Medication Policy

Introduction

Quality Statement associated with this policy:

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes will commit to the following quality statement for Medicines optimisation

We make sure that medicines and treatments are safe and meet people’s needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Fundamental Standards and ‘Managing medicines in care homes: Social care guideline (SC1).’

Scope

This policy outlines the responsibilities of this service to ensure the safe management of medicines and related practices in line with current and relevant guidelines. To enable the delivery of safe, effective, and responsive person-centred care in relation to medication practice for people using this service.

The principles of this policy apply to both paper-based systems and computer-based systems, often referred to as EMAR.

This policy and procedure are provided for the regulated activity of accommodation for persons who require nursing or personal care.

With respect to the prescribing, supply, storage and administration of medicines, Elizabeth Finn Homes (EFH) adheres fully to the Medicines Act 1968, the Misuse of Drugs Act 1971, the Misuse of Drugs (Safe Custody) Regulations 1973, the Controlled Drugs (Supervision of Management and Use) Regulations 2013 and the Nursing and Midwifery Council Guidelines for the Administration of Medicines.

In addition to the above, the home complies fully with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, “Safe Care and Treatment”, which states that the registered person must, so far as reasonably practicable, ensure that medicines are handled safely, securely and appropriately, including controlled drugs.

This policy incorporates NICE guidance and CQC Key Lines of Enquiry (KLOE). It is the responsibility of the Registered Managers to implement this policy. All staff should have read and understood the medication policy with signatures of competence for each member of staff trained in medicines.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Key Points

- Staff who are responsible for the administration of medicines must be appropriately trained and have had their competence assessed to meet safe standards through supervisions and spot checks.
- Competency assessments will be kept under regular review and update training conducted at least annually.
- All medicines prescribed must be recorded in the Electronic Medication Administration Record (MAR) and include instructions on what it is for and how to use the medicine. Specific instruction may also include how long it should be used for, frequency, timing, dose and how soon it will be effective.
- Other relevant information may also be recorded relevant to the individual and the medication prescribed.
- Staff should update EMAR with any changes to a resident's medicines, made by the GP. This should be recorded using the iCare Professional Visit Record and reflected on EMAR.
- The GP is responsible for ensuring that people have their medicines reviewed to check that they are still needed, known as a medication review, and this should take place annually as a minimum. This should be recorded on iCare form 2.10 Care Assessment - Medication, Healthcare Assessment & Treatment Form
- The organisation will work with the resident and their family to prompt and arrange the review with the GP.
- Where the resident lacks capacity in line with the Mental Capacity Act (2005) (MCA) the organisation will liaise with their support network, e.g. family, Powers of Attorney for health and welfare etc, to act in their best interests to organise the review with the GP. The required actions will be recorded within their care plan.
- The medicine orders received must be checked against the original to ensure that the prescriptions and supply match. All records must be kept up to date. Stock must be updated on EMAR accordingly.
- Medicines should be stored in line with the manufacturers' guidance, e.g. insulin should be refrigerated.
- Staff have a duty to report medication errors immediately to the Registered Manager or member of staff in charge at the time so that a record can be made. Failure to do so could result in disciplinary action.
- The Registered Manager is responsible for completing regular audits of medication procedures to ensure that safe processes are being followed.

Policy Statement

This procedure must be read and complied with by all members of staff delivering care and support to people within the service and who may contribute to the safe management of residents' medication.

The Senior Clinical Team for EFH is responsible for reviewing all guidance, regulatory and legislation changes and updating policies, procedures, and training as appropriate.

The Registered Manager for EFH is responsible for the implementation of the policy and its principles.

The Policy

EFH is committed to ensuring the proper and safe use of medicines by adhering to the following principles:

Where staff are responsible for the administration of medicines they must be appropriately trained and have had their competence assessed to meet safe standards. Such assessments will be kept under regular review and conducted annually.

The handling of medicines within EFH must be in line with all related policies and procedures (including those for Infection Control), whether the resident is self-administering their medication or requires support.

Information regarding a resident's medication and health will be accurately recorded, shared with relevant professionals, and treated confidentially in line with current legislation and guidance.

Staff will be trained and competency assessed at induction, and annual training updates and practical competency assessment will take place at supervisions and spot checks.

1 - Reconciliation of Medication

1.1. The Registered Manager as part of the Pre-admission procedure or the person responsible for a resident's transfer into the home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full need's assessment and care plan. Registered Manager or person responsible should ensure this process is completed as soon as possible (within 48 hours) when there is:

- An admission into the home
- A hospital admission (planned and emergency)
- A hospital discharges
- A transfer within the home (e.g. to another unit)
- A discharge from the home into the community or into another care setting

1.2. The following information should be obtained by staff and it is the Registered Manager's responsibility to ensure this is obtained in a timely manner.

- Resident's details, including full name, date of birth, NHS number, address and weight where appropriate, for example, frail and/or older residents.
- GP's details, details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- Any special dietary requirements such as vegan or halal
- Medicines the resident is currently taking, including name, strength, form, dose, timing and frequency
- How the medicine is taken (route of administration) and what for (indication), changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- Other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support / compliance aids) and what information has been given to the resident and/or family members or carers.
- COVID vaccination status
- Allergies and medication reactions

1.3. A minimum of two sources should be used to obtain an accurate list of a person's medicines and conditions but it is the member of staff completing the medicines reconciliation process to ensure that as many sources as possible is used – some sources to consider when completing this process may be:

- Summary Care Record (SCR)
- Repeat prescription list dated within the last 6 months (where no date present the
- repeat list must not be used)
- Medical records
- Patients Own Drugs (PODs) – labelled and dispensed within the last 6 months
- Discharge letters or other clinic letters from specialist services or health services
- Confirmation with previous or current General Practice – written confirmation via a patient summary including patient's full name, DOB, previous address, known allergies, repeat medication, any acute medications in the last 6 months and any letters from specialist services or follow up / monitoring requirements.
- Verbal confirmation with patient confirming any prescribed medicines including external medicines or products which they may buy over the counter (OTC), herbal remedies, supplementary products e.g. vitamins, homeopathy.
- Any medicines from other settings such as hospitals, known allergies and any special dietary requirements.
- Cigarette, alcohol and illicit consumption should also be discussed and referrals made where appropriate

1.4. The staff member conducting the medicines reconciliation is responsible for ensuring the following people are involved in the medicine's reconciliation process:

- The resident and or their family members / carers
- A pharmacist or pharmacy technician

- Other health and social care practitioners involved in managing medicines for the resident, as agreed locally.

1.5. Medicines reconciliation can be carried out by any EFH Registered Nurse or Care Staff provided they are competent and have the skills and the information they need to carry out the task.

1.6. Providers should ensure that the details of the person completing the medicines reconciliation process (name, job title and the date) are recorded and updated regularly.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#accurately-listing-a-residents-medicines.medicines-reconciliation
https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-reconciliation-medication-review

2 - Ordering and Receipt of medicines

2.1. The Home is responsible for implementing a robust ordering system to ensure the correct medicines are supplied in a timely manner to meet their needs with minimum waste. The Registered Manager should ensure there is enough time for the medicines to be checked and necessary actions taken prior to the new cycle starting.
2.2. Good communication between the GP practice, pharmacy and care setting is essential.
2.3. Ordering and receipt of medications should be performed by staff that have been appropriately trained and are competent to undertake this.
2.4. The Home must ensure there are at least 2 members of staff assessed as competent to undertake this task.

Ordering Medicines

2.5. The staff member ordering medicines is responsible for checking the current stock levels prior to ordering to avoid any unnecessary waste. Any excess stock where appropriate should be carried forward onto the next cycle with clear documentation on EMAR.
2.6. If a resident is refusing any medicines or having swallowing difficulties this should be highlighted to the prescriber and documented accordingly in advance of re-ordering
2.6. Medication should be ordered at 28-day intervals allowing sufficient time for prescriptions to be issued, dispensed, checked and delivered.
2.7. The Registered manager is responsible for ensuring staff have protected time for ordering and checking medicines which have been delivered.
2.8. The Home should ensure that at least 2 members of staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.
2.9. Requests for medication should be submitted by the member of staff responsible for ordering medication with copies retained at the care setting. The Home should not delegate this task to the supplying community pharmacy. Requests may be submitted through the repeat list of a resident's medication, secure email or online direct with the general practice.
2.10. The community pharmacy should be alerted to any medicines which have been discontinued to enable this to be removed from EMAR, and where the current EMAR is in use this should be updated and the discontinued medicine should be clearly annotated "discontinued by prescriber" the entry this should be checked by another competent member of staff. Accurate records must also be maintained in the care plan detailing any conversations with clinicians. This should be on Professional visits / Form on ICARE.
2.11. Care staff should use EMAR to order medication to ensure the correct medicines are ordered from the GP. Copy to approved pharmacy using the monthly reorder form from EMAR.
2.12. Homes who are using practices online ordering systems should ensure their local ordering training and competency reflect this. The home will use ICARE Best Interest form for residents where they are assessed as lacking capacity - a best interest decision should be made and recorded in respect of medication.
2.13. The Home should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible.

Receipt of medicines

2.14. Upon receipt of the order from the community pharmacy the order should be signed for by a competent member of staff. Where controlled drugs are being received they must be signed by a member of staff trained and competent

with controlled drugs (see section 5). Any controlled drugs received must be stored as per legal requirements. Medicines requiring storage within the medicine's fridge should be stored immediately as per manufacturer's instructions.
2.15. The member of staff receiving the order is responsible for checking the order in against the original order and highlighting any discrepancies with the General Practice or pharmacy a timely manner (before the medicines are due to be administered).
2.16. Medications should be checked against the new and current EMAR ensuring that the residents name, DOB, allergy status and medicines intolerances are all clearly documented. For residents with no known allergies "NKDA" or "No Known Drug Allergies" should be added to the allergy section of the EMAR
2.17. Staff should ensure the medication received is correct against the original order and current and EMAR checking for resident's name, drug name, strength, formulation, dose and quantity are all correct and will last for the duration of the cycle / course.
2.18. Stock should be counted and checked before storing securely – the staff member completing this duty should sign and highlight the quantity of the medicine on EMAR. Staff should be aware of altering stock balances when receiving new medication. In the event of EMAR failure or another circumstances where a handwritten MAR chart is necessary this should only be done by a member of staff who is trained and competent to do so and be a last resort.
2.19. All hand-written MARs should detail the resident's name, DOB, allergy status, medicines intolerances and the name of the medicine, strength, dose, formulation and route of administration.
2.20. Hand written MAR charts should be signed by the member of staff who wrote it and then signed by another member of staff who has checked the accuracy.

