MEDICATION MANAGEMENT

Care Homes

Committee Approver	Operations Committee
Stakeholder Consultation	Omnicare- Pharmacy Supplier
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Related Documents	Health and Social Care Standards Standard 3.14 *" I have confidence in people because they are trained , competent, skilled and are able to reflect on their practice and follow their professional and organisational codes".*
Location of Electronic Copy	*F:\LIVE POLICIES\Care*

1. Viewpoint Values

Viewpoint is here to help people enjoy their later years. Everything we do is about realising this vision, which is supported by the following straightforward set of values:

- Inspire with positive smiles and words;
- Say 'yes I can and I will';
- Celebrate age, experience and wisdom;
- Do according to our customers' wishes and ambitions;
- Treat people (everyone is a VIP) as we would a "loved one";
- Work hard, have fun and laugh;
- Stay courageous, creative and ahead of the game;
- Work with those that share our values.

These promises shape us. They're a commitment to our tenants, residents, staff, and suppliers. They are fundamental to every single plan, decision, and project we embark on.

Introduction.

Medicine Management, also referred to as Medicine Optimisation has been defined by the Medicines and Healthcare Products Agency 2004 as: *the clinical cost effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need while at the same time minimising potential harm*.
Effective medicine management places the patient as the Primary focus, therefore delivering better targeted care with better informed individuals.

2. Policy Statement

The purpose of this policy is to safeguard residents and staff from any errors where medicine is involved. It is intended to be used by all individuals who deal with medicines within Viewpoint care homes.

This policy applies to any medicine prescribed by a general practitioner (GP), or any non-medical prescriber, Dentist, or Nurse Prescriber and administered to a resident.

Medicines should be administered safely and accurately in accordance with guidance issued by the Royal Pharmaceutical Society of Great Britain in conjunction with the Nursing and Midwifery Council (NMC), and Viewpoint policies and procedures.

3. Aim

The aim of this policy and procedure is to set out the principles and framework for the safe use of medicines and to act as a procedural guide for the supply, storage, and administration of medicines. It is intended to minimise the risk of errors occurring in the use of medicines. The correct administration of prescribed medicines involves medical, nursing, caring and pharmaceutical disciplines and

requires vigilance and caution.

The Royal Pharmaceutical Society (RPS) good practice guidance highlights that the optimisation of medicines in health care is crucial and that the evidence base distinctly demonstrates that health care professionals and patients need to work collectively to improve the quality of medicine usage. There is sound evidence that medicines management supports better and more cost effective care.

The term "medicines" is used as a generic term throughout this policy and covers all products that are administered by mouth, applied to the body, or introduced into the body, for the purpose of treating or preventing disease, diagnosing, or monitoring illness and for contraceptive purposes.

4. Legislation /related policies

- *Guidelines from the Royal Pharmaceutical Society*

  Professional Guidance on the Administration of Medicines in Healthcare Settings (RPS 2019)
- Nursing & Midwifery Council, "The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC 2018) nmc.org.uk/standards/code
- *Nursing & Midwifery Council, Medicine Management (NMC 2020)*
- *Nursing & Midwifery Council's "Medicines Optimisation in care homes"*
- *Health and Social Care Standards relating to Medication*
- *Misuse of Drugs Act 1971*
- *Medicines Act 1968*
- *Misuse of Drugs (Safe Custody) Regulations 2003*
- *Regulators published guidance on administration of medicines in care facilities.*

5. Scope

This policy applies to all Viewpoint Registered Nurses and Qualified Senior Carers. It also applies to Agency Nurses employed on contract or casually.

The Nursing and Midwifery Council requires Nurses to work within their scope of practice and ensure they are up to date with relevant CPD. Revalidation is an essential requirement for nurses and reflections should include medicines management and prescribing.

Senior carers undertake "Administering Medication to Individuals" module as part of their Scottish Vocational Qualification in Health and Social Care Level 3, and are supported and supervised to meet Viewpoints Medication competencies, as well as "Omnicare Pharmacy" training and updates thereafter.

The RCN administration of medicines guidance advises the assessment and demonstration of competence prior to administering medicines. The care home manager is responsible for the assessment of competence of nurses and senior carers.

6. Compliance and Support

The Chief Executive Officer (CEO) has overall responsibility for managing risks associated with medicines in all care environments within Viewpoint.

It is the responsibility of the Director of Care (DOC), supported by the Head of Care and care home managers to ensure that appropriate mechanisms are in place to support the implementation of this policy, including training, maintenance of competency and drawing up local protocols.

Compliance with the policy is the responsibility of all staff, clinicians and practitioners involved with the handling and administration of medicines in all Viewpoint care homes.

Non-adherence to this policy or failure to attend medication management training as required by their manager may result in a disciplinary process.

7. Equality Impact Assessment.

An Equality Impact assessment has not been carried out.

8. Privacy Impact Assessment.

Not carried out

9. Monitoring and Evaluation

Routine in – house medication audits are carried out to coincide with resident care plan audits, at a frequency of 10% per month and can be peer audited if directed by the Care Home Manager. Drug room audits are carried out 6 monthly by the Manager/Deputy Manager or delegated Charge Nurse from another unit. Increased drug auditing will take place if the Manager identifies any deficiencies in practice or processes. Managers will develop action plans to address any "handling of medicines" shortcomings, thus reducing the possibility of re-occurrence.

Regular audits by the servicing pharmacy will also be carried out, if and when discrepancies are highlighted, these will be addressed via an action plan issued by the pharmacy. Managers will put in place a further action plan to reduce the possibility of re-occurrence.

The management of medication in the care home is also the subject of Care Inspectorate inspections.

There may be occasions where face to face auditing cannot be carried out by the servicing pharmacy (for example – pandemic). On these occasions, remote audits must be supported by the care home manager, to ensure compliance.

PROCEDURE

1. Introduction

Good medicines management, is an integral part of most nursing and midwifery practice and includes the administration of medicines, prescribing and supporting people to take their medicines correctly. Effective medicines management places the patient as the primary focus, thus delivering better targeted care and better-informed individuals.

The ultimate goal of safe and effective medicines management is to optimise the benefits that treatment offers and attain the best outcome for each patient. (Department of Health, Northern Ireland 2016).

Medicine management including administration, is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner, non-medical prescriber, or registered nurse prescriber. It requires thought and the exercise of professional judgement which is directed to:

- Confirming the correctness of the prescription
- Judging the suitability of administration at the scheduled time of administration
- Reinforcing the positive effect of treatment
- Enhancing the understanding of residents in respect of their prescribed medication and the avoidance of misuse of these and other medicines.
- Assisting in assessing the efficacy of medicines and the identification of side effects and interactions of medicines.

To meet the standards set out in this procedure is to honour, in this aspect of practice, the NMC expectation – set out in the Code of Practice – which a nurse will:

- Always act in such a manner as to promote and safeguard the interests and wellbeing of patients and clients.
- Ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients or clients.
- Maintain and improve your professional knowledge and competence.
- Acknowledge any limitations in your knowledge & competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.

2. Prescriptions

A medicine shall only be supplied or administered in accordance with:

- The written prescription of a doctor, dentist, non-medical prescriber or

registered nurse prescriber prescribing from the nurse prescriber' formulary.

- Each prescription must be computer generated. On rare occasions a prescription may require to be handwritten (for example for acute medicine such as antibiotics) on to the MAR chart *because a computer-generated prescription would not then be issued.* The prescription must be written legibly in ink, it must be dated, contain the full name and address of the patient, and be signed by the prescriber in ink. NB. Prescription that are issued and require to be handwritten/transcribed onto the MAR by the nurse are less common, however, these must be replaced with a computer-generated prescription as soon as practically possible.
- Prescriptions for controlled drugs as listed in Schedule 2 or 3 of the Misuse of Drugs Regulations, are subject to prescription requirements. They must be written/signed in ink in the prescribers own legible handwriting and comply with both the Misuse of Drugs Act 1971 and the Medicines act 1968. The prescription must be signed and dated by the prescriber and must specify the prescribers address. The prescription must always state the total quantity in both words and figures of the controlled drug to be supplied, the dose, the form and strength of the preparation and the name and address of the patient.

