Lindridge Medicines Code: Safe Handling of Medicines

POLICY NUMBER	TP/CL/040
POLICY VERSION	V1
RATIFYING COMMITTEE	Drugs and Therapeutics Group Professional Policy Forum
DATE RATIFIED	07th July 2021
NEXT REVIEW DATE	06th July 2024
DATE OF EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT (EHRIA)	
POLICY SPONSOR	Chief Nursing Officer
POLICY AUTHOR	Deputy Chief Nurse Associate Director of Operations - Lindridge Care Home Deputy Chief Pharmacist

EXECUTIVE SUMMARY:

- To ensure the safe and secure handling of medicines.
- To ensure compliance with infection prevention and control structure.

This policy must be read and complied with by all members of staff who are involved in the assessment of a service user's care needs or who are involved in supporting the service user with their medicines.

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Team on: 0300 304 1195 or email: policies@sussexpartnership.nhs.uk

Did you print this document yourself?

Please be advised that the Trust discourages the printing and retention of hard copies of policies and can guarantee that the policy on the Trust website is the most up-to-date version.

As a contingency a full set of up-to-date Trust policies are held by the Corporate Governance Team based at Trust HQ, Swandean

carehome LINDRIDGE

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1.0 Introduction

1.1 Purpose of policy

The aims of this document are:

- To promote independence by encouraging people to manage their own medicines as far as they are able.
- To ensure that the safest possible practices are used when supporting people with their medicines.
- To prevent avoidable admissions to hospital by supporting people with their medicines appropriately.

This policy must be read and complied with by all members of staff who are involved in the assessment of a service user's care needs or who are involved in supporting the service user with their medicines.

The following documentation has informed this policy. Staff are encouraged to be familiar with these documents, especially those staff who are registered practitioners.

- **Standards for Medicines Management** (2017) published by The Nursing and Midwifery Council available: https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-medicines-management/

- **NICE Social Care Guidelines (SC1): Managing Medicines in Care Homes** (2014). Published by the National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/Guidance/SC1

- **NICE Quality Standard: Medicines Management in Care Homes** (2015). Published by the National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/guidance/qs85/resources/medicines-management-in-care-homes-pdf-2098910254021

- **NICE Guidelines (NG27): Transition between inpatient hospital settings and community or care home settings for adults with social care needs** (2015). Published by National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/guidance/ng27/chapter/Recommendations

- **The Handling of Medicines in Social Care (2007).** Published by the Royal Pharmaceutical Society of Great Britain, available: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/handling-medicines-socialcare-guidance.pdf?ver=2016-11-17-142751-643

- **CQC – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment – section 2 g/f provides** compliance guidance for care home providers against what Care Quality Commission inspectors are looking for when they visit carehomes.

1.2 Definitions

- MAR- Medicines Administration Record. The legal record of a medicine being administered or not administered.
- OTC- Over the counter in reference to medications/supplements that can be obtained without a doctor's prescription.
- POD- Patient's Own Drugs in reference to the POD locker where they would be stored.
- CD- Controlled Drug.
- GP- General Practitioner.
- RN- Registered Nurse.

1.3 Scope of policy

People should be encouraged, where appropriate and following a risk assessment, to retain, self-administer and control their own medicines in order to maximise their independence and retain control over their own lives. People who have been assessed as being unable to manage their own medicine without assistance need to be protected by the home's medicine policy.

All staff involved in the service user's care are responsible for ensuring that medicines are managed appropriately. The primary responsibility for the prescribing and monitoring of medicines and the service user's condition rests with their General Practitioner (GP) in consultation with other healthcare professionals involved in the care of that individual.

1.4 Principles

1.4.1 The rights of the service user must be respected at all times

1.4.2 The support provided must be tailored to the individual and wherever possible the service user should be able to self-administer their medicines if they wish to do so and this would be safe, following the appropriate assessment.

1.4.3 All people moving into the home must be assessed for the level of support they need with their medicines and agreement reached with the service user regarding the support that the home will provide.

1.4.4 It is the responsibility of relevant health professionals to explain the importance of medicines and any potential side effects to the service user and their families or carers and the staff who administer their medicines.

1.4.5 Guidance for service users and staff can be sought from the homes' own pharmacist, or via the community pharmacy who supplies the medicines. The current regular pharmacy is: Boots Pharmacy –North Street Brighton 01273 749883

1.4.6 The handling of medicines within the home must be in line with medicines policy, whether the service user is self-administering their medicines or requires support.

1.4.7 All medicines administered or non-administered must be recorded as such on the Medicines Administration Record (MAR) sheet.

1.4.8 Service users who wish to self- administer must have had a risk assessment completed (see section 9).

1.4.9 Medicines prescribed and dispensed for one service user must not under any circumstances be used for another service user or for a purpose different to that for which it was prescribed.

1.4.10 While the administration of medicines tends to follow routine administration times; e.g. morning, lunch, tea, night this is not always the case – for example where medicines are to be taken with food/after food. Meal times should be avoided when planning drug administration times (unless specifically to be given at mealtime).

1.4.11 In addition, it is the responsibility of the nurse in charge of the unit for the shift to ensure that medicines which do not fall into the usual pattern are not forgotten/delayed.

1.4.12 Dressings, catheters and creams are individually prescribed items and should be signed for on the service users MAR sheet (or topical MAR if in use). Under NO circumstances should individually prescribed items be used for another service user.

1.4.13 Some medicines will be prescribed in variable doses according to blood results – e.g. Insulin. Extreme care should be taken when administering these medicines to ensure the correct dose is given. If unclear seek advice from the Home Pharmacist/Manager/Care manager/senior registered nurse on shift and counter check prior to administration.

1.4.14 Medicines should never be used as a form of chemical restraint.

2.0 Policy Statement

This policy is intended to ensure that medicines are handled appropriately, in accordance with the following legislation and guidance as relevant to the setting:

- Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities)
- (Amendment) Regulations 2015
- The Medicines Act 1968 and the Human Medicines Regulations 2012
- The Misuse of Drugs Act 1971 and associated regulations
- Guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Pharmaceutical Society.
- Equality Act 2010
- Mental Capacity Act 2005
- Nursing and Midwifery Council (NMC) Standards for Medicines Management 2007

3.0 Duties

3.1 Registered Manager - is responsible for implementing this policy within Lindridge carehome; monitoring and auditing the administration of medicines and ensuring that staff who administers medicines have been trained and are competent to do so.

3.2 Qualified staff – are responsible for ensuring that medicines are administered in line with this policy and professional guidelines and to bring to the attention of the registered manager any breaches of this policy.

3.3 All staff – who administer medicines have a duty to do so safely, professionally and in accordance with this policy.

Staff are reminded that they work within their sphere of skill and competence and while the management of Lindridge will aim to at all times fulfil their obligations to provide staff training/guidance/monitoring and will audit practices. Staff have a duty to bring to the attention of management any concern the may have around their own breath of knowledge and practice to ensure that the right support can be given.

4.0 Procedure

4.1. General principles

4.1.1. The rights of the service user must be respected at all times

4.1.2. The support provided must be tailored to the individual and wherever possible the service user should be able to self-administer their medicines if they wish to do so and this would be safe, following the appropriate assessment.

4.1.3. All people moving into the home must be assessed for the level of support they need with their medicines and agreement reached with the service user regarding the support that the home will provide.

4.1.4. It is the responsibility of relevant health professionals to explain the importance of medicines and any potential side effects to the service user and their families or carers and the staff who administer their medicines.

4.1.5. Guidance for service users and staff can be sought from the homes' own pharmacist, or via the community pharmacy who supplies the medicines. The current regular pharmacy is:

Boots Pharmacy – North Street Brighton - 01273 749883

4.1.6. The handling of medicines within the home must be in line with medicines protocol, whether the service user is self-administering their medicines or requires support.

4.1.7. All medicines administered or non-administered must be recorded as such on the Medicines Administration Record (MAR) sheet.

4.1.8. Service users who wish to self- administer must have had a risk assessment completed (see section 9).

4.1.9. Medicines prescribed and dispensed for one service user **must not under any circumstances** be used for another service user or for a purpose different to that for which it was prescribed.