Urgent prescriptions

2.21. Exceptions to the ordering process may include orders for acute medication such as:

- If a resident is acutely unwell
- Recently moved into the care setting
- Urgent supplies of medication
- Mid cycle supplies
- Changes to prescription

2.22. Urgent orders for prescriptions may be obtained through the regular General Practice (preferred) or through Out-Of-Hours services such as 111 or A&E (if needed).
2.23. Prescriptions should be obtained through the contracted supplying community pharmacy where possible. Where this is not possible (i.e. out of normal working hours) a local community pharmacy with an emergency prescription from the G.P.
2.24. The Home is responsible for ensuring that all urgent prescriptions are collected, dispensed, checked and administered in a timely manner (before the first dose is due to start as advised by the practitioner issuing the prescription).
2.25. It is the responsibility of all staff to ensure the Registered Manager or Deputy is aware of any urgent prescription requests.
2.26. Faxed, scanned or emailed prescriptions are not a legal document and should only be used in exceptional circumstances and emergency situations, the original prescription should be collected within 24 hours or posted by the prescriber to the dispensing community pharmacy.
2.27. Interim or urgent medication will be flagged on the system to alert staff that this medication requires approval, it is the responsibility of staff trained in the administration of medications that approval is managed in a timely fashion to avoid delay in the administration of urgent or interim medication.
2.28. It is the responsibility of staff to ensure if medication has not been delivered within 24 hours and the eMAR system shows no flag for approval to contact the pharmacy / GP to enquire about the delay in receiving medication to the home.
2.29. It is the responsibility of the staff trained in medication administration to ensure monthly medication received in bulk does not contain emergency or interim medication when a flag for approval is noted and medication cannot be located at the home.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#ordering-medicines

3 - Storage of medication

3.1. Only trained and competent staff should have medicine cabinet keys in their possession.
3.2.A record must be kept of who holds the keys and for what duration. Provider managers are responsible for ensuring this is maintained.
3.3. The clinic room, medicines trolley and medicines cabinets must be locked at all times when not in use.
3.4. Where keys are passed onto another member of staff this should be documented for clear audit purposes. Keys for medication cupboard / CD cabinet and entrance to clinical room should be kept separate.
3.5. Any spare keys must be stored securely at all times. The Registered Manager is responsible for the safe storage of the medicine cabinet keys.
3.6. Where medicines trolleys are used to store medication, they must be locked and securely attached to a wall in a suitable place such as the clinic room.
3.7. Medicines cabinets must be sited away from sources of heat, moisture and direct sunlight.
3.8. All medicines cabinets should be securely fixed to a wall.
3.9. Medicines cabinets must be kept clean, tidy and in good condition.
3.10. The member of staff holding the medicine cabinet keys is responsible for ensuring the safe storage of medicines whilst holding the keys. The Registered Manager takes overall responsibility of the safe storage of medicines within the care setting including controlled drugs.
3.11. All medicines received into the Home must be checked, booked in and stored securely within locked medicines cabinets or in compliance with the misuse of drugs act as soon as possible (within 24 hours). No medicines should be left unattended without being stored securely unless there is a risk assessment in place to reflect this (including emollients)
3.12. Medicines should be stored tidily and appropriately with medicines for one resident stored together but separate from another residents' medication. Medicines with a shorter expiry should be stored to the front of the cabinet with longer expiry dated medicines behind to ensure good stock rotation.
3.13. Homely remedies or Over-The-Counter (OTC) medicines should be kept separate from prescribed medicines. There should a log of what medications are stored and dispensing details. There should be a signed homely remedies agreement document signed by the Homes Clinical Lead / G.P.
3.14. All medicines should be kept in the original packaging in which they we're obtained from the pharmacy.
3.15. All prescribed medicines should contain the community pharmacy dispensing label detailing resident's name, date of dispensing, community pharmacy contact details, product name, strength, dose, formulation and route of administration. The packaging should be fit for purpose detailing the batch number and expiry date.
3.16. Nutritional supplements and dressings must be stored securely within a lockable cabinet or lockable room.
3.17. For any products which have a reduced expiry once opened: the date opened should be clearly annotated on the packaging also detailing the expiry date. These products include: liquids, eye drops, eye ointments, creams, ointments, emollients, medicines with special containers. The date opened must always be highlighted on these products. It is the responsibility of the member of staff who first opens the product to ensure this is documented.
3.18. The expiry of products should be checked on a monthly basis by a trained member of staff and appropriate records kept. It is the responsibility of the Registered Manager to ensure this task is undertaken and documented.
3.19. Any products beyond their expiry date must not be used. These must be disposed of as per local medicines waste procedure. (see section 4 for recommendations)
3.20. Where residents self-administer their own medication: risk assessments and capacity assessments must be in place and medication must be stored in a locked cabinet in their room. The resident must have possession of the key at all times unless an alternative care plan and risk assessment has been put in place. The risk assessment should detail what level of accountability the resident and staff have over the medicines including who is responsible for the daily checking and recording of the room temperature.
3.21. Pharmaceutical advice must be sought before any changes to the storage of medicines are made.
3.22. Staff should not leave the premises with the medicine cabinet keys: in the event that this happens an incident form must be completed immediately.
3.23. For controlled drugs storage requirements see section 5.
3.24. Additional bottles obtained by local pharmacy will need the expiry dates checked as this can differ in format from the normal monthly cycle supplies.

Temperature recording

3.25. The room temperature must be checked and recorded daily where medicines are stored including residents' bedrooms. The current, maximum and minimum temperature reading should be recorded at a minimum daily. It is the responsibility of the member of staff holding the medicine cabinet keys to complete this task.
3.26. Where residents are self-medicating, the daily checking and recording of the room temperature should be clearly documented in the care plan and risk assessments. Residents who are deemed to have capacity and are able to undertake this task should record and document this daily. The Registered Manager is responsible for ensuring this is completed daily and risk assessments updated accordingly should circumstances change.
3.27. The temperature must not exceed 25oC. For any readings above 25oC action should be taken such as opening windows and doors to increase ventilation and then re-checked within 1 hour. This should be clearly documented. Seek advice from a pharmacist or contact Operational Support Manager.
3.28. Where the temperature reaches above 30oC the dispensing pharmacy should be contacted to check the stability of the products or contact the manufacturers of each product directly to check the stability and records should be kept of all actions taken.
3.29. Where there are missing temperature recordings. The staff member identifying the incident should report this to the Home Manager or Deputy immediately and the medication incident reporting procedure should be followed (see section 17 for recommendations). Necessary action should be taken to check the stability of the medicine. Contact the medicines manufacturers or community pharmacy for advice and record any advice given.

Medication requiring refrigeration

3.30. All medicines requiring refrigeration must be stored in the locked medicines fridge immediately upon receipt from the dispensing community pharmacy. It is the responsibility of the member of staff holding the medicine cabinet keys to ensure this.
3.31. The medicines fridge must be locked at all times when not in use.
3.32. Only medicines requiring refrigeration should be stored in the medicine's fridge. No food or samples should be stored in this fridge.
3.33. The Registered Manager has overall responsibility for ensuring the cold chain is maintained throughout.
3.34. The medicines fridge should have a calibrated minimum, maximum thermometer attached at all times.
3.35. The current, minimum and maximum temperature reading should be checked and recorded at a minimum daily ensuring the temperature stays within the range of 2o c – 8 o c. Signatures must be recorded by the member of staff undertaking this duty along with documentation of any actions taken when the temperature is not within range.
3.36. The thermometer should be reset as per manufacturer's guidance daily after each reading and it is the responsibility of the member of staff checking the fridge temperature to ensure this is done
3.37. Any readings of 2o c or below or 8o c or above the Registered Manager or Deputy should be informed immediately and the thermometer should be reset and checked again within 1 hour.
3.38. Where the reading continues to be out of range the dispensing pharmacy should be contacted to check the stability of the medicines; or the manufacturers of the products should be contacted directly. A note must be added to the fridge stating "quarantine do not use until further notice". Whilst the stability of medicines is checked. If medicines need to be discarded this should be done following the guidance in section 4 and further supplies will need to be obtained as a priority.
3.39. The Registered Manager or Deputy are responsible for obtaining a new medicines fridge should a replacement be needed.
3.40. The medicines fridge should be defrosted and cleaned in accordance to manufacturer's instructions.
3.41. Records should be made when the fridge is defrosted and details of the next date the defrost is due recorded in the diary. The Registered Manager take overall responsibility to ensure this is maintained.

Storage of oxygen

3.42. If a service user is prescribed oxygen the manager is responsible for discussing storage and administration with the engineer from the company who supplies the oxygen. Their advice should be documented and followed at all times.
3.43. Risk assessments must be completed for the storage and use of oxygen in line with health and safety procedures such as Personal Emergency Evacuation Plans (PEEPs).
3.44. Oxygen cylinders must be stored safely, under cover and not subject to extreme temperatures. This should be in a dry, clean, well-ventilated area away from flammable liquids, combustibles and sources of heat and ignition.

3.45.A statutory warning notice should be displayed in any room / area where oxygen is stored or used stating: "compressed gas. Oxygen: No smoking. No naked lights".
3.46. Cylinders must be handled with care: never knocked violently or allowed to fall over.
3.47. Oxygen cylinders must be switched off when not in use.
3.48. Cylinders must only be moved with a trolley specifically designed for the size of the cylinder unless it is a small portable cylinder.
3.49. Oxygen concentrators must be stored upright and plugged directly into the mains socket. Adequate ventilation must be provided around the concentrator. They must always be switched off when not in use and be included on the housekeeping cleaning schedule (see manufacturer instructions for details). Attention should be made to cleaning schedules for equipment cleaning while in use under the direction of a competent member of staff and documented in care plan.
3.50. In the case of a fire, it is the responsibility of all staff to inform the fire brigade that oxygen cylinders and/or concentrators are present and where they are located.
3.51. The Registered Manager takes overall responsibility to ensure the safe storage of oxygen cylinders and/or concentrators.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#receiving-storing-and-disposing-ofmedicines
https://www.cqc.org.uk/guidance-providers/adult-social-care/managing-oxygen-care-homes
https://www.cqc.org.uk/guidance-providers/adult-social-care/storing-medicines-residential-services
https://www.cqc.org.uk/guidance-providers/learning-safety-incidents/issue-5-safe-management-medicines
https://www.cqc.org.uk/guidance-providers/adult-social-care/storing-medicines-fridges

5 - Safe disposal of medicines

EFH Homes without nursing

4.1. All medicines no longer required or expired medication must be returned to the dispensing community pharmacy which holds the contract for the waste disposal of medication.
4.2. Disposal of medication applies to medication remaining after a resident has died, medication which has been discontinued, medication which may have become contaminated, dispensed refused doses and medication which has passed the expiry date.
4.3. Patients Own Drugs (PODs) can only be returned for disposal after consent has been given by the resident. This medication may have been brought into the care setting by the resident on admission or by a relative / friend of the resident.
4.4. Medication that is refused after it has been in the service user's mouth can be placed within a returns bag awaiting disposal. Safe handling of medicines procedure should be followed at all times see section 7.
4.5.A record of the medication for disposal must be kept by the Home. It is the responsibility of the Registered Manager to ensure this is maintained. It is the responsibility of all trained staff returning medication to record clearly and detail the below as a minimum.
4.6. Records of returned medication must include:

- The date
- The name of the service user
- Product name, form, strength and quantity
- Reason for disposal or return
- Signature of the member of staff returning the medicine

4.7. The medication must then be stored securely until it is collected by the community pharmacy and a signature of the member of staff from the community pharmacy should be recorded to show which items have been received. A copy should be given to the member of staff from the community pharmacy and a copy left with the Home.
4.8. Empty packaging which is not medicines contaminated such as cardboard packaging can be disposed of with general waste, however confidentiality must be maintained at all times, labels must be shredded or confidential text overwritten with permanent black marker to cover the name of the service user, medication and dosage.
4.9. Empty foils from medication should be disposed of with clinical waste.

4.10. Medication belonging to a deceased resident must be kept at the provider for seven days before being returned to the community pharmacy, in case the coroner's officer, police or courts require them as evidence as part of any investigations into the death of the resident.
4.11. Any sharp objects such as injections and vials should be disposed using the yellow sharps bin prescribed for a resident. The sharps bin should only be assembled by a competent member of staff and the date of assembly and date the bin is locked should be clearly detailed on the front of the sharps bin. Sharps bin should only be used for a maximum duration of 3 months and not be overfilled.
4.12. All controlled drugs schedule 3 and above are to be disposed following the controlled drugs procedure, and documented on EMAR. For controlled drugs disposal see section 5.