3. Controlled Drugs

The Misuse of Drugs Regulations 2003 define the classes of person who are authorised to supply and possess controlled drugs while acting in their professional capacity and lays down the conditions under which these activities may be carried out. Controlled drugs are divided into five schedules:

- Schedule 1 includes drugs such as cannabis and LSD which are not used medicinally. Possession and supply are prohibited except in accordance with Home Office authority.
- Schedule 2 includes drugs such as Diamorphine (Heroin), Morphine, Fentanyl, Oxycodone hydrochloride, Pethidine, Quinalbarbitone (secobarbitol) & Cocaine etc are subject to the full prescription requirements, including safe custody, the need to keep registers etc.
- Schedule 3 includes barbiturates, Buprenorphine, Pentazocine and Temazepam etc. They are subject to the special prescription requirements, except Temazepam. Safe custody requirements do apply.
- Schedule 4 includes steroids, Benzodiazepines (except Temazepam & Midazolam, which are schedule 3). Controlled prescription and safe custody requirements do not apply.
- Schedule 5 includes prescription and non-prescription drugs to which safe custody and keeping of registers legislation does not apply.

4. Prescribing for Older People

Up-to-date resources are intended to provide guidance and clinical support for nurses and other healthcare professionals on medicines matters in relation to prescribing & administration of medicines by non-medical healthcare professionals.

Older people, especially the very old, often receive multiple drugs for their multiple ailments. Polypharmacy greatly increases the risk of drug interactions as well as

adverse reactions and may also affect compliance. The balance of benefit and harm may be altered in older people. Therefore older residents medicines should be reviewed regularly and medicines which are not of benefit should be discontinued.

Residents over the age of 75 and on four or more medicines are expected to receive a medication review every 6 months. This can be carried out by a GP, a registered Pharmacist, or a specialist nurse. (NSF 2002)

5. Supply of Prescribed Medication

Guidance on the arrangements for the sourcing and recording of all drugs and medicines prescribed for service users:

5.1 The responsibility for prescribing all medicines for care home residents will be that of the service user's GP.

5.2 All medicines required will be listed upon the appropriate Prescription Form and signed by the GP.

5.3 All prescriptions – repeat or acute - must be seen, checked, signed, and photocopied by the manger/nurse in charge/person in charge before being sent to the pharmacy for dispensing.

5.4 There may be occasion that the dispensing Pharmacy on call pharmacist is contacted to for advice or to supply emergency prescription medication supplies out of hours where NHS on call pharmacist is not available. When acute prescriptions are required quickly these are sent electronically or by phone (barcoded) to the dispensing Pharmacy. In this instance, the Care Home will not see a copy of the original prescription prior to administration. A copy of the G.P prescription will be printed from the Pharmacies, Patient Medical Records (PMR) and supplied with the medication for reference. The Prescription will be reconciled with the original at the earliest opportunity.

5.5 The GP/Dentist/Nurse prescribers' prescription form is the only legal authority to administer medication to a resident in a care home in Scotland. Pharmacists will take into account any medicines prescribed through the use of the NHS Pharmacy first for Scotland Service. Neither pre-printed MAR sheets (nor an Aberdeen Kardex type system), provide the legal authority to do so. Photocopies of prescriptions must be retained safely, in each resident's file, until 3 years after their death or discharge.

5.6 A monthly/two monthly pharmacy cycle will be operational for ordering through to receiving of medication, staff will have copies of the pharmacy cycle available and must follow the process for ordering and receiving the medication (APPENDIX 1). Medication/Prescriptions will be prepared timeously in line with the pharmacy cycle.

5.7 Prescriptions will be collected by a Pharmacy member of staff and the Medication order delivered by a Pharmacy member of staff. *(Alternatively, it may be necessary to send these electronically to the Pharmacist. On occasions a member of the care home staff may be required to deliver a prescription to the Pharmacy or collect a filled prescription from the Pharmacy).*

5.8 Advice will be sought from the GP/Pharmacist regarding medicines used within the home and medicines dispensed for individuals in the home.

5.9 A record will be kept at the home by the Manager/Deputy/Person in Charge of all medicines ordered. This record will be kept in the form of a MAR/

photocopy of the completed prescription re-order slip (or where applicable or required a drug ordering book).

5.10 As part of the monthly/two monthly Pharmacy cycle, staff will be aware of the due date of receipt of the medication order.

5.11 Upon receipt at the home, all medicines received will be "signed in" on the individual resident MAR chart, checking off against those originally ordered in 3 & 9 above.

5.12 Controlled Drugs received will be recorded in the separate, bound, Controlled Drugs Register, in addition to being documented on the resident's individual MAR chart.

5.13 Controlled Drugs received, will be recorded in the controlled drugs register by two members of staff, and one of whom must be a registered nurse.

5.14 Please check that the actual medicines inside the packaging/box/bottle correspond with the prescription and the label on the packaging/box/bottle, the quantity received is correct & check the expiry date.

5.15 All medicines will be kept in the containers in which they were originally supplied. Where appropriate, it may be necessary due to quantity prescribed for medication supply to be decanted into other packaging e.g. a glass amber bottle. In this instance, the dispensing Pharmacy will record the batch number and expiry date of the medication on the supply. Under no circumstances must the container label be altered or changed in any way. If a label becomes detached or illegible then the medicine must be referred back to the pharmacist and if necessary, the prescribing GP.

6. Safe Storage of Medicines and Medical Equipment

Guidance for the safe storage of medicines, non-disposable, and disposable medical equipment to ensure compliance with manufacturers' storage instructions and current legislation.

STORAGE OF MEDICINES:

6.1 All medicines will be stored in a securely locked cupboard or purpose-built storage facility. This facility will be kept locked when not in use. The keys to this facility will be kept by the Registered Nurse or person in charge of the shift. The designated place for storing medicines must be secure and only those staff who are authorised to handle medicines should have access to it. Only medicines should be stored in a medicines cupboard. Internal and external medicines must be stored in separate cupboards, as far as possible. Only authorised members of staff should have access to keys to medicines storage facilities.

6.2 The keys for the medicine area or cupboard should not be part of the master system. Medicine cabinet keys are kept by the Registered Nurse on duty or Person in Charge of the shift at all times. Spare medicine cabinet keys are kept by the Registered Manager/locked cabinet for emergency access.

6.3 If a drugs trolley is used, then the required drugs will be stored in this trolley which will be kept locked and affixed to the wall of the clinic/treatment room with a lockable clamp when not in use. This would be an additional security measure if any unauthorised access were gained to the treatment room. (If the

treatment room is kept locked when not in use then the trolley does not need to be clamped). The keys to the trolley and the fixing clamp will be kept by the Registered Nurse or person in charge of the shift.

6.4 Household Remedies and medicines belonging to individual residents will be stored in the drugs cupboard.

6.5 For medicines requiring low temperature storage *(refer to manufacturer's instructions on the container labels),* e.g. insulin and eye drops, the following action must be taken:

a. All such medicines will be stored in a lockable refrigerator, preferably kept in the clinic/treatment room. This would be an additional security measure if any unauthorised access were gained to the treatment room. (The refrigerator does not need to be locked if it is kept in a locked treatment room). The keys to the refrigerator will be kept with the drug keys.

b. Temperature readings (minimum temperature **2ºC** & maximum temperature **8ºC**) of the inside of the refrigerator will be made on a daily basis (in the last 24hrs) and recorded in a special Temperature Log kept in the clinic /treatment room. Please note: Optimum temperature will be between **4ºC – 8ºC**. Temperature readouts will be verified daily with a calibrated thermometer, recording readings in the Temperature Log.

c. The Registered manager must be alerted if two or more consecutive temperature readings rise above **8ºC**. The care home manager/nurse in charge/person in charge must record the action taken to rectify the problem, i.e. move any medicines to another secure fridge in the interim, confirm how long medicines have been stored out with ideal temperature, contact and discuss with Pharmacist any impact this would have had on the medication (and if it safe to use or requires to be discarded). If medicines fridge is on loan from pharmacy, contact Care Home Service Manager to resolve.

d. <u>All medication</u> and including (liquid medication, with a shorter shelf life) eye drops, creams and lotions should be kept in their original packaging. Upon opening, the date and the signature of the user must be placed legibly, in ink, on this packaging. This date must be checked against the expiry date and the medicine disposed of at the appropriate time. Dating all medicines upon opening will help maintain an effective audit trail.

e. The clinic/treatment room temperature must be monitored daily and recorded in a special Temperature Log (see 1.4.2 above) kept in the clinic/treatment room. The temperature should not exceed **25ºC**. Medicines need to be stored correctly so that the products are not damaged by heat or dampness.