4.1.10. While the administration of medicines tends to follow routine administration times; e.g. morning, lunch, tea, night this is not always the case – for example where medicines are to be taken with food/after food. Meal times should be avoided when planning drug administration times (unless specifically to be given at mealtime).

4.1.11. In addition, it is the responsibility of the **nurse in charge of the unit** for the shift to ensure that medicines which do not fall into the usual pattern are not forgotten/delayed.

4.1.12. Dressings, catheters and creams are individually prescribed items and should be signed for on the service users MAR sheet (or topical MAR if in use). Under **NO** circumstances should individually prescribed items be used for another service user.

4.1.13. Some medicines will be prescribed in variable doses according to blood results – e.g. Insulin. Extreme care should be taken when administering these medicines to ensure the correct dose is given. If unclear seek advice from the Home Pharmacist/Manager/Care manager/senior registered nurse on shift and counter check prior to administration.

4.1.14. **Medicines should never be used as a form of chemical restraint.**

4.2. Confidentiality and sharing of information

4.2.1. Information regarding a service user's medicines and health must be treated confidentially and respectfully. All records must be stored securely where they cannot be accessed by unauthorised persons.

4.2.2. Information about a service user should only be disclosed with that service user's consent unless the home is legally obliged to share the information.

4.2.3. Any information shared must be relevant, necessary and proportionate.

4.2.4. If the service user agrees, relevant information about them can be shared with their relatives or nominated representatives. The agreement for sharing information should be documented in the care plan.

4.2.5. Information should be shared with health and social care professionals involved in the direct care of the service user where it is needed for the safe and effective care of the individual, unless the service user has refused to share the information. The service user's refusal should be documented via the "Permissions sheet" and in their care plan.

4.2.6. If a service user attends an appointment with a healthcare professional outside of the home it is important that information is available to that healthcare professional, unless the service user has refused consent. This information should be given by the service user themselves, wherever possible; however, nurses should ensure that the service user (or the person accompanying them, if appropriate) has with them a copy of the current medicines administration record (MAR) chart or is provided with the same details in another written form. Information should also be provided on recent changes to medicines and changes to the service user's health and wellbeing, as appropriate.

4.2.7. Information sharing must adhere to Information Governance principles.

4.2.8. If the service user lacks capacity to give consent for sharing of information the opinion of the person with lasting power of attorney for health and welfare (if one exists) should be sought, otherwise the decision will need to be made in accordance with the Mental Capacity Act and a best interest decision made.

4.3. Admitting service users into the carehome

When a service user is to be admitted into the home, whether from their own home, following discharge from hospital, from another service provider or where the service user already using the service is returning to the home following discharge from hospital.

4.3.1. Pre-admission:

- Before a planned admission to the home it must be made clear to the service user/their representative or the hospital/other service provider that the following requirements must be met regarding the service user's medicines:

4.3.2. Admission from patients' home: patients admitted directly from their own home or supported accommodation should be issued with a supply of medicines (either from supplying pharmacy or patient's own medicines(s)) and MAR chart prior to admission to the unit. Where this is not possible, nursing staff will be required to transcribe medicines.

4.3.3. Discharge from acute or community hospital: All discharges from other secondary care services are required to provide a minimum of two weeks of all currently prescribed medicines (including any prescribed "as required" medicines") and a discharge summary. Medicines must be correctly labelled for the individual patient, and the discharge summary should detail all current prescribed medicines(s) and any changes during inpatient admission. Where possible the transferring hospital should also supply a MAR chart. Where this is not possible, nursing staff will be required to transcribe medicines.

4.3.4. Transfer from other service provider(s): All discharges from other services are required to provide a minimum of two weeks of all currently prescribed medicines (including any prescribed "as required" medicines") and a discharge summary. Medicines must be correctly labelled for the individual patient, and the discharge summary should detail all current prescribed medicines(s) and any changes during inpatient admission. Where possible the transferring hospital should also supply a MAR chart. Where this is not possible, nursing staff will be required to transcribe medicines.

4.3.5. This is to ensure that both medicines and the means of administering are available to the home on admission of the patient and whilst the home establishes a new and ongoing supply. For short stay/respite the medicines provided should be sufficient to cover the whole stay wherever possible.

4.3.6. All prescribed medicines must be supplied in the container as originally dispensed by the pharmacy/dispensing GP or hospital pharmacy and have the dispensing label attached.

4.3.7. Any non-prescribed medicines must be provided in the original packaging as purchased which includes the manufacturer's full directions for use and the expiry date of the product. Any over the counter (OTC) supplements and non-prescribed medicines should be checked for suitability and drug interactions with the homes' pharmacist. The service users usual prescribing GP must be made aware of any OTC medicines that they intend to keep using.

4.3.8. Before a planned admission it should be determined if the service user requires medicines to be administered by a specialised technique, for example via an enteral tube. If this is the case, to allow the admission to proceed, the home must ensure that sufficient nurses who have up to date training on the specialised technique are available to meet this need or that arrangements are made with appropriate health care professionals to meet the need on a temporary basis while training is undertaken.

4.3.9. Part of the pre-assessment process should determine with the service user or carer how their medicines is to be managed at the home. Where this is not possible, this must be done as soon as possible after admission by the nursing staff and the appropriate procedure as outlined in section 9 for those who may wholly or partially self- administer**.**

4.4. On admission and medicines reconciliation:

4.4.1. The admission process relating to medicines should be undertaken by a nurse.

4.4.2. On the day of admission nursing staff should co-ordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan.

4.4.3. This process should ensure that the patient or family member / carer, a pharmacist and other healthcare and social care practitioners are involved in the process.

4.4.4. Staff must capture:
4.4.4.1 Resident's details, including full name, date of birth, NHS number, address and weight
4.4.4.2 GP's details
4.4.4.3 Details of other relevant contacts defined by the resident and/or their family member or carer (e.g. regular pharmacist, specialist nurse).
4.4.4.4 Known allergies and reactions to medicines or ingredients, and the type of reaction experienced. For example – penicillin: rash
4.4.4.5 Medicines that the resident is currently taking, including name, strength, form, dose, timing and frequency, and how the medicine(s) is taken and what for (if known),
4.4.4.6 Changes to medicines including stopped, started or dose changes.
4.4.4.7 Date and time the last dose of any "as required" medicine was taken or any medicines given less often than once a day
4.4.4.8 Any other information, including when medicine should be reviewed or monitored, and any support the resident needs to carry on taking medicines.
4.4.4.9 Any information given to the patient and/or family member or carer.

4.4.5. The information must be recorded in the patient's notes and staff member(s) completing the medicines reconciliation must record their details – name, job title and date completed.

4.4.6. The above information should be ascertained from hospital discharge letters or the information from another provider. If the service user is coming from their own home this should be provided by the patients' GP. All medicines should be confirmed with the service

user or their carer. If there are any gaps in the information, nursing staff should attempt to obtain the information from the relevant service user, supplying pharmacy or GP practice. Two sources of information should be used when determining medicines on admission to service.

4.4.7. The medicines reconciliation may be performed by the homes' pharmacist on admission. Where this is the case, nursing staff remain responsible for care planning and providing clear documentation as above, in addition to the pharmacy medicines reconciliation.

4.4.8. Where MAR charts or any other supporting information is provided, this must be checked against medicines reconciliation to ensure information is accurate.

4.4.9. Nursing staff should establish at the time of admission when the next dose of medicines is due so that arrangements can be made to ensure the service user does not miss doses of medicines while the admission process is occurring.

4.4.10. For all people entering the home, nursing staff must establish which medicines the service user has brought with them and check each medicine to establish that:

4.4.10.1 Medicines is currently prescribed for the patient
4.4.10.2 Medicines is correctly labelled for the individual service user
4.4.10.3 All medicines are in date
4.4.10.4 The medicines have been recently dispensed (If the date on the label is old this may indicate that the medicines is no longer being used.)

4.4.11. The current medicines must be confirmed by comparison with information from the service user's GP (for example, fax GP summary or pharmacy repeat slip) or from the hospital discharge information.

4.4.12. Discrepancies between the written information and the medicines brought into the home must be recorded and checked with the relevant healthcare professional. Where a service user already living at the home is returning from a stay in hospital, the discharge information and medicines should be compared with previous records of medicines and any unexpected changes queried with the hospital.

