as detailed below:

2.2 The right person – identity is confirmed with the person and/or with photographic proof of identity contained, a photograph being contained on the support plan

2.3 The right route – as per prescription guidance, matched with the MAR sheet, and the label on the blister pack or bottles or packaging. Where the pharmacy has not supplied a MAR sheet, the prescription must be checked against the label.

2.4 The right dose - as per prescription guidance, matched with the MAR sheet, and the label on the blister pack or bottles or packaging. Where the pharmacy has not supplied a MAR sheet, the prescription must be checked against the label.

2.5 The right Medication and form – tablet / Oral medication / transdermal patch / topical (cream/ointment)- as per prescription guidance, matched with the MAR sheet, and the label on the blister pack or bottles or packaging. Where the

pharmacy has not supplied a MAR sheet, the prescription must be checked against the label.

2.6 The right time - as per prescription guidance, matched with the MAR sheet, and the label on the blister pack or bottles or packaging. Where the pharmacy has not supplied a MAR sheet, the prescription must be checked against the label.

2.7 The right to refuse medication – as described in the support plan, including actions to be taken due to refusals

2.8 All staff will complete –

2.8.1 The competency practice assessment which incorporates a minimum of 3 observations of practice. (Appendix 4 – Practice Learning Assessment)

2.8.2 On an annual basis, complete a Medication Competency Assessment with their Line Manager which will include observation of giving medication and completing a stock check in line with policy. A declaration will be signed by the manager at the end of this process. The declaration is stored on Select HR (Appendix 4 - Medication Competency assessment).

2.9 Failure to pass the observation of practice must result in the person being removed from administration of medication until retraining and a further assessment has taken place.

2.10 When supporting people who are unable to take medication orally, it is common practice to administer medicines via a gastrostomy tube, such as a percutaneous endoscopic gastrostomy (PEG) tube. People who receive drinks and nutrition via a gastrostomy tube often cannot manage any type of oral intake, and this includes medications. Where appropriate consult with a pharmacist for advice on the appropriateness of delivering medication to a person supported via a gastrostomy tube. Staff providing this level of support must be provided with the relevant training and updates as required.

3.0 MEDICATION ADMINSTRATION RECORDS

3.1 A record must be kept of all medication administered, including creams and nutritional supplements by either using:

3.1.1 Pre-printed MAR sheets from the pharmacy; or

3.1.2 Handwritten MAR sheet (Appendix 6)

3.2 To ensure safe systems of practice receipt of all medication will be recorded on the relevant record sheet as follows:

3.2.1 Appendix 7 Medication Pods Stock Check / Returns Form (Proto med)
3.2.2 Appendix 8 Medication Stock Check / Returns Form (other medication)
3.3.3 Appendix 10 Medication transferred and returns form

3.3 Ideally MAR sheets are printed versions; in the case of the Handwritten MAR sheets, the medication label received from the pharmacy must be placed on the written MAR sheet and used.

3.4 Wherever possible, "Handwritten" entries must be checked and countersigned by two staff.

3.5 Staff due to finish shift must ensure that any errors/ omissions/refusals are handed over to the staff coming on duty, recording information on the handover form, including actions taken and advice/instructions given. There must be no gaps on the MAR chart for regular medication. If Support Workers identify any such gaps, they must contact their line manager to report this. The reason for the gap must be investigated to establish if the medication has not been given or whether the MAR chart has not been completed. Advice must be sought from the GP/pharmacist regarding actions to take if it is established that the dose has been missed.

3.6 If a medication is discontinued or changed, a trained and competent member of staff must immediately 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 must 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 must sign and date the entry. A corresponding entry should be made in the person's care plan. Where necessary, support plans should also be reviewed and updated to reflect the changes.

3.7 Where a new medication or new dose of current medication is prescribed, a new entry must 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 (if no second member of staff available it must be the next oncoming member of staff at that service) who should also sign the record.

3.8 A body map (Appendix 16) should be supplied by the pharmacy indicating the area in which any topical medication is to be applied e.g., barrier cream and on body map indicating groin.

3.9 The date of opening external preparations/creams should be recorded on the MAR and transferred each month. The date of opening should also be recorded on the tube/bottle label in the event of the packing being discarded.