SPECIAL REQUIREMENTS FOR CONTROLLED DRUGS:

6.6 Controlled Drugs will be stored in a specially designated locked cupboard located within the locked drugs cupboard in the clinic/treatment room, The Misuse of Drugs (Safe Custody) Regulations (1973).

6.7 The keys to the Controlled Drugs Cupboard will be kept by the Registered Nurse on duty or the Person in Charge of the shift, as above. The Controlled Drug key should be kept separate to the main medicine keys.

6.8 All medicines will be kept in the containers in which they were originally supplied. Under no circumstances must the container label be altered or changed in any way. If a label becomes detached or illegible then the medicine must be referred back to the pharmacist and if necessary, the prescribing GP.

STORAGE OF MEDICAL EQUIPMENT:

6.9 This will apply to the storage of disposable equipment items such as sterile and non-sterile medical devices (hypodermic syringes, cannula, catheters, drainage bags, dressings, bandages), and non-disposable items such as sphygmomanometers and glucometers, etc.

6.10 All medical equipment will be stored in the clinic/treatment room, which will remain locked when not in use. The keys to the treatment room will be kept by the Registered Nurse on duty or the Person in Charge of the shift.

6.11 Hypodermics and needles will be kept in a separate cupboard within the locked treatment room/clinic room. The keys to the treatment room/clinic will also be kept by the Registered Nurse on duty or the Person in Charge of the shift.

6.12 Storage requirements are that:

a. Products stored in sterile packaging will not be stored directly on the floor of the clinic/treatment room.

b. Where possible, all items will be stored on shelves for easy identification and access and will not be stored directly on the floor.

c. Products will not be stored near sinks or where there is a risk of water or damp contamination compromising the integrity of sterile packaging.

d. Products kept stored in outer cartons should not be stacked to ceiling height or within range of electric lighting or at a height that would cause a moving and handling/health and safety issue.

7. Administration of Medicines to a Resident

Guidance on the arrangements for ensuring that residents receive only their own medication (exception: Homely Remedies) which they look after if possible, or which is safely stored, recorded, and properly administered by appropriately trained staff:

Reference must be made to the following:

- *Must be sensitive to the service user's cultural needs about medicines*
- *Guidelines from the Royal Pharmaceutical Society*
- *Professional Guidance on the Administration of Medicines in Healthcare Settings (RPS 2019)*
- *Adhere to Nursing & Midwifery Council, "The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC 2018)*
- *Adhere to Nursing & Midwifery Council, Medicine Management (NMC 2020)*

- *Adhere to Nursing & Midwifery Council's "Medicines optimisation in care homes"*
- *Health and Social Care Standards relating to Medication*
- *Misuse of Drugs Act 1971*
- *Medicines Act 1968*
- *Misuse of Drugs (Safe Custody) Regulations 2003*
- *Regulators published guidance on administration of medicines in care facilities.*

8. PRESCRIPTION MEDICINES:

Prescription Medicines, dressings etc are the personal property of the Resident for whom they were prescribed and on NO ACCOUNT should items be recycled to other residents.

The overall responsibility for day-to-day medicines administration will be that of the Registered Nurse/Person in charge of the Shift (staff designated and appropriately trained).

8.1 Prior to administering medicines, staff involved will perform the following tasks.

8.1.2 Wash hands and dry on a disposable towel and thereafter, sanitising hands (using hand gel) in between each resident receiving medication will be implemented.

8.1.3 Check the Medication Administration Records (MAR Charts) to verify which drugs are due to be administered.

8.2 Thereafter, *for each Resident:*

8.2.1 Check the photograph on the medication record with the resident to verify identity *(Photographs must be updated immediately when a change to a resident's appearance is noted, photographs must be as current a reflection of the resident as possible, for clear identification).*

8.2.2 Staff must ensure that the resident medication record photographs are annually updated. Photographs must be reviewed at the time of the resident's 6 monthly care plan review meeting, to ensure that the photograph is in date at this time and consider when an update is due. *(This does not detract from above, but ensures that there is oversight and updates, of all resident medication record photographs, more especially for those residents whose appearance may not have notably changed).*

8.2.3 All photographs must be dated and signed by the nurse updating the photograph.

8.2.4 Dispense the required dosage into a medicine measure (liquids) or plastic cup (tablets/capsules) without touching the medication. Checks should be undertaken at this time also, medicines are in date, right resident, right drug, right dose, right route and right time etc.

8.2.5 Prescribed ointments, creams, lotions should be applied using protective gloves and eye and eardrops applied directly according to manufacturer's instructions.

8.2.6 Check the MAR Chart and give the medication to the resident.

8.2.7 Administer the drug as prescribed (e.g. in their bedroom, in the medicines clinic, from the medicine trolley), offering a glass of water to aid swallowing, as needed. Medication should never be secondary dispensed for someone else to administer to the resident at a later time.

8.2.8 Check that the resident has swallowed the medication, and record the dose given on the MAR Chart. Sign the chart. A check of the current stock should be carried out, monitoring the administration of medication process/stock remains correct. Discrepancies must be reported to the manager as soon as possible.

8.2.9 The signature of the person administering the medication must be linked to each medicine.

8.2.10 A sample signature will be kept for all staff authorised to administer medication.

8.2.11 If the resident refuses the medication, then this should be noted using the appropriate "refusal code" and additional information recorded on the carers record overleaf.

8.2.12 "Refused medication", should be placed into the appropriate container/bag and made ready for returning to the pharmacy. The "returns" documentation must be completed accurately. The GP must be notified when medication is being refused ie on three consecutive occasions. Staff must also explore with the resident the reason why the medicine is being refused and possible alternative solutions, which can be discussed with the GP.

8.2.13 Collect used medicine measures, wash and dry, using disposable paper towels, for future re-use (i.e. if not purchased as single use only measures).

8.2.14 Clean up any spills on the drug trolley. Restock medication supplies required in advance of the next medication round.

8.2.15 In the event that medication is out of stock or to reduce the likelihood of this occurring? The nurse or person in charge should liaise with the Pharmacist. The Pharmacists can prescribe small amounts of regular repeat medication to supply (not any class of CD) which would ensure timely supply without having to contact resident's G.P.

8.2.16 When medicines must be administered by specialised nursing techniques (for example, injections) then the drugs should be given by a registered nurse.

8.2.17 All Medication administered to residents must be monitored in general for effectiveness/ineffectiveness. Staff must contact the GP if medicines do not have the expected effect.

8.2.18 Medication prescribed and administered for pain relief/agitation etc must be closely monitored for effectiveness/results and the follow-up information recorded on the MAR *(if applicable)* and the care plan, poor outcomes from the medication must be follow up with the GP.

8.2.19 Medication prescribed as PRN (pro re nata) or "as and when required medication" is medication administered out with the residents "normal prescribed time frame" *(for example for nausea, vomiting, pain, indigestion, anxiety, agitation, insomnia, asthma, chest pain etc).*

8.2.20 Following administration of PRN (pro re nata) or "as and when required medication", the resident must be closely monitored to assess the effectiveness/result of the medication. The outcome must be recorded on the MAR *(if applicable)* and in the care plan. Poor outcomes from the medication must be discussed with the GP (or NHS24 if urgent) as soon as possible.

8.2.21 PRN (pro re nata) or "as and when required medication" has a supporting protocol in place for each prescribed medication. Protocols will be reviewed annually or more often if required. (Appendix 2)

9. CONTROLLED DRUGS:

9.1 The overall responsibility for medicine administration will be that of the Nurse in Charge /first level Registered Nurse as appropriate.