4.4.13. Where written information is not available (for example, emergency admission) the nurse must contact the relevant health care professional (for example, GP or hospital) to confirm the medicines that the service user is currently taking.

4.4.14. Written confirmation of the information provided should be requested from the health care professional contacted.

4.4.15. The receipt of all medicines must be documented (see section 6). Where staff are to administer the medicines a MAR chart will be required. For residents who are self-administering their medicines (see section 9) self-administration record is required.

4.4.16. On admission nurses must complete the "New Admission 72 Hour Checklist – found on the Sussex Partnership NHS Foundation Trust internal 'B: drive' and advise the unit clerk of new admission medicines requirements. This will initiate the process by which, if

required, a change of GP is initiated and medicines ordered to align with the cycle for the home.

4.5. Prescribing of medicines in the carehome

4.5.1. Healthcare professionals prescribing a medicine must:
4.5.1.1 Assume the patient has the capacity to make decisions
4.5.1.2 Assess a patient's mental capacity in line with Mental Capacity Act (2005)
4.5.1.3 Record any assessment of mental capacity in the resident's care plan.

4.5.2. Routine prescribing and monitoring of medicines should be undertaken by the patient's GP against valid prescription requests.

4.6. Changes in medicines

4.6.1. If a service user's medicines are changed the MAR chart **must** be updated by the prescriber, completing all the mandatory fields to ensure medicines can be ordered and administered. The prescriber must notify the senior nurse to ensure staff are aware of the change in medicines, and supply can be arranged. Where prescriber does not amend the patient's MAR chart, a nurse can amend – this amendment must be second checked by another medicine's competent member of staff against the prescribers' instructions.

4.6.2. Changes to medicines must be communicated with nursing staff on duty. The change must also be noted in the handover information, so that it is passed on the next shift.

4.6.3. The original entry on the MAR chart must be cancelled by drawing a diagonal line through it, and any remaining signature spaces should be ruled through. A note must be added to the entry detailing the change which has occurred, and the name of the health care professional authorising the change.

4.6.4. A corresponding entry must be made in the service user's care plan.

4.6.5. If a verbal change of dose is requested by a prescriber (remote order), for example, during a telephone call, the prescriber must provide written confirmation of the request, either as an email or fax. This must be documented on the MAR chart and in the service user's care notes by the nurse receiving the remote order. This must include the name of the authorising prescriber and the date the change was made. In exceptional circumstance where the prescriber is unable to provide written confirmation, a verbal order may be accepted, but should be repeated by the prescriber to a second trained and competent member of staff, if available. This must be recorded verbatim in the patient notes, and include the name of both staff members receiving the message. The prescriber must be requested to provide written confirmation of the change of dose as soon as possible.

4.6.6. Any medicines held by the home, which has been discontinued by a healthcare professional, must be disposed of in accordance with the home's medicines protocol (see section 20).

4.6.7. The pharmacy/dispensing GP should be informed of any changes to the medicines and asked to remove any discontinued medicines from the next MAR chart, if appropriate. Staff must complete the relevant supplying pharmacy request form to ensure medicines is amended for any future supply.

4.6.8. Patient's care plan should be updated as soon as possible to capture the changes to medicines.

4.7. Medicines review

4.7.1. GPs should ensure arrangements are in place for patients within the home to have medicines reviews as detailed within individual care plans.

4.7.2. Care home staff can identify patients requiring medicines review by referring to the practice GP or practice Pharmacist.

4.7.3. If the home has no record of a review of the medicines occurring within the previous months, the GP must be contacted to ask if a review would be appropriate. The response of the GP must be documented in the resident's care plan.

4.7.4. Relatives or nominated representatives must be included in the review, if this is wished by the resident. If there is a person with lasting power of attorney for health and welfare for a resident without capacity then they should be invited to the review.

4.7.5. If a resident requires support with medicines, a nurse able to provide appropriate information to the healthcare professional undertaking the review must be available.

4.7.6. The review may also include other health care professionals relevant to the resident's care (multidisciplinary review). This will be decided by the health care professional leading the review.

4.7.7. The date of the review and the name of the health care professional undertaking it must be recorded in the resident's care plan. Any outcomes from the review must be documented and actioned.

4.7.8. Nurses working at the home must also keep a resident's health and welfare under review and seek the advice of the GP where appropriate.

4.7.9. Medicines review should consider:

4.7.9.1 the purpose of the medicines review
4.7.9.2 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

4.7.9.3 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

4.7.9.4 all prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
4.7.9.5 how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
4.7.9.6 any monitoring tests that are needed
4.7.9.7 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
4.7.9.8 helping the resident to take or use their medicines as prescribed (medicines adherence)
4.7.9.9 any more information or support that the resident (and/or their family members or carers) may need.

4.7.10. Any changes to medicines should be documented as detailed as above.

4.8. Transcribing of medicines:

Transcribing medicines is permitted within the home in exceptional circumstance where obtaining a printed MAR chart for administration is either not possible or will delay the start to treatment. For example, a newly admitted patient without a MAR chart to the unit. In such instances, the following process should be followed:

4.8.1. General principles

Transcribing should be a last resort - A MAR chart should always be obtained from the supplying pharmacy wherever possible.
4.8.1.1 Transcribing must ALWAYS be double checked by a second qualified person.
4.8.1.2 Ensure you will not be disturbed during the transcribing or checking process.
4.8.1.3 Both the transcriber and checker need to initial each item that has been transcribed (this in is addition to the stock sign-in section on the MAR)
4.8.1.4 A printed MAR chart should be obtained as soon as possible, and once received, replace the transcribed MAR chart(s).

4.8.2. Before transcribing

4.8.2.1 Work from the most up-to-date information source e.g. hospital discharge letter. If a GP visits the home and leaves a prescription to be sent to a pharmacy, photocopy it before sending it to be dispensed so you can check against this when the medicines arrives.
4.8.2.2 Check the dispensed medicines matches the information source you are using:

- *For the correct service user?*
- *Medicines dispensed matches the information source?*
- *Medicines strength matches the information source?*
- *Medicines dose and frequency matches the information source?*

- If the dispensed medicines you are about to transcribe does not match your information source – seek clarification from the prescriber before continuing

4.8.3. Transcribing onto the MAR

If more than one item is to be transcribed - do one item at a time (ensure all other items are out of sight to limit the chance of copying the wrong information.

4.8.3.1 Once you have checked the medicines in front of you matches the information source you are using (discharge summary, photocopy of prescription), you should check the medicines against the dispensing label on the item - check that:

- Medicine name on the label matches the name on the product packaging/foil strips inside the box.
- The strength of the product on the label matches the strength of the packaging/foil strips inside the box.
- The form written on the label (liquid/tablet/capsule/MR tablet etc) matches that written on the product packaging/foil strip inside the box.
- The correct service users' name is on the dispensing label.

4.8.3.2 Transcribe the information on the dispensing label across onto the MAR. As a minimum, the following information should be written onto the MAR:

- **Drug Name - Strength – Form**
- ***Directions for use (and length of treatment if a defined course)***
- ***Specific warnings (store in fridge, take with food etc***

4.8.3.3 If using a new MAR, remember you will also need to fill out the top of the MAR sheet to capture the service users' details including date of birth, GP and allergies.

4.8.3.4 Clearly identify the times of day the medicines should be given (morning, lunch, teatime or bedtime) and highlight using the appropriate coloured highlighter

4.8.3.5 "Box" the first due administration date on the MAR and draw a solid line from the start of the cycle up to this point so it is clear when the medicines will commence.

4.8.3.6 Initial the bottom right of the directions box on the MAR and pass to your colleague for double checking.

4.8.3.7 Another trained member of staff should double check the transcribing by repeating the steps detailed above. The person checking should also refer to the most up to date information source to be satisfied that the medicines and dosage have been prescribed for the correct service user in the first instance.

4.8.3.8 Once the checker is satisfied with the transcription, they should initial in the bottom right of the directions box on the MAR beside the transcriber's initials.