EFH Homes with nursing

4.13. The Home must only dispose of medication with a licensed waste disposal company which may include community pharmacies.
4.14. Disposal of medication applies to medication remaining after a resident has died, medication which has been discontinued, medication which may have become contaminated, dispensed refused doses and medication which has passed the expiry date.
4.15. Residents own medication can only be disposed after consent has been given by the resident. This medication may have been brought into the home by the resident on admission or by a relative / friend of the resident.
4.16. Medication that is refused after it has been in the resident's mouth must be disposed in the medicines waste bin and following the safe handling of medicines procedure see section 7.
4.17. All medicines for disposal should be disposed of using the correct medicines waste disposal bins.
4.18. Medicines waste disposal bins should assemble by a trained member of staff with the
date of assembly and the date the bin is locked clearly detailed on the front of the bin. Medicines bins should be used for the maximum duration of 3 months and not be over-filled. This includes medicines waste bins for: medicines waste, sharps, contaminated, cytotoxic and infectious.
4.19.A record of the medication for disposal must be kept by the Home. It is the responsibility of the Registered Manager to ensure this is maintained. It is the responsibility of all trained staff returning medication to record clearly and detail the below as a minimum.
4.20. Records of disposed medication must include:

- The date
- The name of the resident
- Product name, form, strength and quantity
- Reason for disposal or return
- Signature of the member of staff returning the medicine
- Signature from a second member of staff witnessing the disposal

Record on

4.21. The medication must be disposed of immediately using the medicines waste disposal bins to avoid any unnecessary build-up of waste.
4.22. Empty packaging which is not medicines contaminated such as cardboard packaging labels can be disposed of with general waste. Confidentiality must be maintained at all times, labels must be shredded or confidential text overwritten with permanent black marker which should cover the name of the resident, medication and dosage.
4.23. Empty foils of medication packaging should be disposed of in the medicines waste disposal bins.
4.24. Medication belonging to a deceased resident must be kept at the care setting for seven days before being returned to the community pharmacy, in case the coroner's officer, police or courts require them as evidence as part of any investigations into the death of the service user.
4.25. All controlled drugs schedule 3 and above are to be disposed following the controlled drugs procedure. For controlled drugs disposal see section 5
4.26. If a resident has syringe driver running at the time of death it can be taken down by either the GP, district nurse or trained and competent nurse at the home providing that:

- The manager or deputy or RN in charge on duty acts as a witness
- The syringe driver is stopped by removing the battery
- The syringe is removed from the device
- The syringe is placed into a yellow sharps bin complete with the remaining contents. Do not fill above the marked line and do not discharge the contents of the syringe.
- A record is made on the monitoring chart, nursing notes, care record and in the homes-controlled drugs book if the medication was a controlled drug

- The date, time and amount of the solution remaining in the syringe to be disposed must be recorded; signed by the GP / nurse and witnessed by the Registered Manager or Deputy on duty

4.27. Any unopened ampoules must be returned to community pharmacy or disposed as per procedure above after 7 days or as per local policy.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#receiving-storing-and-disposing-of-medicines
https://www.cqc.org.uk/guidance-providers/adult-social-care/disposing-medicines

5 - Controlled drugs

5.1. EFH must comply with the misuse of drugs act 1971 http://www.legislation.gov.uk/ukpga/1971/38/contents and are responsible for ensuring robust systems are in place for the storage, supply, transport, administering, recording and disposal of controlled drugs safely.

Storage of controlled drugs

5.2. EFH are responsible for ensuring a controlled drugs cabinet meets British Standard BS2881:1989 security level 1.
5.3. The Safe Custody Regulations specify the quality, construction, method of fixing, and lock and key for the cupboard. The controlled drugs cupboard must be: secured to a wall and fixed with bolts that are not accessible from outside the cupboard, fitted with a robust lock & made of metal with strong hinges.
5.4. The walls of the room should be of a suitable thickness and made of a suitable material, for example bricks. This means that the cupboard must be securely fixed to a wall. The cupboard can be fixed to an internal wall as long as it is secure.
5.5. Only trained and competent members of staff should have access to the controlled drugs cabinet.
5.6. Spare keys for the controlled drugs cabinet must be stored securely.
5.7. Only use the cabinet to store controlled drugs.
5.8. The Home should comply with the controlled drugs safe custody requirements for all schedule 2 controlled drugs and some schedule 3. For safe custody guidance see the following guidance from the department of health:

https://www.health-ni.gov.uk/articles/controlled-drugs#toc-8

5.9. All controlled drugs stored should be prescribed for a resident currently residing in the home with the dispensing label attached.
Receipt and recording of controlled drugs
5.10. Only trained and competent members of staff can sign and accept the delivery of controlled drugs.
5.11. The member of staff holding the controlled drugs keys should be informed immediately when controlled drugs are received.
5.12. If the controlled drug received is subject to controlled drugs recording requirements then an entry into the controlled drugs register and EMAR should be documented by a trained and competent member of staff with another trained member of staff present to witness.
5.13. The controlled drugs register must be a bound book with numbered pages. There must be a separate page for each form and strength of each controlled drug for each person.
5.14. An entry into the controlled drugs register must be made on the day the medication was received. All schedule 2 controlled drugs should be entered into the controlled drugs register. Schedule 3, 4 and 5 controlled drugs are not subject to controlled drugs recording requirements but some services may choose to do so.
All entries made into the controlled drugs register must detail:

- Date and time of entry into register
- Where the medication was received from
- Quantity received
- Signature of the member of staff receiving the medication
- Signature of the member of staff witnessing the entry and checked the medication
- Running balance
- Ensure when recording on EMAR it is recorded as a CD.

5.15. All entries into the controlled drugs register should be made with black indelible ink following good practice. Any errors should not be crossed out but a bracket should be made around the error with an asterisk next to it, then an asterisk at the bottom or side of the page detailing the error, then the correct entry onto the next row. All errors should be clear and transparent.

Administration of controlled drugs

5.16. The administration of medicines procedure (section 6) and safe handling of medicines procedure (section 8) should be followed at all times in conjunction with the controlled drugs administration procedure.
5.17. Administration of controlled drugs must only be undertaken by a trained and competent member of staff.
5.18. All administrations of controlled drugs must be witnessed by a second trained member of staff.
5.19. Records should be made and signed on EMAR and in the controlled drugs register by the member of staff administering the medication – counter signed by the second member of staff who witnessed the administration. Entries into controlled drugs register under the relevant section must detail:

- The time and date of administration
- The dose administered
- The signature of the member of staff administering the medication
- The signature of the second member of staff witnessing the administration
- Update the running balance

5.20. Any controlled drugs which are refused after they have been dispensed must be disposed of following the controlled drugs disposal procedure (ref 5.23 – 5.43)

5.21. Residents may self-administer any controlled drugs they may be prescribed but Registered Managers are responsible for ensuring risk assessments are in place to mitigate any risk factors. Lockable drawers or cupboards should be present in each resident's room.
5.22. The Home is not required to keep a record of controlled drugs in the controlled drugs register when the person is wholly independent but may wish to do so for transparency and monitoring. In these circumstances the resident is responsible for requesting and collecting the controlled drug personally from the pharmacy.
5.23. If a resident relies on the home to supply and receive the controlled drug then records should be kept including, receipt from pharmacy, supply to resident and any subsequent disposal (see section 5.8 - 5.13)

Disposal of controlled drugs for EFH Homes without nursing

5.24. The Registered Manager is responsible overall for ensuring the safe disposal of controlled drugs within the care setting.
5.25. Disposal of controlled drugs applies to medication remaining after a Resident has died, medication which has been discontinued, medication which may have become contaminated, dispensed refused doses and medication which has passed the expiry date.
5.26. Controlled drugs in the above circumstances should be stored in the controlled drugs cabinet until collected by pharmacy.
5.27. Medication awaiting collection from pharmacy should be moved away from current in use-controlled drugs. A bag could be used with a note on the front stating "medicines for disposal"
5.28. Controlled drugs which are being returned to pharmacy should be booked out of the controlled drugs register – records should include:

- Date and time
- Controlled drug name and strength
- Number or volume of medicine
- Signature of authorised staff member booking out the controlled drug
- Signature of competent witness
- Signature of member of pharmacy collecting the controlled drug

5.29. Identification should be checked of the member of staff collecting controlled drugs before the transfer can take place even when they are for disposal.
5.30. Any illicit or suspected illicit substances should be stored in the controlled drugs cabinet and entered into the controlled drugs register under "unknown substance" until booked out of the controlled drugs register and returned to pharmacy for destruction. These must be kept separate from prescribed controlled drugs.

5.31. Any discrepancies must be brought to the attention of the registered manager immediately

Disposal of controlled drugs for EFH Homes with nursing

5.32. The Registered Manager is overall responsible for ensuring the safe disposal of controlled drugs within the home.
5.33. Denaturing of controlled drugs is classified as "treating" waste by the environment agency and nursing homes which denature controlled drugs using the denaturing kit are required to have a T28 exemption in place for this process. Doon Bin??
5.34. EFH are responsible for ensuring T28 exemptions are in place for nursing homes which denature controlled drugs. T28 exemptions are free to obtain and valid for 3 years. Registered Managers are responsible for the maintenance of the certificate.

https://www.gov.uk/guidance/waste-exemption-t28-sort-and-denature-controlled-drugs-for-disposal

5.35. Disposal of controlled drugs applies to medication remaining after a resident has died, medication which has been discontinued, medication which may have become contaminated, dispensed refused doses and medication which has passed the expiry date.
5.36. Controlled drugs in the above circumstances should be denatured at the earliest convenience (after 7 days if the resident has passed away). Steps should be taken to reduce the risk of expired or medication no longer required being administered by separating from controlled drugs which are in use.
5.37. Controlled drugs which are being denatured should be booked out of the controlled drugs register at the point of denaturing to ensure all stock is accounted for – records should include:

- Date and time
- Controlled drug name and strength
- Number or volume of medicine
- Signature of authorised staff member booking out the controlled drug
- Signature of competent witness

5.38. The medication should be denatured using the denaturing kits provided by the supplying community pharmacy or provider. The denaturing process must only be undertaken by a trained and competent nurse or registered professional. This must be witnessed by a second competent member of staff.
5.39. Medication should be dispensed into the denaturing kit – transdermal patches should be folded in half and placed into the kit – the safe handling of medicines procedure must be followed in conjunction with this procedure (see section 7)
5.40. The denaturing kit must not be overfilled. Water should then be added up to the marked line highlighted.
5.41. Fix the lid tightly onto the denaturing kit and shake for a couple of minutes.
5.42. Write the time and date of the denaturing on the front of the kit.
5.43. Store the kit in the controlled drugs cabinet for 24 hours to allow the mixture to set.
5.44. After 24 hours and only when the mixture has fully set the kit can then be disposed of in the medicines waste bins.
5.45. Any illicit substances found in the Home or suspected illicit substances must be stored securely in the controlled drugs cabinet and entered into the controlled drugs register until denatured. These must be kept separate from prescribed controlled drugs.
5.46. Any discrepancies must be brought to the attention of the registered manager immediately.