9.2 The Controlled Drug Register must have an index, which in turn provides direction to the resident/service user's individual drug information page.

9.3 Each medicine for each resident is recorded on a separate page in the Controlled Drugs Register.

9.4 On receipt of stock, the Registered Nurse or Person in Charge of the shift and witnessed by another member of staff, will check that the drug and quantity is correct and for the correct person. The date of receipt and the quantity will then be entered in the Controlled Drugs Register and a new stock balance recorded. A receipt for deliveries will be stored in a file within the treatment room/clinic.

9.5 Prior to administering medicines, staff involved will perform the following tasks:

9.5.1 Wash hands and dry on a disposable towel (using hand gel/sanitiser, where appropriate)

9.5.2 Check the Medication Administration Records (MAR Charts) to verify which drugs are due to be administered.

9.6 The necessary recording of administration is made on the resident's Medication Administration Record (MAR) and in the Controlled Drugs Register, where the date, time, dose, and new balance of the medicine must be recorded. The balances recorded in the Controlled Drugs Register must be checked at the end of each week by two Nurses.

9.7 Controlled drugs are stored in the controlled drugs cabinet which complies with The Misuse of Drugs Act and the Regulations of Controlled Drugs Act.

9.8 Thereafter, *for resident :*

9.8.1 Two staff are required for the process of administering a Controlled Drug.

9.8.2 Select the required drug from the Controlled Drugs Cupboard; check expiry date and dosage required. Check stock against last entry in the Controlled Drugs Register.

9.8.3 Check the MAR Chart for the appropriate dosages required. Measure dose(s) and return the remaining stock to the Controlled Drugs Cupboard and lock the cupboard.

9.8.4 Enter the date and residents name in the Controlled Drugs Register.

9.8.5 Take the prepared dose to the service user (via medicines trolley or locked container) and check their identity (photograph on medication record will be of assistance here). Both employees should verify identity.

9.8.6 Check the MAR Chart and administer the drug in the prescribed manner. The 1st level Registered Nurse or the Person in Charge of the shift will then sign and date the chart. The second member of staff does not require to sign and date the MAR chart as a witness, only the staff member who has administered the medication. Witness information can be found in the CD register. As sometimes it can be difficult to fit both staff initials legibly onto the MAR charts, particularly for those on regular doses.

9.8.7 If the resident refuses the medication, then this should be noted on the chart and "refusal code" and additional information recorded on the carers record overleaf. Refused medication will always be returned to the pharmacy, whenever possible.

9.8.8 The doses given and time of administration will then be entered into the Controlled Drugs Register against the resident's name, which is then signed by both staff. The stock balance will be recorded.

9.8.9 Collect used medicine measures, wash and dry, using disposable paper towels, for future re-use (i.e. if not purchased as single use only measures).

CD Stock Check

The Controlled Drug(s), are counted for accuracy prior to commencing the dispensing process and this is compared to the recorded stock balance written in the controlled drug register (*for example once, twice a day or more often, depending on the prescription written by the GP or prescribing professional).*

Controlled drugs are counted at the morning and evening handover by the dayshift and night shift nurses.

A weekly drug room audit of all controlled drugs (*including prescribed anticipatory controlled drugs and PRN (pro re nata) or "as and when required medication")* will be carried out by the registered nurse on duty and the stock balance will be recorded in stock balance folder/book.

Discrepancies must be reported to the care home manager immediately.

10. Disposal of Unwanted Medicines

Guidance on the arrangements for ensuring that surplus and outdated prescription medicines are disposed of in a timely, safe, and hygienic manner.

This policy will apply to all medicines that become superfluous to requirements. This may be due to the following:

10.1 Death of a resident, or discontinuation of a course of treatment, resulting in medicines that are no longer required.

10.2 Where the shelf life of the medicine has expired (liquid medicines, GTN tablets, eye drops, ear drops and ointments).

10.3 Where a residents refuses medication after it has been dispensed.

BASIC REQUIREMENTS:

10.4 All medicines will be checked for expiry dates and should be checked at time of administration and replaced if necessary. Stock retained in the stock cupboard, checked no less than monthly and replaced as necessary.

10.5 Following the death of a resident all relevant drugs/medicines will be retained in the drugs cupboard, appropriately identified, for a period of **seven days** in case the Procurator Fiscal wishes to make an enquiry into the death. Following this 7-day period, the medicines may be disposed of.

10.6 A record of all medicines disposed of/returned to the pharmacy must be kept in each facility.

DISPOSAL OF DRUGS AND MEDICINES

10.7 The medicines must be placed in a container clearly identified as being for unwanted drugs awaiting disposal/return to pharmacy, on agreed date/time.

10.8 All drugs/medicines for return to pharmacy must be recorded on the individual residents MAR chart by the Registered Nurse on duty or Person in Charge of the shift. For each medicine, the following must be recorded.

- Name of the drug/medicine
- Name of the resident
- Date
- Quantity
- Reasons for disposal
- Signature of Registered Nurse/staff member

DISPOSAL OF CONTROLLED DRUGS:

10.8 Controlled drugs (dispensed and subsequently refused by the resident), will be coded appropriately on the MAR, recorded in the return controlled drug register, "bagged and tagged" in the bag provided and secured in the controlled drugs cabinet until arrangements have been made with the Pharmacy for uplift, on an agreed date/time. Returning controlled drugs see 10.13

10.9 The unwanted Controlled Drugs/Medicines must be kept in the locked Controlled Drugs cupboard until the pharmacist or authorised person (i.e. pharmacy driver) comes to collect them.

10.10 Unwanted Controlled Drugs will be disposed of by contacting the dispensing pharmacist. The dispensing pharmacist will make the appropriate arrangements with the care home staff and pharmacy driver for the collection of the surplus drugs from the facility.

10.11 At the time of the Controlled Drug(s) uplift, two Viewpoint registered nurses will sign out the Controlled Drug(s) from the Controlled Drug Register.

10.12 Both nurses will sign the Controlled Drugs Register to verify the removal of the drugs and the remaining stock balance (if for any reason, there is a remaining stock balance at this time).

10.13 All Controlled Drugs being returned to the Pharmacy will be recorded in the Pharmacy Controlled Drugs Returns Book. This can be completed in advance of the Pharmacy driver arriving. The Controlled Drugs Register is not completed until the Controlled Drugs are being collected. The controlled Drugs Register should always be signed by two members of staff and the Pharmacy driver should not be asked to act as a witness. The pharmacy driver and the registered nurse will both sign the Pharmacy Controlled Drug Returns Book. The Pharmacy driver will retain a copy of the return with the medication.

11. ADDITIONAL GUIDANCE

Staff who are responsible for transcribing prescriptions onto the MAR sheet, Medication Record must:

a) Check the original prescription carefully to make sure that they have understood the directions.

b) Write the directions legibly, in Black ink, on a new line of the chart for each item, being careful with spelling. Full details of the medication should be listed name, strength and form, dose and direction including any warnings printed on the pharmacy label. Alternatively, an instruction to read printed warning label prior to administration could be included.

c) Enter round time/appropriate time period etc that the medication is to be administered onto the MAR, having considered the directions on the prescription e.g. with or after food

d) Write the name of the doctor or other prescriber who wrote the prescription.

e) Date and sign the entry.

f) Arrange with the pharmacy for a printed MAR sheet to be issued, as soon as practically possible. The pharmacy team are able to add items or make changes to a MAR entry, if they have a copy of written authority from the prescriber i.e. this is usually in the format of a new prescription. However, if the G.P does not issue a new prescription (i.e. a decrease in dose and enough medication held in stock to cover this, a new MAR chart entry will not be able to be made until a prescription is received).

Staff who are responsible for cancelling or amending prescriptions on the MAR sheet, Medication Record must:

a) Cancel the original direction by scoring through with one single line,

b) Write each new directions legibly in Black ink on a new line of the chart,

c) Write the name of the doctor or other prescriber who gave the new instructions,

d) Date and sign the new entry and the cancellation. The reason for the cancellation must be included (i.e. dose decrease by Dr…… on dd/mm/yyyy).

e) Arrange with the pharmacy for a printed MAR sheet to be issued, as soon as practically possible. See above 11(f).