4.9. Ordering and obtaining prescribed medicines

4.9.1. The carehome operates a 28-day medicines cycle for all patients. Dispensed and labelled for each patient.

4.9.2. All routine medicines are supplied in dispensing boxes or original containers.

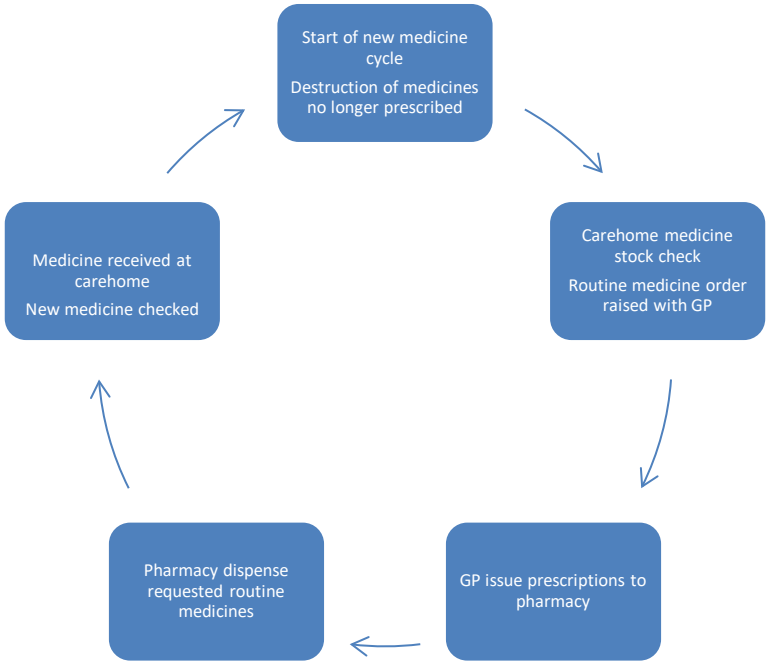
4.9.3. It is essential that no service user is without medicines and adequate stock levels are maintained as prescribed. All staff involved with the administration of medicines have a responsibility to ensure that either the nurse with designated responsibility for ordering medicines or the pharmacy medicines co-ordinator (or RN in charge of the shift in their absence) are informed via the handover procedure and direct communication if a service user is running low on their medicines so that it can be ordered in good time.

4.9.4. For new admissions – there is a 72 hour checklist to prompt actions enabling the ordering of medicines on admission. Found on the Sussex Partnership NHS Foundation Trust (SPFT) internal 'B: drive'.

4.9.5. If necessary, all staff involved in the administration of medicines should be able to order immediately required medicines.

4.10. Ordering procedure

4.10.1. The medicines must be ordered early enough in the cycle to allow for the time required by the surgery, pharmacy and home to complete their required tasks in the process. Process outlined below:



4.10.2. The regular medicines order is completed by the pharmacy and medicines co-ordinator in conjunction with the clinical /unit lead for each part of the home who has the responsibility for medicines.

4.10.3. The registered manager must ensure alternative arrangements are in place to initiate the order if the designated staff member is not available. At least one nurse from each unit must be able to order the medicines using the home's procedure.

4.10.4. Dedicated time must be set aside for the regular order to be done without distractions.

4.10.5. Before requesting any medicines, the current MAR chart must be checked for any medicines which has been changed or discontinued. Current supplies of medicines already at the home must also be checked especially for "when required" medicines; controlled drugs; creams and ointments; inhalers and liquids. Only medicines which will be needed next cycle and for which there is insufficient medicines to last the length of the next cycle at expected usage levels should be ordered.

4.10.6. The expiry date of medicines must be considered as some medicines have a short shelf life, once opened. Also, "when required" medicines which is used infrequently, for example, glyceryl trinitrate (GTN) sprays for angina, may go out of date before they are completely used. The expiry date/shelf life of the medicines must last to the end of the next cycle, if it does not, the medicine should be reordered.

4.10.7. Medicines must be ordered by requesting it from the surgery, using the online ordering as instructed by the surgery. If a medicine is required which is not yet on the online record, the surgery should be contacted to discuss the required medicines and followed up via email. A record of the medicines ordered must be retained by the home, including any notes sent. The record must contain exactly what was ordered for each service user, the date of the order and the initials (signature) of the nurse making the order – this information is currently all captured on the re-ordering MAR sheets sent to Boots for regular medicines.

4.10.8. Most medicines are prescribed electronically and directed automatically to the dispensing pharmacy. It is the responsibility of Lindridge staff to inform the pharmacy of the correct prescription fee exemption for residents who are UNDER 60 years old – this may be particularly relevant in the rehabilitation beds.

- Supplied medicines must be checked against the request sheet/MAR and any queries resolved in good time for the new cycle starting.

4.10.9. The nurse must alert the pharmacy to any medicines that is on the prescription which is not required that cycle, so that it is not dispensed. The surgery should also be informed so they can update their records.

4.11. Mid-cycle medicines

4.11.1. Medicines prescribed outside of the 28-day cycle will need to be ordered separately.

4.11.2. Care must be taken to ensure that medicines prescribed mid cycle does not run out before the next 28-day cycle commences.

4.11.3. Where the medicines are to be continued long term, the GP must be asked if they will prescribe a one-off quantity, which will bring the medicines into line with the regular 28-day ordering cycle. The nurse must advise the GP of the quantity required.

4.11.4. Until the medicines can be brought into line, or where it is only intended to continue for a specified period of time, a running stock balance must be kept on the MAR chart and the medicines reordered, if appropriate, when there are 14 days left. This must be done by the nurse with designated responsibility for ordering medicines wherever possible, but all staff administering medicines must be aware of the stock balance and ensure that the information is passed to the nurse with designated responsibility for ordering medicines, when the appropriate time is reached. This must be done via the handover diary and by direct communication with the designated nurse. Where this is not possible, the member of staff responsible for the administration of the medicines must order the medicines themselves and ensure that this is communicated and documented clearly.

4.11.5. If not already collected/received by the home, the order must be followed up no later than three working days or sooner if necessary, after it is made to ensure that the prescription has been issued. The prescription should be checked against what was ordered and any discrepancies resolved with the surgery.

4.11.6. Where medicines are to be reviewed before continuing, it is the responsibility of the nursing staff to ensure that arrangements are made with the prescriber to review the medicines before it runs out.

4.12. Acute prescriptions

4.12.1. Acute prescriptions are items which are prescribed in response to an illness, for example, antibiotics for an infection.

4.12.2. The nurse should ensure that they check with the prescriber how the medicines is to be taken and how long the course is to continue. Nurses must draw the attention of the prescriber to any allergies that the service user has.

4.12.3. It is essential that such medicines are obtained as soon as possible after it is prescribed and this should be on the same day.

4.12.4. The prescriber should issue a prescription directly to the usual supplying community pharmacy or the nearest open pharmacy if the usual pharmacy is closed.

4.12.5. The Supplying pharmacy should issue acute prescriptions urgently and will be required to issue a separate MAR chart for the acute medicines only.

4.12.6. Where it has been necessary to use a different pharmacy and a MAR chart could not be supplied, nursing staff may transcribe prescribed and supplied medicines on to the patient MAR chart to avoid delay in treatment.

4.13. Emergency supplies of medicines

4.13.1. In the event it is discovered that a service user is without their medicines, urgent action must be taken to establish a supply of the medicines as soon as possible.

4.13.2. The GP (or out of hours service, if necessary) must be contacted to request an urgent supply of the medicines, giving the reason why this is needed. Nursing staff must make arrangements to ensure that the prescription is dispensed as soon as possible.

4.13.3. The pharmacy must be contacted to explain the situation. The supplying pharmacy operates a late night urgent delivery cut-off of 17:00 hrs.

4.13.4. In the event of requiring emergency medicines after 17.00hrs, this must be sourced via the local late night chemist provision.

4.13.5. If the service user will miss doses of their medicines before it can be obtained, nurses must use their professional knowledge and judgement, and take the advice of a relevant health care professional regarding how to proceed. The Trust's omitted medicines can be used to determine appropriateness of delaying treatment. This may also necessitate contacting the out-of-hours GP for advice (via 111) or contacting the Trust on call pharmacist.

4.13.6. Any decision to withhold or delay treatment must be clearly documented in the patient's notes.

4.13.7. If the nurse does not contact a relevant health care professional, the reason must be recorded in the service user's care plan. The nurse is professionally accountable for this decision. The service user and/or their nominated representative must be informed of the situation, as appropriate to the service user.