3.10 Where a body map is not available, based on the advice/instruction from the GP, the manager must produce a body map and indicate the area for the topical treatment is to be applied, separate body maps should be used when treating different areas.

3.11 Patient information leaflets will be supplied by the pharmacy with medications and stored in the medication file for the individual person supported.

3.12 For individuals who do not wish to be directly observed whilst taking their medication, but require staff to administer the medications, a risk assessment must be undertaken to ascertain if they are competent and have capacity and capability to administer the medication themselves, this should be undertaken in association with the GP and reflected within the support plan.

3.13 It is essential that the MAR chart is completed at the GP visit by the support worker accompanying the person supported. Support workers must not sign the MAR chart for any medication administered by others.

3.14 It is acceptable for support workers, following consultation with the team leader, 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.

3.15 Any reminders, omissions, missed doses and any advice given to the person to consult their GP or another healthcare professional must be recorded in the daily record.

3.16 Completed MAR charts must be archived in accordance with policy G011 information governance. These forms must be kept with the person's file.

3.17 People supported suffering with dysphagia (swallowing difficulties) may require thickeners to modify the consistency of foods and fluids. Thickening foods and fluids slow down their movement through the mouth and throat which helps

people with swallowing difficulties to swallow more safely. This in turn prevents food and fluids from entering the lungs and causing complications such as chest infections, pneumonia and choking.

3.18 Thickeners should only be prescribed on the recommendation of a Speech & Language Therapist (SALT) after a diagnosis of dysphagia has been made. The choice and directions must be documented in the person relevant support plan and consistent with the directions recorded on the product label by the dispensing pharmacist. In case of accidental ingestion of thickening powder, carefully consideration should be given to where thickeners are stored to minimise risk to people supported.

3.19 When thickening foods and fluids, it is important that only the scoop provided with the product is used as there can be variation between products. Staff must always refer to the individual product information for instructions on the number of scoops required to achieve the desired texture as each brand uses a different number of scoops to achieve the described consistency.

3.20 Care and support plans must contain clear documentation of consistency (e.g. the number of scoops per 200ml and/or the IDDSI level descriptor) of food and drinks. There must be an up to date and an accurate record of when a fluid has been thickened and to what consistency. When recording the thickening of fluids, it will be more appropriate to record administration on a separate fluid intake chart/thickener record chart rather than on the MAR. Refer to appendix 17 Fluid/Thickener recording sheet.

4.0 'AS REQUIRED' (PRN) MEDICATIONS

4.1 It is recommended that where it is anticipated that someone may need an 'as required' medication (previously known as PRN) such as occasional pain relief, this is discussed with the GP / prescribing professional; details of under what circumstances "as required" medication should be given must be recorded within the individual's medication support plan.

When medications are given 'as required', the prescribers' instructions must state:

- The maximum frequency.
- The maximum number of doses in 24 hours.
- The reason for the treatment.

4.5 Team Leaders must ensure that Support Workers are aware and understand the content of medication support plans and have the required training if 'as required' medication requires administering at level three (specialist technique),

support workers also need to be aware of who to contact should they need any guidance or feel unsure about what actions to take in relation to the plan.

4.6 The administration of "as required" medication should be reviewed as directed by the prescribing professional, the effectiveness of "as required" medication must also be clearly documented within the daily records and reported back to the prescribing professional at the locally agreed timescales.

4.7 It is an individual's right to refuse medicines and staff must never force a person to take a medicine. However, generally it is worthwhile waiting for a few minutes and re-offering the medicine.

4.8 If a person refuses to take their medication, this must be recorded on the MAR chart, using the correct code to indicate refusal has occurred. It will be necessary to contact the person's GP/prescribing professional for further advice where the person supported has refused a dose of medication. The refusal and any advice received from the GP must be documented in the daily records. The GP/prescribing professional may also choose to undertake a review of the medication where it is being frequently refused.

4.9 If a person refuses "as required" medication which staff have offered because they believe the person requires them (for example, the person appears to be in pain) a record should be made in the care plan that the medication has been offered and refused. Where appropriate, the person's GP should be contacted for advice.

4.10 The person should be asked if they would tell you the reason for their refusal to take the medication and the reason documented if they are willing to give it. This may help in assessing potential options regarding the medication.