12. Self-Administration of Medication

12.1 If a resident wishes to look after their own medication in the care home, then a detailed risk assessment must be completed, and a trial self-administration regime introduced prior to full self- administration.

12.2 Residents who self-administer, must have a lockable space in their bedroom in which to store medication to prevent it from being lost or mislaid.

12.3 Concordance aids, such as compartmentalised daily dispensers, are available to help in self-administration but should only be used on recommendation by a pharmacist. The most common form of aid is a monitored dosage system (MDS). A pharmacist seals a service user's medication into compartments or bubbles, each compartment is identified in relation to the day and time each dose is due.

12.4 Such systems also contain a medication administration chart which lists the medication the person is taking, along with instructions for any creams, lotions or gases stored outside the system that the resident is required to use as well. In this way a service user need only take the medication from within each compartment at the appropriate time and follow instructions on the chart rather than be faced with a potentially confusing array of different bottles, packets, and creams. If such aids are to be used it is generally best wherever possible, to get them filled, labelled, and sealed by a pharmacist.

12.5 Residents who self-administer their own medication should be regularly monitored and any concerns noted by staff should be reported immediately. Controlled Drugs would not be self-administered.

12.6 In the event that a resident expresses concerns about their medication or indicates that they will not follow the prescribed regime because of its side effects they must be referred to the appropriate healthcare professional.

13.End of Life Care

13.1 An advanced care plan (ACP) will be in place for each resident, and each aspect of "end-of-life care" will be handled sensitively with the aim of ensuring people are as free from pain and distress as possible, can die in a dignified, respectful manner, and in line with their own wishes.

13.2 Viewpoint staff teams will make every effort to provide all the care and support to make the resident feel comfortable, safe, and as free from as much pain and discomfort as possible.

13.3 Where required, staff will involve community healthcare staff/palliative care practitioners and services and provision of counselling and other forms of psychological support necessary.

13.4 Any changes to the residents' medication regime as a result of any changes to their condition will be authorised and prescribed by the GP/medical practitioner and fully recorded and acted upon.

13.5 The "end-of-life" personal plan will include a detailed plan including when and how to administer prescribed medication in order to:

- Reduce or control a person's pain and discomfort
- Reduce or control signs of restlessness, anxiety or agitation
- Manage or control respiratory secretions
- Manage or control any nausea/vomiting
- Maintain mouth care

Common anticipatory medicines include the following:

- Medicine for pain – an appropriate opioid, for example, morphine, diamorphine, oxycodone or alfentanil.
- Medicine for breathlessness – midazolam or an opioid.
- Medicine for anxiety – midazolam.
- Medicine for delirium or agitation –haloperidol, levomepromazine, midazolam or phenobarbital.
- Medicine for nausea and vomiting – Cyclizine, metoclopramide, haloperidol or levomepromazine.
- Medicine for noisy chest secretions – hyoscine hydrobromide or glycopyrronium.

Some of the medicines can help more than one symptom. (*For example, levomepromazine can treat delirium or agitation, and nausea and vomiting. Opioids can help with pain, breathlessness, and anxiety).*

All medication and prescriptions, including the use of controlled drugs are recorded on the residents' MAR charts in line with established procedures.

Controlled Drugs prescribed as PRN (pro re nata) or "as and when required medication" will have a supporting protocol in place for each prescribed medication. Protocols will be reviewed annually or more often if required.

14.LEAVE MEDICATION

14.1 As far as possible, Medication should not be decanted/dispensed into a monitored dosage system (MDS) for either a day trip or leaving the care home for a holiday/break.

14.2 Medication supplied for either a day trip or holiday/break should be supplied/provided in the original pack(s).

14.3 Medication should be in the original foil where provided and should be clearly marked with the persons' name and checked with a Registered Nurse or Person in Charge of the shift.

14.4 The MAR should be correctly coded to indicate Leave Medication has been dispensed by the Registered Nurse or Person in Charge of the shift.

14.5 The Registered Nurse or Person in Charge of the shift dispensing the medication should give clear instructions to the person taking the Leave

Medication on how it should be taken, i.e. at what time, quantities of liquid medication, whether soluble or not. (PROTOCOL 1)

14.6 When the resident returns form "leave" the Registered Nurse or Person in Charge of the shift receiving the returned (to the care home) medication stock is correct and confirm with resident/responsible person that the prescribed medication was taken whilst on leave.

14.7 If there are indications that medication has not been taken correctly this should be reported to the Registered Manager, the GP and Consultant if appropriate and recorded in the service user's daily record.

14.8 Missed medication should be disposed of as per policy. (see part 3 & 4) A multidisciplinary meeting may be necessary if there are concerns regarding a service user or their family/representatives ability to take or administer Leave Medication appropriately.

15.COVERT MEDICATION

There may be circumstances where covert administration of medication may need to be considered to prevent a service user missing out on essential treatment. Decisions about disguising medication in order to save a life, prevent deterioration, or ensure an improvement in the person's physical or mental health, cannot be taken in isolation from recognition of the rights of the person to give consent.

The covert administration of medicines is only likely to be necessary or appropriate where a resident actively refuses medication, but who are judged not to have the capacity to understand the consequences of the refusal.

The decision to administer medication covertly should not be considered routine. Such a decision must only be made following a multidisciplinary assessment, which involves the resident's family, Power of Attorney (POA) and relevant professionals.

The decisions and actions to be taken, including the names of all parties concerned, must be clearly recorded in the service users care plan using a covert medication pathway, with a date entered on which to review the decision. (Appendices 3 & 4)

To aid service user concordance, alternative formulations of the medicine, that may be more acceptable, should be considered, e.g. liquid preparations.

A medicine should only be crushed or split when it has been shown not to alter the pharmaceutical properties of the medicine. Written guidance should be obtained from the community pharmacy explaining how the medicine can be covertly administered and where this information was gained from. A request to get an update of this information should be done yearly.

The Covert Pathway are generally completed annually by the GP, however, we aim that these are reviewed 6 monthly and if earlier if the residents circumstances change.

16.LABELLING

16.1 For an employee to administer a medicine it must have a printed label containing:

a) The service user's name (unless a homely remedy stock item)

b) Date of dispensing

c) Name and strength of medication

d) Dose and frequency of medication

e) Precautions relating to the use of the product

16.2 Where medications are dispensed in multiple containers, each container must be labelled.

16.3 Medications that have an inner container and an outer box (e.g. eye drops, creams, etc.) must have a label applied to the item instead of or as well as the outer container.

16.4 Should the label become detached from a container, or is illegible, the prompt advice of the Pharmacy must be sought. Until such time, the original container must not be used.

16.5 Employees must never alter labels on dispensed medication, even if a change to the direction is made and the same supply of stock is being used for administration. In this instance an alert sheet can be requested and placed with the MAR charts as a prompt to indicate to follow the MAR chart not the instruction on the medicines label.

17.CHECKS

17.1 Expiry dates of medication are checked by a Registered Nurse or Person in Charge of the shift monthly on the date of the 28-day supply re-order.

17.2 Eye drops will be checked at the end of the medication month as they must be discarded, 28 days after opening.

17.3 Stocks and internal/external medicines are checked as above and re-ordered, as necessary.

17.4 Stock balances of 'As required' medication is checked on a monthly basis by a Registered Nurse or Person in Charge of the shift and entered onto the Stock Balance record.

17.5 The temperature of the refrigerator is monitored daily.

17.6 The temperature of the medicines storage room (clinic) is monitored daily.

17.7 Dispensing Pharmacist will be encouraged to conduct an audit of medication, at least annually. Care Homes under NHS Lothian SLA, visits will be carried out at least quarterly.

17.8 Quality assurance is an important step in measuring the standards relating to the "handling of medicines", therefore, we will continue to complete a variety of routine in-house audits/peer audits within our care homes. Managers must develop action plans to address "handling of medicines" shortcomings, thus reducing the possibility of re-occurrence. (Appendix 5/6)

17.9 Regular audits by the servicing pharmacy must also be carried out, if and when discrepancies are highlighted, these are addressed via the action plan issued by the pharmacy. Managers must also put in place a further action plan to reduce the possibility of re-occurrence.