4.13.8. The incident must be recorded as a medicine related incident and reported to the registered manager who will undertake an investigation to establish why it occurred and to prevent future reoccurrence.

4.13.9. Where harm has been caused as a result of the lack of medicines, a safeguarding report must be raised with the local safeguarding team and CQC informed on the appropriate form and via SPFT's safeguard incident reporting system.

4.13.10. The incident must be fully documented in the service user's care records and on the Trust online reporting system.

4.13.11. **This procedure must not be used to replace good ordering practices**.

4.14. Stock check

4.14.1. In addition to the above ordering process, the pharmacy and medicines co-ordinator will undertake a weekly stock check for all medicines prescribed for all patients, including "as required" and topical, liquids and controlled medicines.

4.14.2. Medicines due to run-out, before the start of the next 28-day cycle should be identified as part of this process. Any medicines due to run out before the next 28-day cycle should be ordered without delay.

4.14.3. Any medicines required before the next 28-day cycle starts should be ordered through the GP practice.

4.14.4. Balances should be recorded on running balance section of MAR charts in the following manner:

- All solid medicine types (tablets, capsules, sachets etc) should have the remaining quantity counted following the last administration of that medicines EACH DAY. Nursing teams are only required to count the number left in the residents' patient own (POD) locker (NOT the entire stock if excess is held in the clinic room)
- This balance should be entered on the MAR chart in the section titled "POD balance"
- Liquid medicines should not be repeatedly measured out as this will cause wastage. An estimate should be entered instead by subtracting the amount administered that day from the previous days balance. As with the solid medicines, this applies to the POD locker supplies only.
- The pharmacy & medicines co-ordinator will perform weekly clinic room counts for any excess medicines held. An excess stock sheet is produced and held in the front of the MAR charts for nursing teams to refer to should the POD stock run low mid-cycle. The pharmacy & medicines co-ordinator will add the excess count to the POD counts and fill in the TOTAL BALANCE box on the MAR charts.

4.15. Receipt of medicines

4.15.1. All medicines received by the home for an individual, whether prescribed or purchased, from whatever source, must be recorded by the nurse. The record must show:

- Date of receipt
- Name, strength and form of medicine

- Quantity received
- Name of the service user for whom the medicine is prescribed
- Signature of the member of staff receiving the medicine

4.15.2. Care should be taken to include medicine brought in from the service user's own home, discharge medicines from hospital and also medicines prescribed mid cycle. Quantities should be recorded on the running balance of the relevant MAR chart entry.

4.15.3. Where medicines have been ordered by the home, the medicines received must be checked against the record of medicines ordered. Any discrepancies, including unexpected changes or missing items, must be resolved with the pharmacy and the prescriber contacted if necessary, to ensure continuity of supply.

4.15.4. If the medicines received into the home differ unexpectedly from those received for the same service user in the past, nursing staff must check with the pharmacist/GP's surgery/hospital as appropriate before administering the medicines.

4.15.5. See section 6.8 for the extra requirements for recording of the receipt of controlled drugs.

4.15.6. A patient information leaflet (PIL) should be supplied with each medicine and these must be made available to the individual and staff administering medicines. If a PIL is not supplied, please request this from the pharmacy/dispensing GP.

4.15.7. Medicines received must be stored in a locked cabinet, refrigerator or controlled drug cabinet, as appropriate. The new supply must not be left unsecured.

4.15.8. Medicines purchased by the home must also be recorded. See section 10.14 for recording of homely remedies stock.

4.16. Labelling of medicines

4.16.1. For staff to administer a prescribed medicine, it must have a dispensing label attached by the pharmacy/dispensing GP containing the following:

- Service user's name
- Date of dispensing
- Name, form and strength of medicine
- The quantity dispensed
- Directions for use
- Precautions relating to the use of the medicine (if applicable)
- Name and address of the place where it was dispensed
- Directions "Keep out of the sight and reach of children"
- **Other details may also be included at the discretion of the pharmacist.**

4.16.2. Where the directions state 'as directed' or 'as before' or similar phrasing, nursing staff must contact the prescriber to clarify the directions. The full directions must be documented in the care plan, along with the name of the health care professional providing them. The directions should also be written on the MAR chart and any supplementary chart in operation. The prescriber must be asked to write full instructions on the prescription so this can be included on the label by the pharmacy/dispensing GP for future supplies.

4.16.3. In the case of multiple containers, each container must be labelled and specify "ONE of XXX containers". If the medicines is contained in several smaller containers within a labelled outer container, the small containers must be left in the labelled outer container.

4.16.4. For medicines which have an inner and outer box (for example, eye drops, inhalers, creams), the pharmacy should be requested to apply the label to the item and the outer container.

4.16.5. If the label becomes detached from the container, or illegible, then prompt advice from the supplying pharmacy should be sought.

4.16.6. On rare occasions, it may be appropriate for nursing staff to add the name of the service user to whom the medicines belong to in order to ensure that it is used for the correct service user.

4.16.7. For all internal and external liquids, insulin pens or where medicines have a limited shelf life once opened, the date of opening must be added to the medicines. The person administering the medicines must check at each administration that the medicines is not being used past its shelf life. Where this is not recorded, the date dispensed should be used to determine expiry date.

4.16.8. Care home staff must never alter the labels of dispensed medicines.

4.17. Storage of medicines in the carehome

4.17.1. The decision of where to store the medicines in the home should consider the size of the home and nature of the medicines supplied to the home. Medicines should be stored centrally or in an appropriate locked cupboard in the service user's room.

4.17.2. Most medicines should be stored below 25ºC and away from sources of heat and moisture. The directions on the product packaging, dispensing label or patient information leaflet should be followed regarding the storage conditions for each medicine. Where staff are not sure, or there are problems with the storage, the pharmacist should be contacted for advice. Examples of places **NOT** suitable for the storage of medicines include kitchens, bathrooms, toilets and sluices or next to heaters.

4.17.3. The room used to store medicines should usually be at a temperature below 25ºC. A thermometer should be monitored daily and the results recorded on the Medicines Refrigerator and Clinic Room Temperature Log (see Appendix 1).

4.17.4. If the ambient temperature exceeds 25ºC for a short period during a heatwave and this results in the clinic room temperature rising above 25ºC for a few days, this will not have an overall damaging effect on the medicines. However, if the temperatures above 25ºC are recorded for any other reason, the reason should be investigated immediately and the advice of the local pharmacy team sort.

4.17.5. All cupboards, trolleys and areas used to store or prepare medicines must be kept clean and tidy and should be in good condition. Spills should be cleared up immediately. Any equipment used in the administration of medicines must be clean and in good condition.

4.17.6. Medicines must be date checked on a monthly basis as part of regular stock checks and out of date medicines disposed of (see section 20). A date checking matrix is in operation for this purpose.

4.17.7. The home operates stock rotation, where new supplies should be placed behind older supplies when medicines is received, so that the older supplies are used first.

4.17.8. Medicines for internal use must be stored in the locked cabinet/cupboard or trolley provided. Cabinets/cupboards used for medicines storage must be of a robust construction, big enough to store the medicines appropriately and have a good quality lock and compliant with Misuse of Drugs Act (1971) standards. If a trolley is used to store medicines, it must be locked and tethered to a wall, or kept in a locked room to which only authorised staff have access to, when not being used to administer medicines. Adequate lockable storage must be provided at all times for all medicines, including those supplied in monitored dosage systems (MDS). This also applies to the new medicines received at the start of the new 28-day cycle.

4.17.9. Medicines must be stored tidily so that it is easy to locate each individual's medicines and to reduce the chances of it being mixed up with other people's medicines.

4.17.10. The security of medicines must not be compromised by cupboards being used for non-clinical purposes, for example, storing money or valuables.

4.18. Storage of Controlled Drugs

4.18.1. Controlled drugs (CDs), that require safe custody and are not being self-administered, must be stored in a CD cabinet which meets the requirements specified in the Misuse of Drugs (Safe Custody) Regulations. The cabinet should be bolted to a solid wall.

4.18.2. CD order paperwork and record books are classified as controlled stationary, and must be securely stored in a locked cupboard in the clinic room.