4.11 If a person is having difficulty swallowing their medication, or requests that tablets are crushed or capsules opened, this must be discussed with the person's GP who may review the medication, be able to prescribe more appropriate formulations or consider referral to a speech and language therapist for further assessment.

5.0 OVER THE COUNTER MEDICATIONS (OTC)

5.1 "OTC" medications are those which do not require a prescription and can be purchased by the individual such as paracetamol, herbal or homeopathic medicines and food supplements. AFG staff will not advise on or purchase over the counter or complementary treatments for the person supported, including

nutritional drinks, and/or diet aids. Where an individual receives a level of support with medication but chooses to purchase over the counter medication themselves, immediate advice must be sought through the G.P/NHS direct or local pharmacists. This advice must then be included in the medication assessment and medication support plan along with the agreed action to be taken.

5.2 Support Workers must remind people supported to check with their community pharmacist before taking or using 'OTC' in order to avoid potential adverse effects or interaction with existing prescribed treatment, the advice provided must be clearly documented within the daily records.

5.3 Support Workers must not purchase or administer any 'OTC' unless suitability has been confirmed with the person's GP/prescribing professional or pharmacist. The advice given and the name and professional title of the person giving it should be documented in the person's daily records.

5.4 Support Workers must only administer 'OTC from the original package as purchased which shows the dose to be taken and the expiry date of the product.

5.5 'OTC' must only be administered in accordance with the directions in the manufacturer's information. Under no circumstances will a dose greater than that given in the manufacturer's information be administered by staff. The effect of "OTC" medication should be clearly documented within the daily record and communicated to oncoming staff.

5.6 When 'OTC' are administered, this must be recorded on the person's MAR chart the same way as prescribed medication and should have the maximum dose, frequency of administration and the route of administration clearly documented.

5.7 Support Workers must immediately seek advice from their line manager / NHS direct if they are concerned that a person is using 'OTC' inappropriately or excessively.

6.0 Concealment (Covert Administration) of medications in food/drink

6.1 A clear best interests plan should be in place for individuals where it has been decided that it is in their best interest to have their medication concealed in food or drinks, including inclusion on or in food/drink to aid swallowing, and those involved in the decision-making process should have signed to say they

agree (Appendix 3 Medication Support Plan) there must also be evidence of a completed Mental Capacity Assessment in relation to the administration of concealed medication within the persons personal file. The dispensing pharmacist must be consulted to ensure the plan for concealing medication is safe.

6.2 Inclusion on or in food/drink to aid swallowing must be supported through guidance in a SALT assessment, cross referenced to the decision-making record and the medication support plan (Appendix 3 medication support plan).

6.3 'Covert' is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. There may be certain circumstances in which covert administration may need to be considered to prevent a person missing out on essential treatment. This may only be done where the person lacks capacity as defined by the Mental Capacity Act or under the conditions defined by the Mental Health Act (MHA).

6.4 If the person has capacity and the MHA does not apply, then they cannot be compelled to take their medication even if this is likely to affect their health or wellbeing.

6.5 Any decision made about the covert use of medication for a person who lacks capacity must be the result of a best interests meeting in accordance with the principles laid out by the Mental Capacity Act. Health and social care professionals, relevant to the individual, must be consulted along with, where appropriate, the person's family or representative. The person's GP and any person with legal authority to act on behalf of the individual for medication issues must be involved and agree that covert administration is in the person's best interest. Information given by informal carers such as relatives or friends should be taken into consideration. The decision reached, the reasons for it and who was involved must be recorded in the person's Person-Centred Plan.

6.6 A written medication support plan must be developed which is specific for that person. The advice of a pharmacist must be obtained for people with swallowing difficulties, regarding the appropriate method of administration for the medication.

6.7 The use of covert administration must be reviewed on a regular basis which must be at least every 6 months, or sooner if circumstances change (The restrictive practice assessment including any relevant deprivation of liberty must also be updated at each review). Any changes to the existing plan must be recorded in the person's care plan.