Dealing with discrepancies

5.47. Routine checks of all controlled drugs held and the recorded running balance should be carried out by two competent members of staff before and after a controlled drug is administered. Homes should check all controlled drugs as a minimum on a weekly basis to ensure stock balances are correct and medicines are still fit for purpose and in date with records made. (This should be recorded in red for transparency)
5.48. Where a discrepancy is found this should be reported to the manager immediately.
5.49. Managers are responsible for investigating any controlled drug discrepancies immediately
5.50. If the discrepancy is found to be an error of subtraction or addition in the calculation of the stock balance the following procedure must be followed:

- Do not change the balance column or use correction fluid

- Bracket the error
- Write the correct figure next to the bracketed error or write a new entry on the next row available
- Asterisk the error
- Asterisk to the side of the page or bottom and write “error corrected” sign by the member of staff and countersigned by the second witnessing member of staff

5.51. Where a dose is given but not entered into the controlled drugs register at the time of administration the following procedure must be followed: on the next available row

- The current days date
- “dose administered but not recorded at the time” followed by the service users details and dose administered
- The signature of the administering member of staff and that of a witness
- The correct balance

5.52. Where a discrepancy is due to the controlled drug not being booked in or out the above procedure should be followed for receipt of controlled drug or disposal – the entry must be made detailing the current date and the words “entered in retrospect” should be added
5.53. Where the discrepancy cannot be rectified the dispensing pharmacist should be contacted for advice and an incident form completed.
5.54. All controlled drug errors and incidents must be reported to the Senior Clinical Team.
5.56. All CDs must be stock checked weekly, both on EMAR and in the CS register.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#receiving-storing-and-disposing-of-medicines
https://www.gov.uk/guidance/waste-exemption-t28-sort-and-denature-controlled-drugs-for-disposal
https://www.gov.uk/government/collections/drugs-licensing
http://www.legislation.gov.uk/ukpga/1971/38/contents
https://www.cqc.org.uk/guidance-providers/adult-social-care/disposing-medicines
https://www.cqc.org.uk/guidance-providers/adult-social-care/storing-controlled-drugs-care-homes
https://www.cqc.org.uk/publications/major-report/safer-management-controlled-drugs

6 - Administration of medicines

6.1. Registered managers are responsible for ensuring that only trained and competent members of staff are administering medication.
6.2. Staff administering medication should have completed an internal competency and this should be reviewed annually with records kept.
6.3. Wash hands and dry thoroughly prior to administering any medications
6.4. Assemble any equipment that may be required e.g. spoons, tablet cutter, table etc.
6.5. Any liquids should be measured into a clearly graduated and marked medication pot or by using an appropriately sized syringe which clearly identifies individual millilitre markings.
6.6. To reduce the risk of errors as a result of distractions or interruptions, staff are encouraged to wear a brightly coloured tabard / apron to identify the medication round is in process and that they shouldn’t be disturbed. Staff should not be answering phone calls while administering medication.
6.7. Staff should follow the safe handling of medicines procedure (see section 8 for recommendations) at all times when administering medication – tablets must never be touched with bare hands by the member of staff administering medication – the tablets should be dispensed into a disposable medication pot without touching the tablets or gloves should be worn to adhere to infection control precautions and for the safety of staff and residents.
6.8. Check the resident’s identity and allergy / intolerances status.
6.9. When administering medication staff should follow the 6 rights of medication administration at all times:

1. Right patient
2. Right medicine
3. Right route
4. Right dose

5. Right time
6. Right to refuse

Resident medication must be checked where practicably possible using the electronic scanning device supplied. If this is not able to be utilised a medication incident form should be completed and escalated to the Manager in charge.

6.10. Consent must always be given by the resident before any medicines are administered. Where the resident lacks capacity; check a capacity, assessment has been completed and where a best interest meeting has occurred follow the covert medication procedure as needed.
6.11. It is the responsibility of the member of staff administering medication to check against the EMAR, care plan and risk assessments to ensure no changes have been made and which medicines are due and noting any time-sensitive medication.
6.12. Where PRN protocols are in place staff must follow these at all times and note any physical signs and symptoms a service user may express to show discomfort.
6.13. Care staff must also consider the environment when giving medication is appropriate and safe to do so.
6.14. Check the physical state of medicines ensuring they are fit for purpose – not damaged or contaminated. The expiry date and label must always be checked.
6.15. The label on the medicines must always match the EMAR. Where there are any discrepancies advice should be sought from the manager, pharmacist, or practitioner for clarification and rectification of the discrepancy before the medicine can be administered.
6.16. Staff must also check for any special instructions detailed on the dispensing label or EMAR and take appropriate action (e.g. 30 minutes before food).
6.17. Medication must never be administered if there any concerns with the stability of medication or that the dose may have already been given.
6.18. Staff should ensure residents are in a standing position or sitting upright when taking medicines. Medicines must be taken with plenty of liquid according to resident preference.
6.19. It is the responsibility of the member of staff administering the medication to seek assurance the medication has been taken. Staff should spend as much time as is required by the resident to take their medicines safely and ensure adherence.
6.20. For any medicines which are refused the safe disposal of medicines procedure must be followed and marked clearly as refused on the EMAR. This must also be communicated to all staff in handovers and to the registered manager on duty. Frequent refusals will require correspondence with the GP. Any physical health monitoring required should be followed e.g. checking blood pressure when blood pressure medication is refused – advice should be sought from a practitioner as necessary.
6.21. For application of external medicines: disposable gloves must be worn and then removed when the activity is complete. Gloves should be disposed in the clinical waste bins and hands washed. Only trained and competent members of staff should administer external medicines.
6.22. Staff should only administer specific medicines such as creams, patches, inhalers, eye drops and liquids if they have had training and been assessed as competent to do so.
6.23. Record the administration of all medicines administered with a signature on the EMAR, Topical Medication Administration Record (TMAR) or other documentation as appropriate as needed.
6.24. Where a resident is having a meal, it is the responsibility of the member of staff administering medication to ensure the medicines are taken after the resident has finished their meal if appropriate. Special instructions should be checked for all medicines due for administration to check if there are medicines which should be taken before food – advice from a healthcare professional should be sought in those circumstances.
6.25. If a resident is asleep at the point of the administration round, staff should continue with the administration of medicines but regular checks should be made throughout the medication round for the suitable time to administer their medicines. If the resident is still asleep at the end of the medication round then advice should be sought from a healthcare professional, checks should be made to check for any time-sensitive or high-risk medicines; in those circumstances where the risks of not having the medicines outweighs the need to wake the resident then suitable steps should be taken to ensure those medicines are not missed and given on time. This should be clearly documented in the care plan and any advice from healthcare professionals given. Staff may need to consider alternative arrangements for the times of administration where residents are not having the medicines as highlighted on EMAR charts – staff should always refer to the prescriber or pharmacist for any alterations of the timings of medicines.
6.26. Return any medicines to safe storage as identified in the risk assessment.
6.27. Staff should only administer medicines within their competency. Records must be kept of all staff training competencies. Certain medicines must only be administered by registered professionals unless specialist training has

been provided for a non-registered member of staff to undertake this duty (see delegated task recommendations - 6.60-6.62). Advice must always be sought from a healthcare professional if there are any concerns regarding the route or administration of any medicines.
6.28. Medication should only be removed from its original container when administering medication.
6.29. Staff should never dispense medication then ask another member of staff to administer to the resident. It is the responsibility of the member of staff dispensing the medication to administer to the resident.
6.30. Medication must never be left with the resident unless risk assessments are in place for self-administration.
6.31. Medication must always be given as prescribed and at the agreed times identified on the EMAR. The home, prescriber and the pharmacist should agree with the resident the most appropriate time for the resident to take their medicines.
6.32. Where medicines trolleys are used it is the responsibility of the member of staff holding the medicines keys to ensure this is locked at all times when not in use.
6.33. Only medicines prescribed for the individual should be administered – staff must not use other residents' medicines to administer a different resident's medication.

Administration through enteral tubes

6.34. Residents who have swallowing difficulties or dysphagia and require enteral feeding through a nasogastric tube (NG), Percutaneous Endoscopic Gastrostomy (PEG) or nasojejunal (NJ) tube must have clear instructions and direction from the prescriber where medicines are to be administered off-license.
6.35. Medicines administered through enteral tubes must only be done so by trained and competent members of staff. Training must have been provided by the specialist who oversees the care of the resident.
6.36. The competency of staff must be assessed regularly
6.37. Where medicines are being administered via the enteral tube without the patients. knowledge the covert administration procedure and documentation should be followed.
(see section 9)
6.38. Written confirmation should be available for staff administering the medicines on how to prepare each medicine safely (the safe handling of medicines procedure must be followed see section 8)
6.39. Medicines should be administered individually and a flush of water given between each medicine. The amount of flush required should be clearly documented which should take into consideration if the person is fluid restricted.
6.40. Never use hot water to flush the tubes.
6.41. Not all medicines are suitable for administration through enteral tubes. For example, it might not be appropriate to give an oral liquid via an enteral tube. Always seek guidance from your pharmacist or GP.
6.42. Clear records must be made on EMAR and care plan (see section 6.43 – 6.55)

Medication Administration Recording

6.43. The EMAR must record:

- Which medicines are prescribed for the person?
- The quantity of any medications received
- The time medicines are to be administered
- The dose of the medication
- Any special administration requirements
- The name and designation of the person making the record
- Copies of emails, texts, faxes and transcriptions of phone messages must be kept and stored or uploaded onto residents Documents on ICARE with the care plan
- When required "PRN medication" as a cross reference to the PRN medication chart
- An up-to-date photograph of the service user

6.44. It is the responsibility of staff administering the medication to record what they have done when they do it. As medicines are given they should be recorded immediately.
6.45. Record any medications not given and the reason – use the agreed codes as identified on EMAR
6.46. Correct any mistakes with reference on EMAR
6.47. Any medicines administered by other healthcare professionals must also be recorded such as district nurses / specialist services.

6.48. Medication with variable doses should be clearly recorded on EMAR with the actual dose given. It is the responsibility of the member of staff administering the medication to ensure that the actual dose given is clearly documented on EMAR
6.49. For any medicines which are not to be administered daily such as weekly patches, or medication being administered every other day. The schedule must be clearly shown on EMAR to prevent any avoidable errors. This task must only be undertaken by a member of staff who is trained and competent to do and must be checked by a second competent care staff.
6.50. Medication which has been discontinued on EMAR should clearly state the date, name and role of the member of staff who had the interaction with the prescriber. Where possible the authorised prescriber should discontinue on the Medication Administration Record.
6.51. Clearly document the reason for discontinuation such as “course complete”
6.52. Where a change of timing is need – a new entry should be made on EMAR and the previous entry discontinued as per policy (ref 6.38 - 6.39)
6.53. Where residents have issues with communication the home must ensure the correct documentation is used to meet the residents needs which may include: bowel charts, fluid charts, pain scale charts, PRN protocols, behavioural charts etc. All trained staff are responsible for ensuring the documentation is kept up-to-date clearly documented.
6.54. Any additional charts such as behavioural charts, PRN Protocols, fluid charts etc. must be resident centred detailing the level of care and physical signs and symptoms a service user may show when in discomfort.
6.55. ETMARs must be clear and records kept up-to-date with signatures of the members of staff administering the topical medicines. The directions on the ETMAR must match that on the dispensing label of the product. “As directed” is not acceptable and the GP or pharmacist should be contacted to ensure the directions are clear detailing specifically how and where to administer the cream and also the frequency of application. Where ETMARs are being used, the body map must clearly highlight the areas of application.
6.56. Transdermal patch body maps located on EMAR, must be used for all residents prescribed a patch. This must be clear and accurate detailing the medicines name, strength, formulation and directions for administration. Records must be made when and exactly where the patch has been applied and when the patch has been removed. The Home must ensure the correct site rotation occurs as per manufacturer’s instructions to ensure medicines are administered safely.
6.57. All handwritten entries should only be completed by a trained and competent member of staff this then should be countersigned by a competent second member of staff both adding their signature and date to the entry.
6.58. Handwritten MAR charts should only be used in exceptional circumstances where it is not possible to obtain EMAR due to a loss of service (refer to handwritten MAR advice in section 2.18-2.20)
6.59.NMC standards for administration of medicines expect nurses to administer or withhold a medication depending on the service user’s condition e.g. digoxin is not to be given if the pulse is below 60 beats per minute.
Specialised administration (delegated tasks)
6.60. In some circumstance’s healthcare professionals may delegate certain tasks to care staff. This may include administration of injections and administration via Percutaneous Endoscopic Gastrostomy (PEG) tubes.
6.61. The Registered Manager care must ensure that:

- Staff administering the medicines have received extra training and assessed as competent by the delegating healthcare professional – records must be kept
- The process is authorised by Compliance Manager and EFH Policy and guidance to undertake this task
- The resident receiving the medicine has granted consent and this should be documented in the care plan
- The roles and responsibilities of each individual should be agreed and recorded

6.62. The healthcare professional remains the responsible person for ensuring the care worker can safely and effectively administer the medicine

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#dispensing-and-supplying-medicines
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#care-home-staff-administeringmedicines-to-residents
https://www.cqc.org.uk/guidance-providers/adult-social-care/enteral-feeding-medicines-administration
https://www.cqc.org.uk/guidance-providers/adult-social-care/external-medicines-such-creams-patches
https://www.cqc.org.uk/guidance-providers/adult-social-care/fluid-administration-charts
https://www.cqc.org.uk/guidance-providers/adult-social-care/time-sensitive-medicines

7 - Self-administration of medicines

7.1. Registered nurses and care staff working in a home should assume that a resident can take and look after their medicines themselves unless a risk assessment has indicated otherwise.
7.2. The home should carry out an individual risk assessment to find out how much support a resident need to carry on taking and looking after their medicines themselves. Care staff will perform the medication assessment on ICARE and should consider:

1. Resident choice
2. Will self-administration be a risk to the resident or to other residents?
3. Can the resident take the correct dose of their own medicines at the right time and in?
4. the right way?
5. Does the resident have capacity?
6. Does the resident have manual dexterity for self-administration?
7. How often the assessment will need to be repeated based upon individual resident
8. need?
9. How the medicines will be stored?

This should be written in the resident's care plan detailing the level of support needed
7.3. It is the responsibility of the Registered Manager or Deputy to coordinate the risk assessment and this should help to determine who should be involved. This should be done individually for each resident and should involve the resident (and their family members or carers if the resident wishes) and staff with the training and skills for assessment. Other health and social care practitioners (such as the GP and pharmacist) should be involved as appropriate to help identify whether the medicines regimen could be adjusted to enable the resident to self-administer
7.4. It is the responsibility of the Registered Manager to ensure all documentation is clear and up to date in the care plan detailing the conversations and agreement with the resident and healthcare professionals
7.5. Records must be made when adult residents are supplied with medicines for taking themselves or when residents are reminded to take their medicines themselves. It is the responsibility of the member of staff supplying or reminding the service user to ensure this is recorded.

7.6. For residents who are self-administering controlled drugs, Registered Managers are responsible for ensuring risk assessments are in place and that the ordering, supply, storage, reminding, recording and disposal: meets national standards and are adhered to at all times (ref section 5)
7.7. It is the responsibility of EFH to develop risk assessment templates for the self-administration of medicines within their service.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#helping-residents-to-look-after-and-take-their-medicines-themselves-self-administration
https://www.cqc.org.uk/guidance-providers/adult-social-care/self-administered-medicines-care-homes

8- Safe handling of medicines

8.1. It is the responsibility of the Registered Manager to ensure that the handling of medicines within their service is safe.
8.2. All staff handling medicines are responsible for following the safe handling of medicines procedure: ensuring the safety of themselves and others at all times
8.3. This policy should be followed at all times in conjunction with other standard operating procedures used to carry out a task involving medicines within the home
8.4. Staff should never touch any medicines with their bare hands; gloves should be worn at all times when handling medicines or the medication should be transferred from the dispensed packaging to the medicines pot without being touched. This is to protect staff from any risks associated with handling the medicines and to adhere to infection control standards
8.5. Hands must be washed before and after handling medicines this includes in-between different patients during the medication round or gloves should be changed

8.6. Cytotoxic and cytostatic medicines are mainly used in the treatment of cancer as they are toxic to cells. This includes skin cells so these medicines must be handled with extra care to prevent skin coming into contact with the medicine.
8.7. Pregnant women and all staff of child bearing age should avoid handling cytotoxic medicines and due to the reproductive risks.
8.8. Protective clothing should be worn when handling cytotoxic medicines such as gloves and gown as appropriate
8.9. Registered Managers are responsible for ensuring the appropriate Personal Protective Equipment (PPE) are available and used by staff to reduce the risks of handling medicines.
8.10. Cytotoxic medicines should be disposed of in purple lidded waste bins.
8.11. Homes are responsible for ensuring the Control of Substances Hazardous to Health (COSHH) 2002 regulations are followed at all times by:

- Identifying the hazards
- Deciding who might be harmed and how
- Evaluating the risk
- Recording your findings
- Reviewing your risk assessment

8.12. EFH are responsible for the control of exposure. Measures to control exposure should be applied in the following order:

- Issue personal protective equipment where adequate control cannot be achieved by other measures alone.

The broad measures described above will include more specific controls, such as:

- reducing the quantities of drugs used; the number of employees potentially exposed; and their duration of exposure, to the minimum;
- ensuring safe handling, storage and transport of cytotoxic drugs and waste material
- containing or contaminated by them;
- using good hygiene practices and providing suitable welfare facilities, e.g. prohibiting eating, drinking and smoking in areas where drugs are handled and providing washing facilities;
- Training staff that handle cytotoxic drugs or deal with contaminated waste, on the risks and the precautions to take.

8.13. Monitoring includes any periodic test or measurement which helps confirm the effectiveness of controls. Under COSHH, monitoring is necessary when:

- deterioration of control measures could result in a serious health effect; measurement is required to ensure an occupational exposure limit or in-house working standard is not exceeded;
- Any change occurs in the conditions affecting employees' exposure which could mean that adequate control is no longer being maintained.

8.14. In accordance with the COSHH Approved Code of Practice (ACOP), monitoring is normally necessary where there is potential for exposure to carcinogenic compounds. HSE publication, Biological monitoring in the workplace: A guide to its practical application to chemical exposure, provides further information.
8.15. Where appropriate, EFH will use an occupational health service to help identify risks, get advice on suitable precautions and control measures, and provide services such as;

- Health surveillance programmes;
- Feedback and advice to employers following employee health assessments, e.g. pre-employment, following sickness absence, or rehabilitation and return to work and
- Employee information and training in the health aspects of their work

8.16. Clear procedures, which staff who handle cytotoxic or contaminated waste should be familiar with, must be in place for dealing with spillages or contamination of people or work surfaces. Measures to prevent or contain spillages should be used at all times. Any spillages that do occur should be dealt with promptly.
8.17. Employees handling cytotoxic drugs must be given suitable and sufficient information, instruction and training, relevant to their work. Employees must be made aware of the risks of working with cytotoxic and the necessary precautions.
8.18. Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR) the accidental release of any substance which may cause a major injury or damage to health is classed as a dangerous

occurrence and should be reported. However, small spillage of a cytotoxic drug which is well contained and easily dealt with is not a reportable. Spillage of a large amount, to which people could have been exposed, is reportable.
8.19. The responsible person must notify the enforcing authority without delay, in accordance with the reporting procedure (Schedule 1). This is most easily done by reporting online.

References

https://www.hse.gov.uk/pubns/books/hsg167.htm
https://www.hse.gov.uk/riddor/report.htm#online
https://www.hse.gov.uk/riddor/
https://www.hse.gov.uk/coshh/
https://www.cqc.org.uk/guidance-providers/adult-social-care/handling-sharps-adult-social-care

9 - Covert administration

9.1. Registered Nurses or care staff should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care.
9.2. EFH are responsible for ensuring that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the staff involved in administering the medicines.
9.3. Covert administration is only likely to be necessary or appropriate where:

- A person actively refuses their medicine
- That person is judged not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005
- The medicine is deemed essential to the person's health and wellbeing

9.4. Covert administration of medicines should be a last resort. Homes must make reasonable efforts to give medicines in the normal manner. Staff should also consider alternative methods of administration. This could include, for example, liquid rather than solid dose forms.
9.5. Before considering covert administration, homes should test decisions and actions against the five key principles under the Mental Capacity Act 2005:

1. Every adult has the right to make his or her own decisions. You must assume they have capacity to do so unless it is proved otherwise. You must not assume someone lacks capacity because they have a particular medical condition or disability.
2. A person is not to be treated as unable to decide unless all practicable steps to help them do so have been taken without success. You should make every effort to encourage and support people to make the decision for themselves. If you establish lack of capacity, it is important to involve the person as far as possible in making decisions.
3. A person must not be treated as unable to decide merely because he or she makes an unwise decision. People have the right to make decisions that others might regard as unwise. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.
4. Anything you do for or decide on behalf of a person who lacks mental capacity must be in their best interests.
5. When deciding or acting on behalf of a person who lacks capacity, you must consider:

- whether there is a way that would cause less restriction to the person's rights and freedoms of action
- whether there is a need to decide or act at all

9.6. All decisions must be in the person's best interest. Give due consideration to the holistic impact on the person's health and wellbeing.
9.7. Hold a 'best interest meeting' involving staff, the health professional prescribing the medicines, pharmacist and family member or advocate, to agree whether administering medicines covertly, is in the person's best interests. Keep records of what was discussed at the meeting.
9.8. If the situation is urgent, it is acceptable for a less formal discussion to occur between the staff, prescriber and family or advocate making an urgent decision. A formal meeting should be arranged as soon as possible.

9.9. Covert administration must be the least restrictive option when all other options have been tried. You could carry out a functional assessment to try to understand why the person is refusing to take their medicines.
9.10. Record the reasons for presuming mental incapacity and the proposed management plan, including consideration of Deprivation of Liberty Safeguards (LIBERTY Protection Safeguards from April 2022) when medicines, such as sedatives, are to be given covertly.
9.11. Staff must identify the need for covert administration for each medicine prescribed. Each time new medicines are added, you must identify the need again.
9.12. Hold 'best interest meetings' when new medicines are prescribed or doses changed.
9.13. Administering medicines in food or drink. This can alter their therapeutic properties and effects. They could become unsuitable or ineffective. Always seek advice from a pharmacist or clinician to make sure medicines are safe and effective and ensure this is recorded.
9.14. Use covert administration for as short a time as possible
9.15. Regularly review the continued need for covert administration within specified timescales You should also review the person's capacity to consent. Homes are responsible for detailing the specific timescales for reviewing covert administration.
9.16. Regular formal reviews of whether covert administration is still needed should be set with a timescale based on individual circumstances.
9.17. Record and regularly review assessments of mental capacity.
9.18. The decision-making process must involve discussion and consultation with appropriate advocates for the person. It must not be a decision taken alone. It must be a multi-disciplinary team decision.