4.18.3. If CDs are incorporated into a monitored dosage system then the whole system which contains the CD must be kept in the CD cabinet.

4.18.4. People who are self-administering their prescribed CDs can hold their own individually dispensed supply of controlled drugs in their personal lockable, non-portable cupboard/drawer in their room.

4.18.5. Two appropriately trained members of staff should be involved in all aspects of controlled drug (CD) medicines. This must be two registered nurses or one registered nurse and a trained healthcare assistant. All healthcare assistants performing a second check of CDs must have had appropriate training to ensure that they are fully knowledgeable regarding the task for which they are to be involved. They must have been supervised by the registered manager and signed off as competent in this task using the form in Appendix 2. All completed forms must be retained for inspection by the registered manager. The healthcare assistant must also be aware of the procedure to follow if there are any concerns.

4.18.6. All controlled drugs must be entered into the controlled drug register. One page should be used per service user per specific drug. All entries must be signed by the designated person making the entry and then checked and countersigned by another member of staff. Entries must include receipt, administration and destruction of CDs. A running stock balance must be kept at all times and checked against the actual stock held.

4.18.7. When medicines are due to be given it will be signed, checked and countersigned out of the controlled drug book which will then be checked against the service user's MAR sheet before being administered and then recorded on the MAR sheet.

4.18.8. Liquid medicines should be dispensed using an appropriate measure for the volume of liquid to be dispensed – i.e. oral medicines syringes

4.18.9. All controlled drugs held in each unit are checked by a weekly and monthly manager check. These checks must be recorded in the CD register.

4.19. Storage of oxygen

4.19.1. Oxygen is a prescription only medicine and MUST be prescribed on an individual service user basis and is not transferable.

4.19.2. A risk assessment must be completed for the storage and use of oxygen in line with health and safety procedures.

4.19.3. Oxygen cylinders should be stored safely, under cover and not subject to extreme temperatures. This should be in a dry, clean, well-ventilated area away from highly flammable liquids, combustibles and sources of heat and ignition. A statutory warning notice should be displayed in any room/area where oxygen is stored or used, stating: "**Compressed gas. No Smoking. No naked Lights"**

4.19.4. Cylinders should be handled with care, never knocked violently or allowed to fall over. They must be switched off when not in use. Cylinders should only be moved with a trolley specifically designed for the cylinder size unless it is a small portable cylinder.

4.19.5. 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.

4.19.6. In the case of fire, it is the responsibility of staff to inform the fire brigade that oxygen cylinders and/or concentrators are present and where they are located. When evacuating people from the home, oxygen concentrators or cylinders left in the home should be switched off, where it is safe to do so, as part of the evacuation process.

4.20. Medicines administration

Responsibility for the administration of medicines

4.20.1. Where a service user is not administering their own medicines, a registered nurse will have overall responsibility for safe administration of the medicines.

4.20.2. The administration of medicines could be delegated to appropriately trained and competent members of care staff. This is most commonly done for the application of bland emollients, the use of barrier preparations and the administration of nutritional supplements. The administration of internal oral medicines must only be performed by qualified nurses, nurse associates or senior carers who have satisfactorily completed the medicines competence assessment.

4.20.3. The nurse authorising the task to be delegated is responsible for ensuring that the member of staff is competent to carry out the task. The training and competency assessment for the member of staff must be recorded. Competency should be reassessed on an annual basis or sooner if required. A written record should be kept of the members of care staff who are trained to carry out delegated tasks and which tasks have been delegated to them.

4.20.4. The whole task should be delegated including the selection of the product and recording of the administration. The nurse delegating the task must make checks as detailed in section 10 to ensure that the medicines is being administered as prescribed and retains overall responsibility for the principles of administration.

4.20.5. The member of care staff undertaking the delegated task must ensure they follow the home's procedures and must report any problems to the nurse, including when supplies of medicines are running low.

4.20.6. Nurses delegating tasks to members of care staff should ensure that they do so in accordance with the requirements of the NMC Standards of Medicines Management.

4.20.7. The administration of controlled drugs should not be delegated to members of care staff, although suitably trained and competent members of care staff could act as witnesses to the administration of controlled drugs when necessary.

4.20.8. The administration of medicines given by invasive or specialised techniques should not be delegated to care staff and should only be performed by qualified nurses who are competent in these specific techniques.

4.20.9. Members of care staff who have not been trained and assessed as competent must not administer any medicines under any circumstances.

4.20.10. In accordance with the above, medicines that is not being self-administered will only be administered by registered nurses or a trained and competent member of care staff to whom the task has been delegated by a registered nurse.

4.20.11. Medicines must only be administered by a registered nurse or a trained and competent member of care staff to whom the task has been delegated by the responsible nurse.

4.20.12. Staff involved in the administration of medicines must only give medicines that they are competent to administer.

4.20.13. Medicines must be administered strictly in accordance with the prescriber's instructions. Nurses have a duty to use their professional knowledge to ensure that it is appropriate to administer the medicines on each occasion, and to contact the prescriber if they have concerns.

4.20.14. Medicines prescribed for one service user must never be given to another service user, or used for a different purpose.

4.20.15. Medicines must be administered in a way which respects the dignity and privacy of the service user. The wishes of the service user must be documented and complied with wherever possible.

4.20.16. When medicines are being administered, distractions should be limited as far as possible. All staff must support the service user administering medicines in this by deferring questions and telephone calls etc. until after the medicine administration process is complete, unless it is urgent that the incident is dealt with at that time. For example, the phone call is in regard to medicines changes.

4.21. When administering medicines

4.21.1. Before starting a medicine round the following items must be available:

- Jug of water with glasses
- Medicine pots that can be used to decant medicines into.

- Drug trolley containing medicines required e.g. items from the fridge, medicines from the residents' POD locker.
- Small container (labelled 'medicines for disposal') for refused/unwanted medicines.
- MAR sheets – currently in use.
- Photographs or other form of identifying service users.
- Black pen.
- Wash hands before administering the medicine

4.21.2. Staff must adhere to the below procedure remembering the key headlines for safe practice:

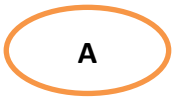
4.21.2.1 Read the instructions on the MAR chart including checking for any specific preferences/information for the individual.
4.21.2.2 Check that the prescribed dose has not already been given or cancelled.
4.21.2.3 Select the medicine required by reference to the MAR chart.
4.21.2.4 Check the label on the medicine against the MAR chart entry. Where there is a difference, satisfy them self as to the dose to be given by referring to the care plan or the service user's GP, as necessary.
4.21.2.5 Ask the service user if they want their medicines, unless otherwise stated in the service user's care plan.

4.21.3. Prepare the medicines for administration double checking:

4.21.3.1 The name of the service user receiving the medicines
4.21.3.2 The name, strength and form of the medicines
4.21.3.3 The dose
4.21.3.4 The way the medicines is to be administered
4.21.3.5 Check the identity of the service user receiving the medicines
4.21.3.6 Assist the service user into an appropriate position, if needed.
4.21.3.7 Administer the medicine, offering a glass of water as appropriate.

4.21.4. Record the administration on the MAR, after visually witnessing the service user taking the medicines, by placing their initials in the correct space on the MAR chart or completing the supplementary chart, as appropriate

- **OR**
- Record that the medicines has not been taken by using an appropriate code which is explained on the MAR chart - Circle the entry and initial below. This will enable clear identification of medicines not administered.



- ***Initials of administering nurse here***

4.22. At the time of administration:

When medicines are transported around the home, it must be done in a secure manner using a medicines trolley or locked box. It must be possible to quickly lock away the medicines in the event of an emergency. The medicines trolley must be locked by the person administering the medicines when they need to move away from it, for example, to administer the medicines to a service user.

4.22.1. The trolley if left unattended, even briefly, must be locked at all times

4.22.2. The identity of the resident must be checked using either a photograph or other suitable means.

4.22.3. Check the MAR sheet for medicines due to be given at that time of day. Note if any medicines have been signed as given already, e.g. medicines that may need to be given before food, or if the resident may prefer to use certain items in the privacy of their own room. e.g. eye drops/ointments/inhalers etc.