7.0 MEDICATION ERRORS

7.1 In the event of a medication error there is a process to follow to support managers to grade the severity of medication errors and provide guidance around appropriate management and decision making following an incident. The Team Leader and Area Manager must ensure completion of this process as detailed within the Guidance for the Management of Medication Errors- (Appendix 11 Management and medication errors Guidance and process). 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, and/or 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 (HR will advise where this is necessary)

7.2 The error must be logged in CARISTA as a significant event by the team leader; errors must be reviewed on a regular basis by the Area Manager to identify any trends if they exist and to learn from the incidents to prevent recurrence wherever possible.

7.3 Where advise is sought from NHS direct / GP / other prescribing professional in relation to a medication error the name and position of the health professional contacted and the advice they gave must be recorded on the paper event form and significant event in CARISTA with the details of the staff member who made the call.

7.4 The person affected and / or relevant others (e.g., family member, advocate) must be informed of what has occurred and action that will be taken e.g. monitoring requirements. If the person affected or a person acting on their behalf is unhappy with any aspect of the error or the response to date, offer must be made to instigate the complaints process and access to an advocate. 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 in the management of all medication errors should be offered to the person regarding the incident. A copy of any information relating to the error must be kept in the person's records as should any further communications regarding the incident.

7.5 Safeguarding issues related to the administration of medication must be reported to the local authority, CCG and where appropriate CQC in line with their reporting requirement. 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 must 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.

7.6 Under no circumstances should entries on MAR sheets be corrected using total cover of the error by pen or other substance such as Tippex. Errors should have a line through and be initialled, and the line manager informed if it is not the manager making the error/correction.

7.7 Where errors have occurred, any packaging, containers, labels and MAR sheets or any item relating to the medication must be retained at the persons property until the incident has been fully investigated.

8.0 MEDICATION OMITTED BY MISTAKE

Where staff forget to give medication, they must contact their line manager as soon as possible to inform them of the situation. A decision will need to be made by the persons line manager 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 NHS direct, 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, where appropriate.

9.0 COMPLAINTS

9.1 AFG 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.

9.2 Any member of staff who is approached with a complaint about medication handling or administration must inform the Team leader / Area Manager or registered manager who will establish the details of what has happened and ensure its logged in accordance with the complaint's procedure.

9.3 An investigation must be carried out and documented in the person's care plan along with any actions taken to prevent reoccurrence. Following investigation, if changes are made to policy and procedure, then staff must be made aware of the changes by their line manager.

9.4 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 as detailed within AFG complaints policy

9.5 If the complaint or concern is about the medication itself this should be referred to the person's GP/ prescribing professional.

9.6 The person and/or their nominated representatives should be encouraged to report concerns or complaints regarding the handling or administration of medicines to the Area Manager/Head of Operations or another member of staff if they feel more comfortable.

9.7 A copy of the complaints easy read 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.

9.8 A record of the complaints must be kept by the service on Carista, 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.

10.0 ORDERING MEDICINES

If it is identified at the assessment stage that Support Workers will be responsible for ordering prescriptions and/or collecting medicines from the community pharmacy arrangements must be fully documented in the support plan (Appendix 3 Medication Support Plan). The information should include:

10.1 How the medication is to be ordered and where this should be recorded.

10.2 How the prescriptions are to be obtained from the prescriber to the person responsible for dispensing the medication.

10.3 How the medication will be obtained for the person.

10.4 How the process will be monitored to ensure medication is received in good time.

10.5 How medication collected/received will be recorded.

10.6 Where the person themselves or their nominated representative is responsible for the ordering and collection of medication that Support Workers are giving there must be a robust arrangement, detailed in the support plan, of how staff are to inform the person ordering the medication that new supplies are required. Support Workers should document in the person's notes when they have requested the new supplies and any reminders issued.

11.0 PROCESSES REQUIRED TO ENSURE THAT THE PERSON DOES NOT RUN OUT OF MEDICATION.

11.1 Medicines must be ordered from the surgery approximately a week before they are due to run out. The details of how this is done must be recorded in the individual's support plan.

11.2 A record must be made that the medication has been ordered along with the date the order was placed.

11.3 No more than 28 days' supply of medicines, including those on repeat prescription, should normally be requested for an individual at any one time (exceptions to this should be discussed with the persons GP or prescribing professional).

11.4 Surgeries usually require two working days to process requests for repeat prescriptions. After this time, the prescription (or medication if a dispensing GP is used by the person) can be collected.