17.10 There may be occasions where face to face auditing cannot be carried out by the servicing pharmacy (for example – pandemic). On these occasions,

remote audits must be supported by the care home service/care home manager, to ensure that quality assurance continues, (Appendix 7/8).

17.11 The individual medication remote audit (form) being submitted will also be used internally also by the care home manager, as part of our audit for continuing quality assurance. This includes supplementary documentation such as PRN protocols, covert medicines pathways etc.

18. DRUGS REPORTED MISSING

1. On discovering drugs are missing the Nurse in charge or the Person in Charge of the shift should complete an incident report and report the incident to the Manager. A full investigation will be carried out by management. The following people may be contacted:
    a. Head of Care
    b. Director of Care
    c. Chief Executive Officer
    d. Police and / or Adult Support and Protection
    e. Pharmacist
    f. Commissioner (Local Authority and Local Health Board)
    g. Regulating Authority

Findings will be given to all parties concerned and any necessary action taken.

19.REVIEWS

The Named Nurse/Registered Manager is required to ensure a medication review takes place at least annually and is responsible for arranging appointments with GP/ Pharmacist/Nurse Specialist.

Polypharmacy reviews within Lothian can now be requested via the new Care Home hub on the NHS Lothian webpage- https://services.nhslothian.scot/CareHomes/SupportingResidentsNeeds/ReferralPathways/Pages/Pharmacy.aspx

20.STAFF COMPETENCY REQUIREMENTS

Staff deemed competent to check and administer medication are:

20.1 First Level Registered Nurses**.** .

20.2 Care Assistants with an SVQ 3 level qualification and with competencies /training specific to the task being undertaken. NB Unregistered staff must be assessed and deemed competent by the Manager, before being able to administer medicines to individual service users unsupervised.

20.3 Student nurses may check and administer medicines under the direct supervision of a Registered nurse, according to their experience and course requirements.

20.4 Care assistants with an SVQ level 2 qualification may be a second signature for a controlled drug once "trained in the process of witnessing" and deemed competent to do so by their manager/nurse in charge.

21.AMENDMENTS

NO-ONE may add items to prescriptions written and signed by a GP, Dentist, Non-Medical Prescriber or Registered Nurse Prescriber.

22.HOMELY REMEDIES

Homely remedies are non-prescribed medication that can be purchased "over the counter" for minor complaints. Not all over the counter remedies are benign and some can interact with prescribed medication. Each Home must have a Homely remedies protocol in place that has been agreed with their local GPs. (appendix 9).

Care home staff should also be aware that NHS Pharmacy First for Scotland service can be utilised. This service does not replace Homely Remedies however, should work alongside this.

The protocol should include:

- The name of the medicine and what it is for
- A resident may be excluded from receiving specific homely remedies - for example you must not give paracetamol to a resident who already takes medicines that contain paracetamol
- The dose and frequency
- The maximum daily dose
- Where any administration takes place, this should be recorded, on the medicines administration record (MAR).
- How long the medicine or product should be used before referring the resident to a GP.

Any homely remedy administered must be recorded on the resident's MAR sheet and recorded on the resident's (PCS) care plan. The effects of the administered medication must be monitored closely, and appropriate action taken when it has been identified that the medication has not had the expected outcome for the resident. Nurse's & Senior Carers responsible for maintaining accurate recorded information pertaining to the effects/outcome of the administered medication as well as general recording of the administered medication.

23. SKIN CARE APPLICATIONS

23.1 All ointments, creams and lotions should be kept in their original packaging, when first opened, the date and the signature of the user must be placed legibly, in ink, on this packaging. This date must be checked against the expiry date and the medicine disposed of at the appropriate time.

23.2 Prescription only skin applications e.g. steroidal preparations, will be printed on the MAR and treated with the same care as any other prescription medicine, this administration can be cross referenced on the PCS system for auditing purposes.

23.3 Over the counter preparations or non-prescribed e.g. moisturisers, which have been ordered as part of the care plan for keeping the skin healthy, do not need to be written in the MAR, however, instructions for use are written in the care plan and commented on in the daily care report. *(Body charts and directional use, must be kept in the resident/service users bedroom for staff to access, however, this is not required if using PCS system for recording)*

23.4 Prescribed and over the counter skin care preparations should be applied using protective gloves in compliance with infection control policies and procedures.

24.MEDICATION ERRORS

What is a Medication error? The National Patient Safety agency defines a medication error as

"an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing advice about medicine, regardless of whether or not any harm occurred".

Examples of medication errors can include:-

a. Administering the wrong medicine
b. Administering the wrong dose of medicine
c. Administering the medicine at the wrong time
d. Administering the medicine on the wrong date
e. Administering the medicine to the wrong person
f. Administering the medicine by the wrong route
g. Administering an un-prescribed medicine (unless it is part of the agreed "homely remedies" policy)
h. Administration of a medication to which a resident has a known allergy
i. Administration of a medication past its expiry date.
j. Omission – any prescribed dose not given or where a medication was administered, however, not signed for (potential risk of second administration)
k. Transcription errors – inaccurate transcribing of prescribed orders onto the MAR sheet

What to do if an error occurs

24.1 Appropriate first aid measures should be provided.

24.2 The administration error should be reported to the G.P. and or Pharmacist without delay. Advice given by the G.P. and action taken to safeguard the residents' wellbeing should be clearly recorded on the MAR sheet and care plan.

24.3 Medication administration errors should also be reported to the manager or deputy manager immediately and a comprehensive incident report completed.

24.4 The manager will investigate the circumstances of the incident and will put an action plan in place to reduce the likelihood of recurrence.

24.5 A one-off medication error is not a disciplinary offence, but the action plan may require the offender to undertake a supervised medicine round and/or a medication competency assessment. Persistently making medication administration errors – more than once a month - could lead to disciplinary action.

24.6 Failing to sign the MAR sheet is not in itself a medication error but rather an example of poor record keeping that could lead to adverse outcomes for the resident. Persistently poor record keeping could lead to disciplinary action.

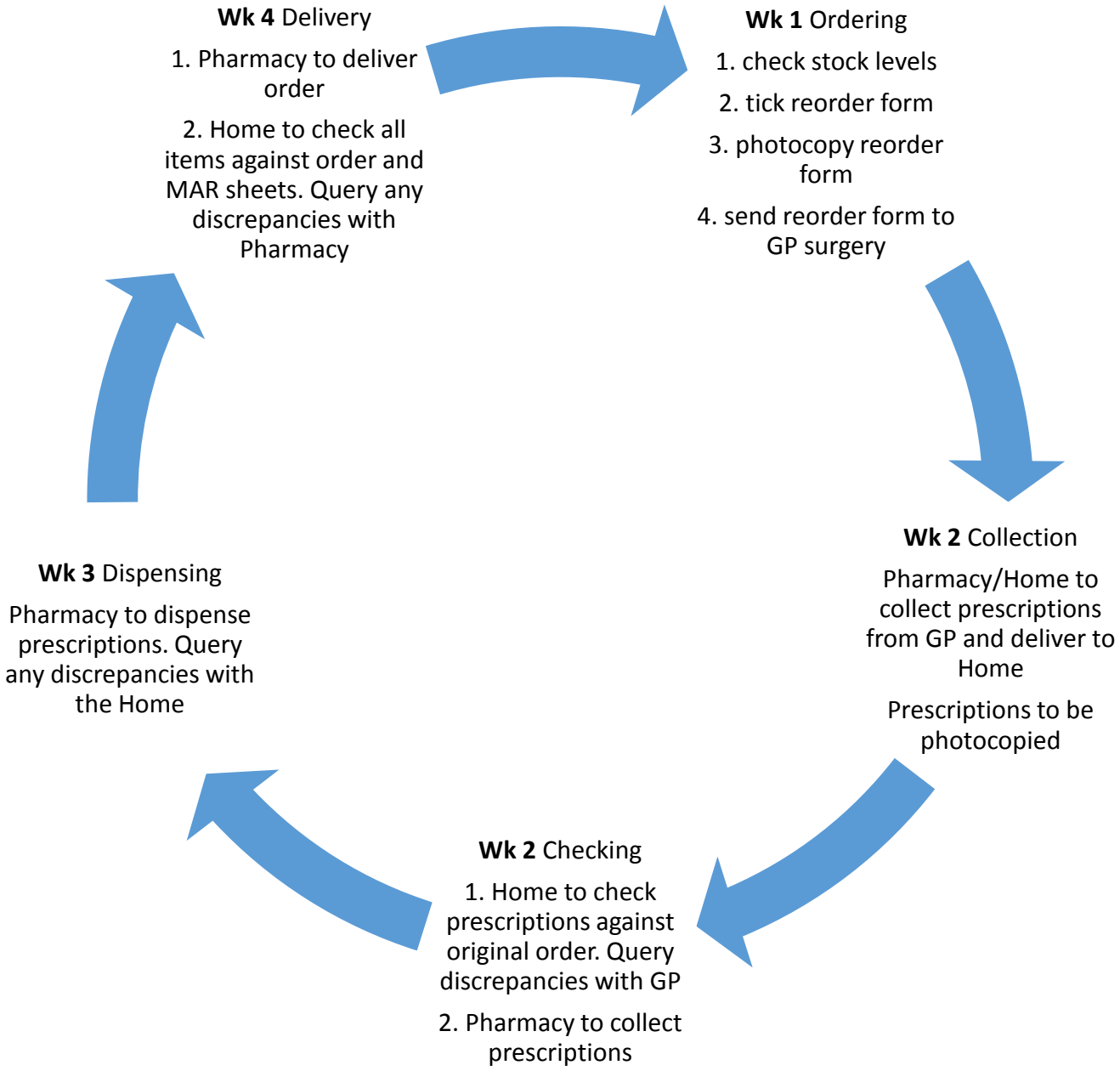
24.7 Medication errors must be reported to the Care Inspectorate and Social Care Direct (Duty of Candour).