Plan how medicines will be administered covertly, with detailed and recorded specialist input to show suitability of the method chosen:

- Some medicines can become ineffective when mixed with certain foods or drink

Crushing a tablet or opening a capsule before administration may make its use 'off-licence'. Those prescribing and administering medicines in this way should be aware of this, as altering the characteristics may change a person's response to the medicine. For example, crushing a tablet designed to release slowly over 24 hours might result in overdose or increased adverse effects due to the whole dose being released too quickly
9.19. Maintain a clear record of which medicines are administered covertly and when. This is particularly important for people with fluctuating capacity.
9.20. Record actions taken to give medicines in the normal manner. Include how you considered:

- Whether the medicine is unpalatable
- Adverse effects (actual or perceived)
- Swallowing difficulties
- Lack of understanding about what the medicine is for
- Lack of understanding of the consequences of refusing to take a medicine
- Ethical, religious or personal beliefs about treatment

9.21 Homes are responsible for detailing how records are made and maintained. Written confirmation from all involved in the meeting of best interest and specifically how the medicines are to be administered from the healthcare practitioner must be evidenced on medication care plan on ICARE.
9.22. It is the responsibility of the Registered Manager to ensure regular reviews for the need of covert administration is maintained. Covert medication practice will necessitate a best interest care plan and Risk assessment with documented GP approval of the covert process.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#care-home-staff-giving-medicines-to-residents-without-their-knowledge-covert-administration
https://www.cqc.org.uk/guidance-providers/adult-social-care/covert-administration-medicines
http://www.legislation.gov.uk/ukpga/2005/9/contents

10- Homely Remedies / Over the Counter (OTC) Medicines

This home understands a homely remedy medicine to be a medicine that can be bought over the counter for the treatment of minor symptoms for short term use only. (i.e., headache, cough, indigestion). Examples include mild pain relief medicines, cough medicines, antihistamines (type of medicine that is used for treating reactions to allergies), anti-diarrhoea (type of medicine used for treating diarrhoea) preparations and laxatives (type of medicines used for treating constipation).
10.1. Homes offering non-prescription medicines or other over-the-counter-products (homely remedies) for treating minor ailments will have a homely remedies process, which includes the following:

- The name of the medicine or product and what it is for
- Which residents should not be given certain medicines or products (for example, paracetamol should not be given as a homely remedy if a resident is already receiving prescribed paracetamol)
- The dose and frequency
- The maximum daily dose
- Where any administration should be recorded, such as on EMAR
- How long the medicine or product should be used before referring the resident to a GP.

10.2. Advice from a healthcare professional, such as a GP or pharmacist, should be sought on the use of homely remedies for any contraindications. You should do this for each resident in advance or at the time of need. Any advice or special precautions given must be recorded and written confirmation obtained. Email authorisation should be filed appropriately in resident documentation for evidence.
10.3. Usually a limited range of minor ailments are treated with a short duration of treatment stipulated, for example, up to 48 hours.
10.4. All homely remedies should be clearly identifiable as a 'homely remedy'
10.5. Homely remedies should be stored securely and kept separate to the residents prescribed medication.
10.6. Homes should promote self-care as appropriate.
10.7. There are exceptions to the guidance such as:

- Patients being treated for long term conditions
- Circumstances where the product licence does not allow the medicine to be bought over the counter

10.8. Homes will therefore need to liaise closely with clinicians to identify people who are affected and make appropriate arrangements.
10.9. Residents (or their relatives) may provide their own homely remedy products following consultation with the GP or Pharmacist. In a home these are not for general use and must remain specific to that person. The home should document receipt of such homely remedies. If the care staff are responsible for administration, this should be recorded on EMAR.
10.10. All OTC products purchased on behalf of the resident or brought into a home should be checked, to make sure they are suitable for use, in date and stored according to the manufacturer guidance.
10.11. EFH are responsible for ensuring that there is a policy to support people who wish or need, to self-care. The policy outlines the necessary safeguards to support people to self-care when carers or relatives provide OTC products. For example, how people who may lack mental capacity to make decisions are protected.
10.12. Staff who administer non-prescription medicines or other over-the-counter products (homely remedies) to residents should be named in the homely remedies process. They should sign the process to confirm they have the skills to administer the homely remedy and acknowledge that they will be accountable for their actions. Only trained and competent members of staff should administer or organise the use of homely remedies within the home.
10.13. There should be a clear care plan including how reviews will be triggered to ensure that medicines given are safe and still appropriate.

References

https://www.england.nhs.uk/publication/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed-in-primary-care-guidance-for-ccgs/
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#care-home-staff-giving-non-prescription-and-over-the-counter-products-to-residents-homely
https://www.cqc.org.uk/guidance-providers/adult-social-care/over-counter-medicines-homely-remedies

11- When required medication

11.1.Homes are responsible for ensuring a “when required” “P.R.N.” protocol is in place and adhered to at all times.
11.2. All staff administering medication should ensure an accurate and up-to-date PRN protocol is in place for each resident who is prescribed medicines when required.
11.3. Staff must follow the PRN protocols in place at all times.
11.4. Registered Managers are responsible for ensuring PRN protocols and care plans contain enough information to support staff to administer when required medicines as intended by the prescriber. This should include:

- Details about what the medicine is for
- Symptoms to look out for and when to offer the medicine
- Whether the person can ask for the medicine or if they need prompting or observing
- for signs of need, for example, non-verbal cues
- When to review the medicine and how long the person should expect to take it

Where there is more than one option available, the plan should make clear the order to try them. For example, when using multiple painkillers, you might try paracetamol first then codeine
11.5. This information must be kept on EMAR
11.6. Care plans for when required medicines should be person-centred detailing specific physical signs and symptoms for when a PRN medicine may be required. Special consideration must be made for residents who lack capacity or are unable to communicate to help staff administering medicines when required. This information will be located under a best interest care plan relating to medication.
11.7.PRN protocols should detail how to offer the medicine (such as outside the normal medicine round). The plan should also tell staff what records to make. For example, glyceryl trinitrate spray is occasionally used for chest pain in angina. You might record this only when needed.
11.8. Another example is pain relief that you assess at each medicine round. You might record this each time you assess it. Or you might only record when it’s given. This will depend on the requirements laid out in the care plan.
11.9. There should be a protocol for when required medicines which includes:

1. The reasons for giving the when required medicine
2. How much to give if a variable dose has been prescribed
3. What the medicine is expected to do
4. The shortest time to wait between doses if the first dose has not worked
5. Offering the medicine when needed and not just during medication rounds
6. When to check with the prescriber if there is any confusion about which medicines or
7. doses to give
8. Recording when required medicines in the resident's care plan

11.10. Registered nurses and carers working in a home should ensure that 'when required' medicines are kept in their original packaging.
11.11. Medicines should be offered in a person-centred manner. Offer the medicines to the person when they are experiencing the symptoms. Do not limit the offers to medicines rounds. Make a record of the exact time and the amount of medicine given.
11.12. Your records will show if you're regularly giving someone a when required medicine. If this happens, you should refer the person to the prescriber to consider a medicines review.
11.13. If medicines do not have the expected effects: contact the prescriber.
11.14. Records must be kept of any responses from prescribers about queries to medicines.

References

https://www.cqc.org.uk/guidance-providers/adult-social-care/when-required-prn-medicines
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#ensuring-that-records-are-accurate-and-up-to-date
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#care-home-staff-administering-medicines-to-residents

12 - End of life care

12.1. During end of life care there should be one clinician responsible for the service users care.
12.2. Medicines must be reviewed by a clinician to ensure all medicines are appropriate and needed. A holistic approach must be used ensuring the residents wants and needs are met.
12.3. Homes should ensure there are regular reviews with a clinician to ensure the resident's needs; wishes and symptom control are being met.
12.4. Homes must maintain clear guidance or protocols and review them regularly to ensure they contain enough information to help staff to administer 'when required' or PRN medicines safely and effectively.
12.5. When PRN medicines are prescribed, it must be clear what they are being used for.
12.6. Where medicines are poorly controlling symptoms or a resident appears to be experiencing adverse effects from medicines: advice must be sought from a clinician.
12.7. For homes with nursing a small stock of anticipatory medicines may be kept for controlled drugs stock the provider must hold a license with the home office to keep a stock of controlled drugs (see section 5)
12.8. Where anticipatory medicines are stored within the home care staff are responsible for ensuring they are stored as per manufacturer's guidance. Where controlled drugs are stocked the controlled drugs register must be maintained (see section 5)
12.9. Only care staff who are trained and assessed as competent should administer medication through a syringe driver. This is usually trained nurses and they are responsible for:

- Checking that medicines used in a syringe pump are compatible with the diluent and with each other. If compatibility is an issue, you may need two syringe drivers. Staff should check with a pharmacist, medicines advisory service or palliative care services if staff are not sure about compatibility.
- Checking compatibility by having access to recognised sources of information.
- Check that syringe drivers have been maintained adequately. Ask for the last service date and documentation.

12.10. Once a syringe driver is commenced, label and check the syringe driver. Do this as agreed in your local policy and the person's care plan. The care plan should make it clear who to contact for help, including out of hours.
12.11. Homes should ensure that the resident and their families are involved in all decisions around their end of life care – where possible the needs and wishes of the resident must be met and clearly documented in the care plan. A medication review will be undertaken and medication stopped in consultation with the GP and relatives.

References

https://www.cqc.org.uk/guidance-providers/adult-social-care/end-life-care-planning-medicines-optimisaiton
https://www.nice.org.uk/guidance/ng142/chapter/Recommendations#identifying-adults-who-may-be-approaching-the-end-of-their-life-their-carers-and-other-people

https://www.nhs.uk/conditions/end-of-life-care/

13 - Medication away from the home

13.1. Where a resident is away from the home as soon as staff are made aware this should be communicated with the person who is responsible for the resident's medication – if this is another healthcare professional their name and contact details must be obtained.
13.2. Where a family member will have responsibility for medicines administration care staff must ensure that they understand the medication that needs to be administered, including, name, dose, strength, frequency, any special instructions, indication and any side effects to monitor.
13.3. Secondary dispensing occurs when medication is removed from the container in which it was received from Pharmacy and put into a different one prior to administration. Other containers may include dispensing pots, unlabelled bottles or boxes, different compliance aids to those dispensed, small bags or envelopes. It is not permitted to supply medication away from the home in this way.
13.4. Care staff must obtain enough medication to cover the period of leave away from the care setting. This may include obtaining an acute prescription to cover the leave or booking out medication from the care settings stock. Documentation on EMAR must be clear and appropriate and indicate details of the medicines taken away from the home and where they have been taken to.

13.5. Care staff should seek advice from their community pharmacy or GP for advice if there are any queries about obtaining medication to cover a period of leave.
13.6.A risk assessment must be in place in the resident's care plan to document the resident's ability to manage their medicines.
13.7. Only trained and competent members of staff and/or informal carers can administer medication on behalf of the service user away from the home – this must be clearly documented in a risk assessment.
13.8. For medication on permanent transfer, the transfer of care procedure should be followed copy of EMAR will be located on the ICARE 999 document which can be printed.
(see section 15)
13.9. Care staff are responsible for ensuring that a copy of the current assessment, most recent review and current prescription are transferred together with the resident. In an emergency EMAR can be printed.
13.10. Records must be made in the resident's documentation regarding transfer information
13.11. Original copies of all documents relating to medications for the resident must be retained in accordance with normal practice for storage and retention.
13.12. Homes are responsible for ensuring sufficient medication is transferred with the resident on permanent discharge (minimum 7 days) unless sufficient medication has already been obtained by the destination of transfer. Care staff are responsible for ensuring the medication is fit for purpose at the point of transfer and records are kept of medicines which are to be transferred including the total quantity.
13.13. Upon discharge from the home, care staff are responsible for ensuring enough medication is given to the resident or their authorised representative (minimum 7 days) to allow enough time for alternative supplies can be obtained if needed.
13.14. Care staff must ensure medication supplied at discharge is fit for purpose with a clear audit trail of medication booked out and who the supply has been handed over to
13.15. Any medication belonging to the resident which is not required at discharge – consent must be sought from the resident for disposal.
13.16. Registered Managers have the overall accountability for ensuring the procedures for medication away from the home are adhered to at all times and reviewed where necessary to ensure the safe administration of medication away from the home.