11.5 When the medication is to be dispensed at a community pharmacy, Support Workers should take the prescription to the person's preferred pharmacy to be dispensed. If available, the pharmacy's prescription collection and/or delivery service should be used, if appropriate for the person with their consent. Wherever possible, the person's chosen pharmacy should be used to provide all the person's medication. This means that the pharmacy will have a complete record of the person's dispensed medication which is helpful if advice is needed.

11.6 For those that are assessed as requiring support at level 3, Support Workers should request prescribed medications be provided in traditional containers, complete with dispensing label and patient information leaflet, rather than within monitored dosage packs.

12 MONITORING STOCK LEVELS

Support Workers are accountable for -

12.1 Ensuring adequate stocks of medication are available when supporting people at level 2 with both ordering and collection of repeat prescriptions or, when administering medicines at level 3

12.2 Correct completion of the MAR chart

12.3 Referring any concerns regarding any discrepancies in medicine stock levels to their line manager.

13 Obtaining New Supplies

13.1 If it is identified at the assessment stage that Support Workers will be responsible for ordering prescriptions and/or collecting medicines from the community pharmacy/dispensing GP practice (Level 2) the arrangements must be fully documented in the support plan.

13.2 Where the person themselves or their nominated representative is responsible for the ordering and collection of medication that support workers are giving there must be a robust arrangement, detailed in the support plan, of how support workers are to inform the person ordering the medication that new supplies are required. Support workers must document in the person's notes when they have requested the new supplies and any reminders issued.

13.3 Medicines must be ordered from the surgery approximately a week before they are due to run out by the support worker. The details of how this is done must be recorded in the individual's support plan.

13.4 For those people that are assessed as requiring support at level 3, support workers should request prescribed medications be provided in traditional containers, complete with dispensing label and patient information leaflet, rather than monitored dosage packs.

14 RECEIPT OF MEDICATION

14.1 Regular prescribed medication must be accompanied by a printed MAR sheet from the pharmacy dispensing the medication. Where a new medication is prescribed mid cycle (regular / one off) this must be recorded/ hand-written on the MAR sheet in black ink and countersigned by a second staff member.

14.2 'Administration of as required' medication and once only medication, is recorded on the reverse of the MAR sheet in black ink and must be entered on a Medication Stock Checklist (Appendix 8 Medication received stock check list/Returns Form). All 'as required' medication must be checked and the total remaining recorded on the stock check list, other one-off medication should be checked weekly if applicable.

14.3 Medication within a monitored dosage system will be checked in according to the numbers of pods received and times they are due to be given. There will be clarification about the types of medication recorded on the pre-printed MAR sheet, where this is absent the dispensing pharmacy must be contacted for clarity. There is a stock check sheet Medication Pods visual checks and returns form – (Appendix 7 Medication pods stock Check and returns form) on which this is recorded. It is not possible to see the actual medication within each pod until the pod is opened prior to administration.

14.4 Stock received for all medication not within the monitored dosage system must be entered on the MAR sheet and Medication Stock Checklist/Returns form (Appendix 7 Medication pods stock Check and returns form) and this medication should be stock checked on a weekly basis. This includes recording

the amount of medication received, total weekly usage and total amount in stock (adding the amount received and the stock level together to give a total amount of medication in stock)

14.5 Any balance of medication which is to be carried forward to the new medication cycle must be recorded on the MAR sheet

14.6 The MAR sheet must contain the name of the person supported and specify the following:

- Name of the medication.
- Strength and dose.
- Timing and frequency.
- Route of administration (e.g. oral).
- Site of application for special treatment (e.g., to left eye etc)
- Special instructions (e.g., with food, avoid alcohol).
- Medication received, carried forward and returned.

Note:

- 'As before' or 'as directed' are not acceptable instructions. This includes the use of creams where the instructions often may be ''as directed'
- When medications are intended for 'as required' use, the label should state the minimum interval between doses and an indication of the use of the medication.
- If the instructions are not clear, the help of the prescribing doctor or pharmacy must be sought.
- The date and the amount supplied must be clearly stated on the label.

15 SAFE STORAGE OF MEDICATION (Support levels one, two and three)

15.1 The person will be supported wherever possible to store medications in their own room within a locked cabinet, wardrobe, drawer etc. Individuals will manage the storage of their own medication unless otherwise stipulated in the individual's medication support plan.