4.22.4. Locate medicines that is due to be administered.

4.22.5. Check with the resident that they wish to take their medicines now.

4.22.6. Identify and obtain each medicine to be given against the MAR sheet, ensuring that all the details on the pharmacy label are the same i.e. drug name, strength, dose, directions etc. If there is a discrepancy, check with the pharmacist or person in charge before giving to the service user.

4.22.7. Decant the medicines into a suitable container. This must be done without physically handling the medicines i.e. 'No touch technique'. In the case of blister packs, this can be done by placing the medicine cup directly below the blister which can then be pushed through into the cup.

4.22.8. **Medicines must never be decanted before the actual time of administration, when it should be removed from the original packing or container** except in very exceptional circumstances following a robust risk assessment such as for short periods away from the home.

4.22.9. The member of staff who removes the dose from the original container must personally administer it to the resident.

4.22.10. Solid tablets/capsules can be placed in the same container for the resident to take. Take note of tablets that may require to be dissolved.

4.22.11. Liquids must not be mixed with other liquids or tablets/capsules unless potential issues have been satisfied from the pharmacy. This discussion should be documented.

4.22.12. Staff must not come into direct skin contact with a service user's medicines. Solid-dose oral preparations should be directly transferred from the dispensed container into a small pot as a way of hygienically handing it to the service user. Liquid medicines must be

measured using an oral syringe, or medicine measuring cup as appropriate to the size of the dose to be given. Teaspoons or similar must not be used to measure liquid medicines. Syringes intended for injections should not be used to measure oral liquids.

4.22.13. Gloves must be worn for administering such items as creams, suppositories, pessaries and any other medicines as determined by the responsible nurse.

4.22.14. Give the medicines to the resident with a glass of water or a cold drink of their choice

4.22.15. The resident must be observed to ensure that all the medicines is taken. The medicines must never be left with the resident to take later. If the resident finds your presence obtrusive, withdraw a short distance, but still be in a position to witness them take the actual medicines.

4.22.16. If medicines have not been administered i.e. refused, spat out etc, then this must be recorded on the MAR sheet. A number of approaches can be adopted, which are detailed in the Refusal of Medicines section below.

4.22.17. If the resident is adamant that they do not wish to take one or all of their medicines and it has been decanted from the blister pack or original pack, the medicines must be disposed of in a container marked 'medicines for disposal' and the MAR sheet recorded appropriately. E.g. R=Refused, S=Sleeping etc. A full list of codes and brief explanations can be found on the bottom of the MAR sheet.

4.22.18. If the member of staff responsible for administering medicines is called away, for whatever reason, all medicines must be secured and locked.

4.22.19. Complete administering one resident's medicines before starting the next.

4.22.20. **Once the medicines have been taken the MAR sheet must be signed** using both initials, in the appropriate place, by the person administering the medicines. Only those items that have been given and witnessed are to be signed for. Where there is a choice of dosage e.g. one or two tablets, the number of tablets that has actually been administered must be recorded. MAR sheets must never be signed in advance of a drug round, or retrospectively.

4.22.21. The time of administration must be carefully considered for each medicine for each service user. Advice from the GP or pharmacist must be sought if directions are not clear or if issues arise. Specific directions regarding taking the medicines with or without food, or with other medicines, must be adhered to even if this does not coincide with the medicines rounds. Some medicines must be given at specific times which should be specified on the dispensing label (for example, Parkinson's medicines). It is essential that such medicines are given on time. Where necessary, a list of medicines which is to be administered outside of the usual medicines round times must be kept as a reminder for staff.

4.23. "When required" medicines and variable-dose medicines.

Medicines prescribed “when required” should be administered in accordance with the needs of the service user within the directions given by the prescriber. This may not be at the usual medicine administration times. Staff should be aware of the protocols for “when required” medicines and be alert for indications that they are needed. It is essential that recording the administration of “when required” medicines is done as given.

4.23.1. Before administering “when required” medicines it is essential to check when the last dose was given to ensure that there is an appropriate interval between doses.

4.23.2. The reverse of the MAR charts should detail why “when required” was needed and the subsequent effect. This is especially important in the case of residents who lack capacity such as those with dementia. In this situation the administration record is forming part of the clinical assessment to determine if “when required” medicines is needed and the effectiveness of the intervention.

4.23.3. In the instances where the “when required” medicines are an analgesic, dispensing staff must ensure that a pain assessment is completed and subsequent assessment to assess effectiveness – in the event that the medicines is not effective, immediate advice must be sought from the medical practitioner.

4.23.4. It should be remembered that the management of chronic pain is best served by the regular administration of analgesia and appropriate professional guidance via the GP/pain clinic should be sought to ensure that the resident’s needs are met.

4.24. Medicines administration record (MAR chart)

There must be a MAR chart in use for each service user where staff are administering all or some of that service user’s medicines. See section 9 – self-administration for records required for people who are self-administering their medicines.

4.24.1. The MAR chart must include **all** medicines taken by the service user (prescribed, homely remedy, the individual’s own bought medicines or complementary medicines/supplements) and be used to record the administration of all medicines by staff. Blank MAR charts should be available at the home.

4.24.2. Medicines that is administered by visiting health care professionals, or medicines that is administered at the doctor’s surgery or hospital, for example, depot injections, must also be included on the MAR chart. The chart should clearly state who is responsible for the administration of this medicine.

4.24.3. The responsibility for producing MAR charts lies with the dispensing pharmacy and they should be informed of new admissions by using the Boots service user update form.

4.24.4. It is the responsibility of the nursing staff to ensure the MAR chart is up to date. Including ensuring that patients have a MAR chart when entering the home for the first time or coming to the home for respite stays.

4.24.5. The pharmacy-produced MAR charts must be checked by the nursing staff as part of the receipt of medicines process. Nursing staff must inform the pharmacy of any discrepancies identified to allow the pharmacy to amend the MAR for the next cycle, for example, regular medicines not included, discontinued medicines not removed from the MAR.

4.24.6. Where a handwritten MAR charts is required it is the nursing staff responsibility to ensure a MAR chart is in place and following the process relating to transcribing medicines.

4.24.7. For each MAR chart in use for an individual, the following details must be included:

4.24.7.1 The full name and date of birth of the service user and their room number.
4.24.7.2 Start date and day of the MAR chart
4.24.7.3 Any known drug allergy or "no known drug allergy" as appropriate
4.24.7.4 GP's name
4.24.7.5 Name, form and strength of the medicines
4.24.7.6 The directions for use of the medicines
4.24.7.7 Any precautions or special requirements relating to the use of the medicine
4.24.7.8 The quantity of any medicines carried forward from the previous cycle
4.24.7.9 Date of discontinuation of medicines, if appropriate.

4.24.8. Information regarding bought medicines should be taken from the manufacturer's packaging. The name, form and strength of prescribed medicines and precautions should be taken from the dispensing label. The directions for use should be taken from the dispensing label or from any subsequent directions from a relevant healthcare professional.

4.24.9. Each medicine must be entered on the MAR chart individually, even if the medicines is supplied in a multi-dose monitored dosage system prepared and sealed in pharmacy. Where a medicine is supplied in more than one strength or form, each strength or form must have its own entry.

4.24.10. Charts should enable a running total of medicines to be maintained (see section 6.10.4 for details). This balance should be reconciled with actual stock on a regular basis, for example, at the end of cycle, and any discrepancies reported to the registered manager and investigated immediately. Each time a medicine is given the person administering the medicine must record this by placing their initials in the relevant space on the MAR chart for each specific medicine. Records must be made at the time of administration, for each service user, after visually witnessing the service user taking their medicines **NOT** at the end of the medicines round or before the medicines is administered.

4.24.11. If the medicines are not administered for some reason, a code must be used, which is explained on the MAR chart, to document why it has not been given. See also section on storage of medicines at home for short periods away from the care home and Section 10 details for refusal of medicines.

4.24.12. The MAR chart should also be used to indicate the date medicines, which is only given infrequently is due, for example, medicines given weekly or monthly *and to indicate the date of any blood tests due, for example INR tests for warfarin*.

4.24.13. Information about the way the service user prefers to take their medicines, or specific support a service user may need to take their medicines should be included with the MAR chart and in the service user's care plan.