References

https://www.cqc.org.uk/guidance-providers/adult-social-care/administering-medicines-when-away-from-usual-care-setting
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#sharing-information-about-a-residents-medicines
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#ensuring-that-records-are-accurate-and-up-to-date
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#dispensing-and-supplying-medicines

14 - Medication review

14.1. The Registered Manager should ensure that there is a home schedule for medication reviews which involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team). This may include a:

- Pharmacist
- Community matron or specialist nurse, such as a community psychiatric nurse
- GP
- Care Staff
- Practice nurse

14.2. The roles and responsibilities of each member of the team and how they work together should be carefully considered and agreed locally.
14.3. The home should agree how often each resident should have a multidisciplinary medication review. They should base this on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review.

14.4. The frequency of planned medication reviews should be recorded in the resident's care plan. The interval between medication reviews should be no more than 1 year.
14.5. The home should discuss and review the following during a medication review:

- The purpose of the medication review
- What the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand
- The resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines
- All prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
- How safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
- Any monitoring requirements
- Any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
- Helping the resident to take or use their medicines as prescribed
- Any more information or support that the resident (and/or their family members or carers) may need

14.6. The home is responsible for ensuring regular reviews are maintained with healthcare practitioners; this includes with specialist services such as in secondary care. Any appointments must be documented along with any monitoring requirements or special instructions with written confirmation from the practitioners.
14.7. Some prescribed medications may require more regular reviews such as antipsychotics, medicines prescribed under a consultant clinic or newly prescribed medications. Homes are responsible for ensuring any advice and follow-up appointments are adhered to as per the prescribers' instructions.
14.8. Details of the medication review must be made in the resident's care plan.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#reviewing-medicines-medication-review
https://www.cqc.org.uk/guidance-providers/adult-social-care/polypharmacy-deprescribing

15 - Transfer of care

15.1. EFH implements a process for information governance covering the 5 rules set out in the Health and Social Care Information Centre's A guide to confidentiality in health and social care (2013):

1. Confidential information about residents or patients should be treated confidentially and respectfully.
2. Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.
3. Information that is shared for the benefit of the community should be anonymised.
4. An individual's right to object to the sharing of confidential information about them should be respected.
5. Organisations should put policies, procedures and systems in place to ensure that confidentiality rules are followed.

15.2. The process also includes the training needed by staff and how their skills and competency should be assessed. This is through eLearning and local training where necessary.
15.3. Homes are responsible for ensuring the efficient and accurate transfer of care of any residents within their service. This includes transfer to and from healthcare settings, admission or discharge from the care setting.
15.4. The manager on duty at the point of transfer of care is responsible for ensuring that all the relevant information regarding a person's care is available.
15.5. Only staff who are trained and competent in what information must be transferred with the resident should undertake this duty. Sources of information which should be considered may include:

- Advance care plans
- Behavioural issues (triggers to certain behaviours)
- Care plans
- Communication needs

- Communication passport
- Current medicines
- Any acute medications in the last 3 months
- Hospital passport
- Named carers and next of kin
- Other profiles containing important information about the person's needs and wishes such as printed EMAR, best interest decision making, mental capacity assessments, DNACPR, DOLs (LPS), This Is Me document, personal belongings etc.

15.6. Homes are responsible for ensuring that any information about a resident's medicines that is transferred contains the following information as a minimum (Print 999 record):

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

15.7. Homes should ensure that either an electronic discharge summary is sent or a printed discharge summary is sent with the resident when care is transferred from one care setting to another. See recommendation 15.6 for the minimum information that should be transferred.
15.8. Homes should ensure that all information about a resident's medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another.
15.9. All staff should check that complete and accurate information about a resident's medicines has been received and recorded, and is acted on after a resident's care is transferred from one care setting to another
15.10. Homes should have a process for recording the transfer of information about residents' medicines during shift handovers and when residents move to and from care settings.
15.11. Confidentiality must be maintained at all times and be part of the home's process on managing information about residents' medicines.
15.12. Care staff should ensure that records about medicines are accurate and up-to-date. This process should cover:

- Recording information in the resident's care plan
- Recording information in the resident's medicines administration record
- Recording or uploading to residents' documents on ICARE information from correspondence and messages about medicines, such as emails, letters, text messages and transcribed phone messages
- Recording information in transfer of care letters and summaries about medicines when a resident is away from the home for a short time
- What to do with copies of prescriptions and any records of medicines ordered for residents.

15.13. Homes are responsible for ensuring everyone receiving care is seen as individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.
15.14. Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.

References

http://www.legislation.gov.uk/ukpga/2005/9/contents

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#sharing-information-about-a-residents-medicines
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#ensuring-that-records-are-accurate-and-up-to-date
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#accurately-listing-a-residents-medicines-medicines-reconciliation

16 - Training and competency

16.1. Homes must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent.
16.2. Homes must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents.
16.3. Employees must maintain mandatory training and competency to undertake their duties.
16.4. Staff must read, understand and sign the Standard Operating Procedures (SOPs) / competency frameworks before undertaking certain tasks.
16.5. Staff must follow their local SOPs / Competency frameworks at all times.
16.6. EFH have access with collaboration with Boots the Chemist and Access and Clinical for an internal and/or external learning and development programme so that staff can gain the necessary skills for managing and administering medicines. The programme meets the requirements of the regulators, the residents and the training needs of staff.
16.7. Homes will provide induction training to all staff at the start of their employment. Make it relevant to the type of care setting they are working in and the tasks undertaken.
16.8. Identify the training, learning and development needs of each new member of staff. Review these at appropriate intervals during their probation then ongoing employment.
16.9. Supervise new staff as appropriate. Assess whether they have the required or acceptable levels of competence. When they show they are competent, allow them to carry out their role unsupervised.
16.10. Staff should receive appropriate ongoing or periodic supervision in their role. This will help to maintain their levels of competence.
16.11. Support staff to take part in training. Make sure the training is flexible and accessible enough for the home.
16.12. Make sure staff can access extra training as required to maintain their competence.
16.13. Train care staff to administer medicines using specialist techniques if this is required, some of which will be delegated tasks. Examples include:

- Subcutaneous injection
- Rectal or vaginal preparations
- Inhalers
- Oral syringes
- Other medical devices
- Train staff to use electronic medicines administration systems

16.14. Homes use Boots as an 'accredited learning' provider so that staff who are responsible for managing and administering medicines can be assessed by an external assessor.
16.15. Registered Managers are responsible for ensuring that all staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines.
16.16. Homes should identify any other training needed by staff responsible for managing and administering medicines. If there is a medicines-related safety incident, this review may need to be more frequent to identify support, learning and development needs.
16.17. Registered Nurses working in EFH should work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines for residents living in a care setting.
16.18. Registered Managers should keep records of staff competencies and assessments in their personal file / training matrix
16.19. All staff are responsible for the maintenance of their training competencies and requirements.
16.20. Any staff members who feel they would benefit from further training should discuss with their line manager and not perform any duties outside of their confidence or competency.

References

https://www.cqc.org.uk/guidance-providers/adult-social-care/training-competency-medicines-optimisation-adult-social-care
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#training-and-skills-competency-of-care-

17 - Incident reporting and near misses

17.1. Homes should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents.
17.2. Registered Managers are responsible for ensuring robust medication audits are taken monthly to identify any medication errors.
17.3. All staff are responsible for reporting incidents and near misses.
17.4. All incidents and near misses – suspected or confirmed should be reported and recorded by the member of staff who identified the error.
17.5. Staff should be encouraged to report and document incidents or near misses.
17.6. An incident is when an error has happened which may cause harm. Some examples could be but not limited to:

- Incorrect medication administered
- Incorrect dose given
- The medication administered has not been prescribed
- Not following any special advice or warning instructions
- Administration of a medicines the resident has an allergy to
- Administration of an expired medicine
- Doses given at the wrong time of day
- Missed doses
- Wrong route of administration
- Adverse Drug Reactions (ADR)
- Overdose

17.7.A near miss is when an error is identified before it becomes an incident. An example could be but not exhaustive to:

- Wrong medication inside the packaging of a medicine but none have been administered
- Administration error that was spotted before the medication was administered
- Community pharmacy dispensing errors if none of the incorrect medicine has been given
- Incorrect entries on EMAR if this has been picked up before an incident has occurred

17.8. When an incident or near miss is found this should be reported as soon as it is possibly safe to do so. The member of staff who has identified the error or near miss must report this to the manager and complete an internal incident form located on ICARE.
17.9. Staff are responsible for ensuring that relatives of the residents are informed of any incidents and errors as part of duty of candour.
17.10. Registered Managers are responsible for ensuring that the correct governance procedures are followed.
17.11. Any medication incidents which have potential to cause harm should be considered for a safeguarding referral. The Compliance Manager / Clinical Director should be contacted immediately. All medication errors will be recorded on the EFH safeguarding matrix if they have the potential to cause harm.
17.12. All incidents which have caused harm must also be reported to the Care Quality Commission (CQC).
17.13. Staff are responsible for contacting the relevant healthcare professionals for advice through their GP, pharmacy, 111 or 999. Where there is a medical emergency the emergency services should be contacted immediately.
17.14. Staff must give full accurate details of any incidents and ensure this is documented which must include: name of resident, time and date of the incident, full description of the incident including details of any medicines involved, any staff members involved, any action already taken and what the result of the incident was.
17.15. Registered Managers are responsible for ensuring that all incidents and near misses are investigated in line with CQC Quality Statement for medicines optimisation are lessons learned and improvements made when things go wrong?

17.16. Registered Managers with the support of the Compliance Manager / Clinical Director must investigate all incidents and near misses which should include reviewing any current policies to provide assurance that the policies in place protect people from avoidable harm. Changes must be made to any policies where incidents have occurred when the policy has been followed. A root cause analysis must be undertaken.
17.17. Registered Managers should review incidents to see why the incident or near miss has occurred what could be done differently or what can be put in place to prevent this from happening again. How can the degree of harm be decreased and what is best practice?
17.18. EFH promotes a patient safety culture where staff feel comfortable and confident to report incidents and near miss without a blame culture.
17.19. All trained and competent members of staff are accountable for their actions and incidents should be treated fairly and training or support offered to staff whose actions have resulted in a medication error as per their local policy.
17.20. The Registered Manager must document any investigations and the lessons learned or what has changed as a result of an incident or near miss to prevent future avoidable harm.
17.21. Any incidents involving controlled drugs including missing or stolen controlled drugs should be reported to the Clinical Director without delay
17.22. Any Adverse Drug Reactions or side effects as a result of medication must be reported to the original prescriber and can be reported to Medicines and Healthcare products Regulatory Agency (MHRA) through the yellow card scheme.
https://yellowcard.mhra.gov.uk/
17.23. Registered Managers are responsible for keeping records of all incidents and near misses along with any investigations and lessons learned for evidence upon inspections from CQC.
17.24. Providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines.