24.8 Medication errors are considered on individual merit, seriousness of the error, and or recurring incidences. There will be occasions whereby a member of staff will be reported to their professional body, namely the NMC/SSSC or other.

24.9 The resident's next of kin/POA must be informed and advised of actions taken and measures that have been put in place to reduce the risk of re-occurrence.

Appendix 1

Suggested Cycle for Medication Ordering



When Required Medication Protocol

When an individual's GP prescribes a new when required medication, we must ensure this form is completed in conjunction with their GP and/or dispensing pharmacy and added as a supplement to their Care Plan.

Resident's Name: D.O.B:

Allergies:

Medication:

Dosage:

Start Date: _____Review/Discontinuation Date

Minimum Time between Doses:

Maximum Doses in 24 hours:

Reason for Administration of Medication and Notable Symptoms:

Steps to take before Administering When Required Medication:

Expected Results from giving the When Required Medication:

When to see GP; If medication is not effective/medication review

Possible Side Effects:

Special Instructions/Monitoring/Preparation:

Prepared by Signature: _____Date: _____

Manager's Signature: _____ Date: _____

1st Review Due: (Sample 08/07/2021)

Review date:	Signature:	Next review due:

Appendix 3

Covert medication care pathway

Name of patient: _____ DOB: _____

What treatment is being considered for covert administration?	
Why is this treatment necessary? Where appropriate, refer to clinical guidelines e.g. SIGN.	
What alternatives did the team consider? (e.g. other ways to manage the person or other ways to administer treatment) Why were these alternatives rejected?	
Treatment may only be considered for a person who lacks capacity. Outline the assessment of capacity. Assessed by:	
Treatment may only be administered under a certificate of incapacity (Section 47, AWI) or appropriate mental health Act documentation. What legal steps were followed?	Legal documentation completed: AWI S47 □ MHC &TSA □ Date:
Treatment may only be given if it is likely to benefit the person. What benefit will the person receive?	
Is this the least restrictive way to treat the person? Give reasons.	
What are the person's present views on the proposed treatment, if known?	
Has the person expressed views in the past that are relevant to the present treatment? If so, what were those views?	

Who was involved in the decision? N.B. *A qualified pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink.* N.B. If there is any person with power to consent (welfare attorney, welfare guardian), then the treatment may only be administered covertly with that person's consent, unless this is impracticable.	Practitioner staff involved: Relatives or other carers involved:
Do any of those involved disagree with the proposed use of covert medication? If so, they must be informed of their right to challenge the treatment.	Yes/No Date informed:
When will the need for covert treatment be reviewed?	Date of first planned review:

Signed:_____ Name: _____

Designation: _____ Date:_____

Appendix 4

Covert medication care pathway review

Name of patient: _____ DOB: _____

Is treatment still necessary? If so, explain.	
Is covert administration still necessary? If so, explain why.	
Who was consulted as part of the review?	
Is legal documentation still in place and valid?	
Date of next review	

Signed:_____ Name) _____

Designation _____ Date _____

Appendix 5

Individual Service Users Medication Audit

Service:_____ Date:_____

Service User Name:_____ Room Number:_____

No	Name of Medication	Opening Balance A	Quantity Recorded on MAR chart B	Expected Closing Balance C	Actual Closing Balance D	Comments on any Discrepancies between C and D

A (drugs received from pharmacy at the start of this cycle + stock if any) – **B** (drugs administered) = **C.** e.g. 56 tablets received from pharmacy, no stock, 7 tablets administered, closing balance = 49

Actions Required	Completion Date

Incomplete Actions from Last Audit	New Completion Date

Signed Auditor: _____Date:_____

Signed Manager: _____Date:_____

Appendix 6

Medicines Management Audit

Name of Home	Date of Audit

Section 1 Basic Information

1. Unit/Wing/Floor audited			
2. Name of community Pharmacist regularly supplying medicines.			
3. Signature sheet is available and includes signatures of all staff who are responsible for administration of medicines.			
4. Total number of service users self-administering medication?		5. Of these how many service users are fully independent with their medication?	

Section 2 Assessment of Policies and Procedures

Policies & Procedures	Comments	Review Date
1. Are up to date policies and procedures available to staff?		
2. Are up to date NMC guidelines for medicines management available to staff?		
3. Are staff aware of policies, procedures, and guidelines? Ask 2 staff		

Section 3

a) Supply of Medicines

1. Who has day to day responsibility for ordering medicines?	
2. Is this specified in the policy?	
3. Does the actual process for ordering medicines correspond with policy?	

b) Supply of medicines – record keeping

All medicines coming into the facility and being returned to pharmacy should be recorded. The record must include date, name, strength, quantity of medicine, and – unless homely remedy – name of service user. N.B. service users who – following risk assessment – are deemed capable of independently managing their own medication may not **always** have medicines recorded on receipt into the home. As a minimum a list with details of current medication for these service users should be kept.

Records of medicines received/returned?	Record Kept?	Entries signed?
1. Brought in on admission		
2. Obtained on repeat prescription		
3. Newly prescribed – including via out-patients		
4. Homely remedies		
5. Returned medicines/drugs register		
6. Controlled Drugs Register		

Section 4
Storage of Medicines

Facilities	Yes/No	Practice	Yes/No
1. Dedicated room for storing medicines?		2. Medicines room kept locked and the keys secure?	
3. Hand washing facilities?		4. Is the room temperature monitored?	
5. Temperature below 25ºC?		6. Is the medicine room clean and tidy?	
7. Separate secure storage cupboards for internal and external medicines?		8. Any medicines out of date?	
9. Adequate size facilities for all medicines, including new supply & returns?		10. More than 3 months' supply? If yes, Why?	
11. Is there a controlled drugs cupboard?		12. Any controlled drugs currently in stock are clearly labelled with service user's name?	
13. Is there a controlled drugs register?		14. Quantity in stock tallies with register balance?	
15. Is there a medicine trolley?		16. Is it secured when not in use, i.e. chained to the wall?	
17. If no trolley what is the alternative for transporting medicines?		18. Does this arrangement provide adequate safety and security?	
19. Is there a drug fridge? If no what is the alternative? Is this adequate?		20. Are temperatures of refrigerated facilities monitored? (2-8ºC)	
Is there a lockable space for service users managing own medicines? Are arrangements suitable?		21. Medicines checked by staff if need identified in service user's risk assessment?	
22. Is there outside storage for oxygen cylinders awaiting use? If no, what alternative arrangements have been made?		23. Is Oxygen in current use?	
24. Is there a trolley or stand for transporting or securing oxygen cylinders?		25. Oxygen cylinders in use are not presenting an H & S hazard?	