15.2 Where the person supported does not store medication in their own rooms, alternative arrangements must be discussed with the health or social care professional involved with the person supported to identify a suitable alternative storage option, this alternative storage option must be agreed with the team leader.

15.3 Some medicines may need to be stored in a refrigerator; the directions for refrigerated medications will be stated on the dispensing label by the pharmacy supplying the medication.

15.4 Medication must not be transferred into any other containers.

15.5 It is important to note that certain 'as required' medicines must never be locked away and should remain available to the person supported at all times. If, on assessment, the person is deemed to be at risk from these 'as required' medicines this must be raised by the support staff/team leader to the prescriber and any identified actions should be carried out by the support staff/team leader as has been directed by the GP. Such "at risk" medicines include reliever inhalers (such as salbutamol) and glyceryl trinitrate spray (GTN spray) Benzodiazepines (diazepam).

16 CONTROLLED DRUGS AND STORAGE OF

16.1 The Misuse of Drugs Act 1971 controls the availability of drugs that are considered sufficiently 'dangerous' or 'harmful' with a potential for misuse. These drugs are termed Controlled Drugs (CDs). It is a criminal offence to possess, possess with intent to supply or administer these drugs without authorisation.

16.2 There are strict controls for the prescribing, administering, safe custody, dispensing, record keeping and disposal of CDs. Under this policy Oramorph 10mg/5ml (morphine sulphate) liquid, Temazepam and Tramadol will be controlled in the same way.

16.3 Once a controlled drug is in the person's own home it should be treated the same as all other medication. The additional safe storage and recording requirements for controlled drugs in care homes do not apply within supported living settings. As with all medication, controlled drugs must be kept securely locked at all times, these do not need to be in a separate cabinet within the bedroom of the person supported but must be in a lockable draw or cabinet which is specific for the purpose. Staff should store controlled drugs safely and consider the risk of misuse and diversion.

16.4 Adult Care Homes must comply with the Misuse of Drugs Act 1971 and associated regulations when storing CDs. If a CD requires safe custody, then it must be stored within a CD cupboard. The CD safe or cabinet must comply with the requirements specified in the Safe Custody Regulations. It must be made

of steel, have a specified locking mechanism and be permanently fixed to a solid wall or floor with rag or rawl bolts (see The Misuse of Drugs (Safe Custody) Regulations 1973 - Schedule 2, structural requirements in relation to safes, cabinets and rooms used for keeping drugs). The CD cupboard must only be used for the storage of CDs and no other medicine, money or valuables should be stored in the cupboard. If the CD is provided in a monitored dosage system (MDS) the entire MDS must be stored in the CD cabinet.

16.5 Access to the CD cabinet must be restricted. The CD cupboard keys must be kept under the control of a designated person and there should be a clear audit trail of the holders of the key.

16.6 If the person supported self-administers their medicine, in accordance with an appropriately completed self medication risk assessment, this must be stored in a locked, non-portable cabinet or drawer in the person's room.

16.7 For any controlled drug, same as with any drug prescribed the MAR should be in place to indicate under what circumstances the medication should be administered and the route to be used.

16.8 If possible, Methadone should be administered at designated pharmacies or local clinics agreed with medical professionals.

16.9 For Adult Care Homes a Controlled Drug (CD) register is a legal document and must be a bound book with pages clearly numbered. It is used to record the receipt, administration, transfer (e.g. when a patient goes into hospital) and disposal of CDs by the Care Home. A running balance must be kept, and it is good practice to verify the balance each time an entry is made.

16.10 The CD register must not be used for any other purpose, it must be kept locked in a secure place - preferably in the CD cupboard when not in use.

16.11 The CD register must have a separate page for each drug, form, strength and for each person which corresponds to the index page. All entries must be signed and dated by two competent staff members.

16.12 Adult Care Home will comply with the NHS Principles of Safe Medicine Administration in a Care Home Setting

17 Safe disposal of medicines

17.1 The disposal of unwanted or out of date medication should usually be the responsibility of the person supported and/or their nominated representative (support worker / team leader). They should be encouraged to return any such medication to their community pharmacy on a regular basis to prevent it being taken inadvertently, the medication stock checklist should be updated to reflect the return of all medication to the pharmacy.