References

https://yellowcard.mhra.gov.uk/
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#identifying-reporting-and-reviewing-medicines-related-problems
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#keeping-residents-safe-safeguarding-2
https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents

18 - Safeguarding

18.1. EFH takes the responsibility to safeguard people from abuse and implements a safeguarding policy.
18.2. All staff are responsible for reporting and responding to safeguarding incidents to keep people safe, in line with local policies and procedures.
18.3. Any medication incidents which have or have potential to cause harm should be considered as safeguarding and staff should refer to the safeguarding policy.
18.4. Staff should contact the residents GP to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident.
18.5. Any staff members who are unsure if the incident should be reported then advice must be sought through the Compliance Manager / Clinical Director or the social services in the local authority.
18.6. Adult social care can be contacted on:
In hours LOCAL HOME CONTACT NUMBER
Out of hours
18.8. For reporting of incidents and near misses follow the “incident and near miss” procedure (section 15)

References

https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#identifying-reporting-and-reviewing-medicines-related-problems
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#keeping-residents-safe-safeguarding-2

19 - Audit and monitoring

19.1. EFH are responsible for ensuring that medicines are managed safely and effectively in the home which includes auditing medicines to provide assurance or identify any areas of concern or where support / review may be needed.
19.2. Registered Managers are responsible for ensuring a robust medication audit takes place regularly to monitor the management of medicines within the care setting.
19.3. The audit should cover all aspects of medication and all the above sections of this medication policy.
19.4. EFH are responsible for design and detail of the medication audit but this must provide assurance that all aspects of medication are being managed safely and effectively
19.5. Action plans must be implemented where there are areas of concern or improvement and it is the responsibility of the Registered Manager to ensure the action plan is created and implemented
19.6. More frequent medication audits may be required where there are concerns with medication for example weekly audits may be completed to provide assurance or smaller or more detailed audits in a certain area may be implemented to identify any further areas of concern or to monitor improvement
19.7. Training and support will be sourced or offered where there are areas which require improvement with the management of medicines.
19.8. Any incidents or areas of concern which have not been picked up in the medication audit: the audit must be reviewed to ensure all areas of the management of medicines are covered which may involve adding in some more areas to audit.
19.9. EFH will work jointly with Boots audit staff to help improve the management of medicines within care settings which may include external medication audits.
19.10. All audits must be recorded and stored appropriately along with any action plans implemented.
19.11. Medication audits must be kept as evidence upon inspections from CQC.
19.12. The Compliance Manager is responsible for ensuring the medication audit template is reviewed with the Clinical Director annually alongside the medication policy.

References

https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#training-and-skills-competency-of-care-home-staff
https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#developing-and-reviewing-policies-for-safe-and-effective-use-of-medicines

20 - Warfarin and Anticoagulants

20.1. Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital. They must therefore be administered and managed with extreme caution and with appropriate safeguards in place.
20.2 Residents are prescribed anticoagulant therapy where they are at risk of their blood clotting within their blood vessels and disrupting the flow of blood around the body (thrombosis). Such an event may lead to other serious medical conditions such as:

- Strokes
- Transient ischaemic attacks (TIAs)
- Heart attacks
- Deep vein thrombosis (DVT)
- Pulmonary embolism.

20.3. Thrombophilia
Thrombophilia refers to the blood having an increased tendency to form clots. People with thrombophilia are particularly at risk of developing a DVT or a pulmonary embolism.
Warning signs of a DVT include:

- Pain, swelling and tenderness in the legs (usually the calf)
- A heavy ache in the affected area
- Warm skin in the area of the clot
- Redness of the skin, particularly at the back of the leg below the knee.

20.4. The symptoms of a pulmonary embolism are:

- Chest or upper back pain
- Shortness of breath
- Coughing, usually dry but may include coughed-up blood or mucus containing blood

- Feeling lightheaded or dizzy
- Fainting.

20.5. Residents experiencing any of these symptoms should be encouraged to see their GP immediately.
20.6. There are different types of thrombophilia. It is diagnosed by having blood tests which identifies anticoagulant deficiencies. Those diagnosed with thrombophilia may be referred to a haematologist, a specialist in diagnosing and treating blood disorders.
In mild thrombophilia, treatment may not be needed.
20.7. Those who develop a blood clot will need treatment to disperse the blood clot and to prevent further clots. This will usually take the form of warfarin tablets or an injection of heparin. In some cases, people may be prescribed a low-dose of aspirin which also works to reduce the risk of blood clots.
20.8. Warfarin and heparin are anticoagulants which interfere with the clotting process and are commonly used to treat or prevent DVT and pulmonary embolisms. Warfarin is usually prescribed for clot prevention. A heparin injection is usually given where somebody needs instant treatment for an existing clot.
20.9. To maintain safety, the dose of warfarin will need to be adjusted for each person so it prevents the blood from clotting too easily but does not raise the risk of bleeding problems, the main risk with such medication. Under treatment can result in thrombosis (clot formation), which can be life-threatening. Equally, over-anticoagulation can result in haemorrhage (bleeding), which can be fatal and outweigh the benefits of preventing the thrombosis.
21.0. The adjustment will usually be made by the residents GP or anticoagulant clinic on the basis of a regular blood test, called the International Normalised Ratio (INR), which measures blood clotting ability while taking warfarin. Blood tests are usually monthly and an INR of two to three is usually the aim.
21.1. Warfarin is taken once a day, usually in the evening, and should be taken with a full glass of water.
A resident's GP should be contacted immediately if any of these side-effects appear:

- Prolonged nose bleeds (longer than 10 minutes)
- Blood in vomit or sputum
- Blood in the urine or faeces
- Passing black faeces
- Severe bruising
- Bleeding gums
- Unusual headaches
- Other side-effects include the following
- Sudden severe back pain
- Difficulty breathing or chest pain
- Rashes
- Diarrhoea
- Nausea and vomiting
- Jaundice (yellowing of the eyes or skin)

21.2. Head Injury & Warfarin – In the event of a resident who is prescribed warfarin, sustains a head injury, then the emergency services must be called without delay (999).
21.3. NICE Guidelines (CG176/3) 22/1/14 – advises that a patient on Warfarin with a minor head injury is at greater risk of an intracranial haemorrhage (Bleed). Therefore, immediate action is required and a CT scan should be performed within 8 hours of the injury to allow for appropriate management. September 2019 NICE guidelines updated its advice and Warfarin has been replaced with Anticoagulants when investigating for brain injury.
21.4. The home understands that a key component of the care of residents with health needs is the empowerment of people to be as independent as far as is possible or as much as they wish to be. This is also a key element of the national care standards, which emphasise that people living in care homes should be able to maintain their dignity, autonomy and independence.
21.5. This policy therefore encourages residents to retain control over their medication wherever it is safe for them and they choose to do so.
21.6. Where a resident develops anti-coagulant medication needs during their residency an assessment will be conducted in partnership with their GP and with any specialist healthcare services involved.
21.7. The initial assessment should be designed to determine exactly how much support the resident will require in coping with their condition and to identify what assistance is required in providing that care. The results of the assessment should be entered electronically on the resident's agreed plan of care on the i-care system. It should be compliant with all evidence-based best practice in the prevention of blood clot complication and the administration of anticoagulant therapy. The assessment should identify one or more of the following typical patterns of care:

- Residents who are able to safely maintain control of their condition and medication but who might require further monitoring.
- Residents who can take partial control over some aspects of their anticoagulant

care and who will need support and monitoring by staff.

- Residents who need support on a temporary basis but will be able to resume control as soon as this is possible.
- Residents who are unable to take full control of their medication.

21.8. Each resident who requires anticoagulant therapy and is prescribed warfarin can expect:

- To be encouraged to play an active role in their own care in accordance with their choices and wishes.
- To have an individualised care plan which they have directly been involved with and /or with the support of family members/advocates.
- To have an annual review involving their GP and other members of professional healthcare team.
- To have support and assistance from a named and trained Nurse or care staff who will act as a key worker for their care management, assisting them in monitoring their health care needs and in managing their medication as required in the plan of care and in compliance with the policy on medication administration
- They will be given adequate information about warfarin therapy.
- The staff to work closely with local healthcare teams and provide access to local specialists for advice, support, and educational material, including relevant community healthcare professionals
- Access to consultant specialist care by direct referral from the general practitioner or by an agreed community health professional when required.
- Assistance, if required, in attending specialist hospital outpatients or clinics for INR blood monitoring tests and other treatment. (Some homes have their own INR testing equipment and are able to monitor INR levels and directly liaise with GP). Results for INR levels will then be entered electronically onto EMAR and into the resident's care plan on ICARE. Additionally, an alert maybe entered onto the hand-held electronic devices used by staff, to advise on the use of blood thinners.

21.9. Staff administering medication should always double check the most recent INR report when giving a dose of warfarin. It is essential that dosages are not given from old INR report. This would raise the risk that an improper dose of warfarin is given. To mitigate this risk there must be an established process for ensuring blood tests are taken at the correct time, that INR results are received by the resident, confirmed with the GP and that the correct dose is entered onto the EMAR system.

22.0. The home should ensure that the warfarin dose is correctly recorded as milligrams (mg) of dose rather than numbers of tablets. The home should work closely with the pharmacy and GP involved to ensure that all doses are correct and that any changes are actioned immediately and accurately recorded.

22.1. Warfarin should be administered from original packs. It should be taken at the same time each day with a full glass of water.

22.2. Staff will have received appropriate training and education in the management of warfarin within the home, including awareness of:

- Recognition of the signs and symptoms of DVTs and pulmonary embolism
- Risk assessment of thrombophilia
- Management of warfarin and other anti-coagulant therapy. i.e. Rivaroxaban,
- Apixaban, Clopidogrel, Enoxaparin etc.

22.3. The date when the next INR blood test is required will be clearly recorded in the relevant plan of care under professional visits on ICARE to ensure that resident is prepared and enabled to have the relevant test on the specified date.

22.4. All warfarin dose changes necessary after an INR test result will be confirmed by the prescriber in writing (e.g. by fax/designated and secure NHS email).

22.5. Warfarin doses will not routinely be changed on a verbal request only. INR results and any confirmation records will be entered onto the residents EMAR.

22.6. Where an INR result is not provided automatically by the GP practice or clinic, the home will follow up the appointment and request the result.

22.7. It is safe practice to upload to Residents Documents the written oral anticoagulant dosage supplied by the GP practice/clinic to EMAR.

22.8. If there are any concerns that the INR result for a resident is out of date, staff will contact the relevant GP/anticoagulation service for advice.

22.9. Residents who are transferred to another care setting will be accompanied by all relevant records about their anticoagulant treatment, including a printed copy of EMAR chart which can be downloaded and their warfarin administration record.

23.0. Before using over-the-counter medicines, residents will be advised to get advice from their pharmacist or GP. Oral anticoagulants interact with a variety of other medicines, such as commonly prescribed antibiotics and painkillers which may affect their INR levels.

23.1. If a dose is missed, a note will be made on the EMAR with the drop-down option for reasons. An extra dose will never be given to “catch up”. If a resident accidentally takes an extra dose or takes the wrong dose of warfarin, staff will contact the resident’s GP immediately for advice/call out of hours GP service.
23.2. The organisation recognises that careful monitoring is required while people are taking warfarin. Any resident experiencing excessive bleeding or any other side- effects should be seen by their GP.
23.3.A full list of medications and anticoagulant treatment, including dosage and frequency information, and arrangements for the administration of the medication (i.e. whether self-administered or administered by staff) also to be recorded on ICARE and on EMAR. This should also include the dietary restrictions which may be required to prevent medication reaction.

Review date	Next Review Date
January 2024	January 2027