26. Appropriate Oxygen masks and tubing available?		27. Are Oxygen masks and tubing hygienic and dust free?	
28. Medicines Auditing system in place?		29. Evidence of individual service users' medicine audits being carried out?	
30. All homely remedy stock is in date?		31. All homely remedy liquids dated when opened?	

Section 5
Administration of Medicines

Practice	Comments
1. All medicines administered by registered nurse (nursing care)?	
2. Photocopy of all current prescriptions available?	
3. Designated staff have received training in administration of medicines?	
4. Method of administration? E.g. direct from bottle or monitored dosage system (MDS)?	
5. All service users have their own individual supply of medicines?	
6. Were service user's identities checked before administration?	
7. Was one person involved in administration throughout process?	
8. Is there evidence of secondary dispensing? E.g. "potting up" more than one person's medication at a time?	
9. Are records signed at time of administration?	
10. Is there a reference book to guide staff? e.g. BNF, MIMMS, NMC guidance	
11. Is there evidence of covert administration? Jam, spoon, pestle, and mortar possible indicators.	
12. Are eye drops, creams, ointments etc dated at time of opening?	

Section 6
Medication Administration Records (MAR)

Practice	Comments
1. Pre-printed or handwritten MAR?	
2. Service users' name, DOB, GP recorded?	
3. Photographs used?	
4. Drug name, strength, dose, route, time recorded?	
5. Drug allergies recorded?	
6. Is the information accurate and legible?	
7. Any correction fluid used?	
8. Are there gaps in recording?	
9. Are reasons noted for non-administration?	
10. Amendments/Cancellations are made with one line through the item and are signed and dated?	

Section 7
Controlled Drugs Register

Practice	Comments
1. Controlled drugs all logged into register?	
2. Record of administration includes name of service user?	
3. Drug name, strength, dose, route, time recorded?	
4. Two signatures recording administration	
5. Is there evidence of regular stock / balance check?	
6. Is there evidence that the community pharmacist has checked CDs?	
7. Any evidence of borrowing one service user's medication for another?	
8. Is the information accurate and legible?	

Action Required	By Whom	Timescale

Incomplete Actions from previous audit

Action Required	Persons to complete	Date for completion	New date for completion

Signature	Date

Appendix 7/8

Individual Resident Medication Audit Fc

Remote Auditing- Treatment Room inc

Appendix 9

Homely Remedy Protocol for Minor Ailments.

Resident ..... DOB .....

I, Dr..... agree to the following "over the counter" medicines being administered to the above named resident in accordance with the following directions.

(Please delete any medication on the list that would be inappropriate for this resident)

Medicine	Dose	Route	Directions & Reason for Administering	Maximum dosage
Paracetamol For persons less than 50kgs	500mgs	Oral	4 – 6 hourly for Pain	No more than 4 tablets (2G) in 24 hours. Do not administer if resident is already prescribed any medication that contains Paracetamol
Paracetamol	1G	Oral	4 – 6 hourly for Pain	No more than 8 tablets (4G) in 24 hours. Do not administer if resident is already prescribed any medication that contains Paracetamol
Peptac Suspension	10mls	Oral	After meals and at bedtime for Heartburn and acid reflux	6 times per day
Simple Linctus	10mls	Oral	Non-productive cough	4 times per day
Senna Tablets	2 tabs	Oral	At night for Constipation	Once per night. (Acts in 8 – 12 hours).
Senna Solution	10mls	Oral	Twice daily for constipation	Review after 3 days
Loperamide	2mg	Oral	4mgs initially for diarrhoea, followed by 2mg after loose stool	Do not exceed 8 capsules per day

Please note:

- Treatment should not last for more than 72 hours without referring to a doctor.
- Medication administered must be recorded on the reverse of the residents MAR sheet along with the reason for administration and the outcome.

Dr's. Signature .....Date .....

Managers Signature . .....Date .....

Annual Review Date .....

VIEWPOINT CARE HOMES – LEAVE MEDICATION WHEN RESIDENT IS AWAY FROM THE CARE HOME (PROTOCOL 1)

This document is to explain the care home's approach to those occasions when a resident spends time away from the home e.g. visiting family, and needs to continue taking prescribed medication that would otherwise be administered by the home's staff.

It is not intended to cover times when the person has been admitted to hospital. Where residents are responsible for their own medication in the home it can be expected that they will continue to be responsible for their medication when away from the care home, subject to an assessment of any risks to the safe taking of their medication while away.

The Royal Pharmaceutical Society (RPS) has defined secondary dispensing as 're-packaging a medicine that has already been dispensed by a pharmacist or a dispensing doctor'. This is not good practice. Supplied medicines need to be labelled in line with legislation or the dose administered immediately. There will be unavoidable circumstances when you need to supply medicines at short notice. If the prescriber or supplying pharmacy are unable to provide a solution, you may need to consider alternative measures to ensure the person does not miss any doses. Seek advice from the prescriber on how this can be done legally and safely. You must assess the risk of these measures. You must fully document any decisions taken.

Where staff are responsible for the administration of medication within the home it can be expected that the responsibility for continuing to give the prescribed medication away from the home will be assumed by a designated carer such as a relative or friend. The home will then enter into an agreement with the designated carer that she/he will be responsible for the resident taking their prescribed medication safely in line with the prescription and care plan.

The home will always make sure that the designated carer:

- Is included in the assessment of risks, identifying and minimising any potential problems - for example, the risk assessment should identify issues related to controlled drugs or other medicines liable to abuse
- When the resident cannot take their medicines without support – the designated carer will support them while they are away?
- Knows what the medicine is intended to do.
- Is supplied with the correct medication as originally prescribed by the GP and dispensed by the pharmacist.
- Clear directions and advice on how, when, and how much of each medicine the resident should take.
- The time of the last dose taken and when the next dose of each medicine will be due.
- Knows how to support the resident, to make sure resident in their care receive medicines safely.
- Knows whether there are any special precautions, e.g. to give the medicine with food.
- Knows, If any medicines are to be taken 'when required', there should be clear instructions provided on when to take the medicine.
- Specific medications such as control drugs will have specific instructions and guidance.
- Will be able to confirm by recording that the medication has been taken as prescribed.

- Will report any discrepancies or difficulties in following the prescription plan so that any implications can be checked.
- Will take action to remedy any difficulties and knows how to obtain help and advice if necessary, e.g. if the medication runs out.
- Will keep the medicines in a safe place and in line with storage instructions.
- Will not administer any additional medication without seeking professional advice.
- Will not administer any medication covertly.
- Will return to the care home with any remaining medication (including medication not taken) to be signed back in by care home staff and the completed record sheet. The record sheet should then be kept with the current MARs and archived together.

The home asks the designated carer to sign to confirm that she/he:

- Accepts the responsibility for the safe storage and administration of ALL the person's medication, and this includes medication that requires to be refrigerated.
- The designated carer accepts and agrees, that the correct quantity of medication(s) have been issued to them for the duration of the residents leave period.
- Quantities being checked out on behalf of the resident to the designated carer, have all been detailed individually.
- Can meet the conditions that are described above.
- Will report on the residents return, that the medication has been administered safely as prescribed and will report any difficulties that have arisen.
- During the period of absence the designated person/carer responsible for the administration of medication, must ensure the resident's medication record is kept up to date, recording the medication has been taken and or recording that it has not.
- Care Home staff should provide the designated person/carer with the supplying pharmacist & GP details and contact telephone numbers for help and advice in dealing with the specific circumstances.
- Care home contact telephone/mobile numbers should be provided to the designated person/carer.
- The homes staff must not secondary dispense the resident's medications into another container (i.e. not to re-package a medicine that has already been dispensed by a pharmacist).
- The medicines are the person's property, not the care homes.

NB: It is the responsibility of the practitioner, to ensure that he/she always refers to the most up to date guidance when dealing with all aspects relating to medicine handling.

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