17.2 Medicines must be disposed of when they are no longer needed because the prescription has changed, or the treatment is completed or the expiry or 'do not use after' date is reached. Where a person supported refuses to return medication to the pharmacy, the pharmacy must be notified of all failures in returning medication.

17.3 When Support Workers arrange for the disposal of medicines on a person's behalf, consent for disposal must be given by the person and details of medicines that have been returned to the pharmacy and quantities returned recorded on the medication stock checklist

18 Changes to the needs of a Person Supported

18.1 Support Workers must keep their line managers immediately 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.

18.2 Any advice given to the supported person to consult their GP, or another healthcare professional must be recorded in the Daily Diary.

18.3 Line managers must respond to, and where appropriate, investigate any concerns about medication related issues raised by Support Workers. 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 Support Workers on actions to take.

19 Interface Issues in Transfer of Care

19.1 On occasions the person being supported may go into respite care or hospital. It is important to be aware of possible changes to their medication on discharge (please see the Physical Health Hospital Booklet T858 which includes the medication process upon admission and discharge from a hospital setting). People recently discharged from hospital are at a higher risk of administration errors due to changes in medication. If a support worker notices a discrepancy or change in medication after a person has been discharged from hospital, the line manager must be contacted. The support worker must check arrangements have been made for any new prescription needed following changes in medication. Any person going into hospital or respite care should ideally take their medication with them, where the person chooses not to take their medication with them a documented list of current medications should be completed by the support worker to take with them to the hospital. Support workers can pack medicines for the service user to take. If a service user is visiting day care the team leader must identify a safe process for the transfer of medicines or doses of medication which should be clearly agreed with the receiving healthcare professional and documented in the care plan and absence noted on MAR sheet as social leave.

20 Emollient and skin creams

20.1 **The unsafe use of emollient creams can result in serious or fatal injuries from fire.** It is important to be aware of the fire safety risks when providing care and support to people who use emollient and skin creams. You might use emollient creams to help manage dry skin conditions such as eczema or psoriasis or when using emollients to help treat bed sores and skin ulcers. They come in a variety of forms: creams, lotions, ointments, gels or sprays. They can also include soap alternatives. They may be water-based, contain paraffin or natural oils. All cover the skin with a protective film to reduce water loss.

20.2 Emollients are easily transferred from skin on to clothing and bedding. There may also be reactions between emollients and fibres of dressings, clothing and items such as towels used to carry out personal care. When fabric with dried-on emollient comes into contact with a naked flame, the resulting fire burns quickly and intensely.

20.3 Scientific testing, (refer to CQC Guidance) shows that fabric burns quicker and hotter when contaminated with emollients. These fabrics include clothing, towelling, bandages or bedding. The emollients tested include those that:

- contain paraffin
- do not contain paraffin, such as those made with natural oils
- contain other flammable constituents

20.4 In 2008, the National Patient Safety Agency reported a fatal incident. A paraffin-based skin product was in contact with a person's dressings and clothing. A naked flame ignited the clothing. The Medicines and Healthcare Products Regulatory Agency (MHRA) issued a safety alert in 2008. MHRA updated the alert in 2016 and again in 2018.

20.5 The 2018 alert extends the warnings about the risk of severe and fatal burns from emollients. This includes all paraffin-based emollients regardless of paraffin concentration. It also includes paraffin-free emollients. Guidance included:

- advise people who are using emollient creams of the risks the creams may pose, and:
    - not to smoke
    - not to use naked flames
    - not to go near anyone smoking or using naked flames.
- change people's clothing and bedding daily because emollients soak into fabric and can become a fire hazard - people need to be aware that washing does not remove the risk
- be aware that fabric such as bedding or bandages that have dried residue of an emollient on them will easily ignite and to report any fire incidents with emollients or other skin care products to MHRA's Yellow Card Scheme.

People should continue to use emollients but to avoid serious injury the above guidance should be followed.

20.6 The Fire Safety Order 2005 requires the identification of individuals at risk as part of the fire safety risk assessment for the premises and to take appropriate action to remove or reduce the risk. It is advisable that where possible, flammable emollients are reviewed with the GP and a safer alternative is requested where possible if the person supported smokes.