4.24.14. Any available supporting information about allergies and the type of reaction experienced should be recorded in the service user's care plan

4.25. When required and variable dose medicines

When a medicine is prescribed on a "when required" (PRN) basis, the MAR chart must be supplemented by a protocol which clearly describes the circumstances in which the "when required" medicine should be given. The protocol must include:

4.25.1.1 the name, strength and form of the medicines
4.25.1.2 the reason the medicines is prescribed,
4.25.1.3 the directions for use
4.25.1.4 the maximum dose and interval to be left between doses (if applicable) and the expected effects of the medicine.
4.25.1.5 Administration of the PRN should be captured on the MAR charts only.

4.25.2. The prescriber should be contacted for further information if necessary. The protocol must be written by the pharmacist or nursing staff, signed and dated, and kept with the service user's MAR charts. The protocol must be reviewed by a nurse at least every six months or sooner if circumstances change.

4.25.3. The administration of the "when required" medicines must be recorded on the MAR chart. The actual time that the medicines is given must be recorded along with the staff signature. A running balance must be maintained for audit purposes. A record should **only** be made if the medicines is given **UNLESS** the resident lacks capacity (e.g. has dementia) in which case the "not needed" code should be used for all meds round where the PRN was not given due to the practitioner's clinical judgement.

4.25.4. When variable-dose medicines are prescribed (for example, give ONE or TWO tablets), the actual dose given must be recorded. This must be done on the MAR chart or, where considered necessary for clarity, a supplementary sheet can be used. There must be a protocol in place, similar to that used for "when required" medicines, which details how the dose to be given must be determined. The protocol must be written by nursing staff who must contact the prescriber for more information, if required. The protocol must be kept with the service user's MAR chart. The protocol must be reviewed by a nurse at least every six months, or sooner if circumstances change.

4.25.5. If a supplementary sheet is used to record "when required" or variable dose medicines, this must be kept with the MAR charts. The main MAR chart must be annotated

across the signature space with the instruction ‘see supplementary sheet’, so that all staff involved in the administration of medicines use the same record.

4.26. Creams/ointments and nutritional supplements

4.26.1. When creams, ointments or nutritional supplements are prescribed, an entry must be made on the MAR chart.

4.26.2. The administration of these products must be recorded on the MAR chart or on a supplementary sheet (topical MAR), if more appropriate. If a supplementary sheet is used, the MAR chart must be annotated across the signature space with the instruction “see supplementary sheet”, so all staff involved in the administration of these medicines use the same record. If the supplementary sheet is not kept with the MAR chart during the cycle, a note must also be made on the MAR to indicate where it is located.

4.26.3. At the end of each cycle, the supplementary records should be collected and stored securely with the relevant MAR chart.

4.27. Controlled drugs (CD)

For medicines that are controlled drugs, and subject to CD recording requirements, the care home must also keep a separate CD register, in addition to the record on the MAR chart. The CD 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 service user. A running balance must be included in the register for each medicine. The CD register must be used to record the receipt, administration, transfer or disposal of CDs.

4.27.1. Nursing staff must ensure that:

4.27.1.1 The name, strength and form of each CD, as given on the dispensing label, is written at the top of the page along with the name of the service user to whom the medicines belong. Each receipt, administration, transfer or disposal of the stated controlled drug for the named service user must be recorded on this page.

4.27.1.2 The receipt of the medicines is recorded in the CD register on the day it is received into the home. The date of receipt, the quantity received and where the medicines was received from should be clearly documented on the appropriate page. The nurse making the entry must sign it to provide an audit trail.

4.27.1.3 The administration of each dose is recorded on the appropriate page of the register **as well as** on the MAR chart. The entry must include the date and time the dose is given, the actual dose given, and the signature of the nurse administering the medicines. Wherever possible, a second trained and competent member of staff should witness the process of selecting and administering the CD and also sign the CD register (only the nurse administering the medicines should sign the MAR)

4.27.1.4 The transfer of any CD is recorded in the CD register and the appropriate transfer of medicines documentation. This would include returning medicines to the service user or their representative on leaving the home; transfer to the service user if they are self-administering their medicines; transfer to another service provider or hospital. The record must be made on the appropriate page in the register and must include the date of transfer, the quantity transferred, the place or service user it was transferred to and the signature of the nurse arranging the transfer. The transfer should be checked by a second suitably trained and competent member of staff who must also sign the register as a witness.

4.27.1.5 The disposal of any CD is recorded in the CD register as well as in the medicine disposal record.

4.27.1.6 The running balance for each CD is checked against the medicines in the CD cabinet and updated when new supplies are received, administered, transferred or disposed of - including zero balances where appropriate. Any discrepancies identified must be dealt with as detailed below.

4.27.1.7 Any mistakes in the documentation in the CD register are amended by use of a signed and dated footnote, or marginal note, linked to the identified error. Crossings out, overwrites or deletions must not be made in the CD register. Correction fluid must not be used.

4.27.1.8 An index is kept in the register and kept up to date. This must show the name of the service user, the name, strength and form of the CD and the current page number of the record.

4.27.1.9 When a page is completed, the information is transferred to a new page and a note is made at the bottom of the completed page indicating the page number that the record has been transferred to. The first entry on the new page must be a dated and signed entry indicating which page the balance has been transferred from and the balance transferred. The index must also be updated.

4.27.1.10 Balances in the CD register must be checked daily at handover by a nurse and a second trained and competent member of staff and reconciled with the actual medicines in the CD cabinet. An entry must be made in the register, on the appropriate page, to indicate that a check has taken place.

4.27.1.11 Any discrepancies found between the recorded balance in the CD register and the actual medicines in the CD cabinet should be reported to the registered manager and investigated immediately. The MAR chart and medicines disposal/transfer records should be checked to try to identify if the discrepancy is due to a documentation error. The running balance should be inspected closely to ensure that an inadvertent calculation error has not been made. An incident form must be completed and the Trust Controlled Drugs Accountable Officer informed with a factual account of actions taken and to whom this has been reported

4.27.1.12 Where the discrepancy can be resolved, an entry can be made in the CD register correcting the error. The entry must include a cross reference to any supporting

documentation, the signature of the nurse making the entry and the date of the entry. The entry must be marked as being “retrospective”.

4.27.2. If no supporting documentation or information can be identified to resolve the discrepancy, then the nurse in charge must report it on the Trust incident reporting system, also contacting the registered manager and the Trust Controlled Drugs Accountable Officer for further advice relating to an ongoing investigation.

4.28. Arrangements for short periods away from the care home

The home has a duty to ensure that a service user has access to their medicines when they need to take it if they are away from the home, for example, attending day-care services or on a social outing with relatives.

4.28.1. The trained and competent member of staff who is arranging the transfer of medicines should establish who will be responsible for the medicines whilst the service user is away from the home. This could be, for example, the service user themselves (following a robust risk assessment), a representative or staff from another service such as day care.

4.28.2. The supply as originally dispensed by the pharmacy or dispensing GP, whether in traditional packaging or a monitored-dosage system, should be transferred to the person who will be responsible for the medicines whilst the service user is away from the home. If the medicines are in a monitored-dosage system, the member of staff arranging the transfer should ensure that the person who will be responsible for the medicines knows how to use the system correctly and must document in the service user’s care plan that they have provided this advice.

4.28.3. The member of staff must keep a record of the details of the medicines transferred, including the name of the service user; the name, strength, form and quantity of the medicines transferred; the date of the transfer and who the medicines was transferred to.

4.28.4. Where a service user has regular planned absences, such as attendance at a day-care service, it may be appropriate to contact the GP to establish if it is possible to move the timing of the dose to avoid administration whilst away from the home, or if other medicines may be available which does not require administration at that time.

4.28.5. If the dose must be taken whilst away from the home, the pharmacist/dispensing GP could be contacted to ask if a separate supply is possible to cover the times the service user is away. If this is not possible the original dispensed supply should be used.

4.28.6. In **exceptional circumstances only and following a robust risk assessment**, it may be necessary to place an individual dose of medicines (for example, the lunchtime dose) into a daily compliance aid. Such arrangements remove an important safety element of being able to check the dispensing label at the time of administration so that there is a risk of making an error in selecting the medicines. However, in some circumstances these risks may be less than those of providing the full quantity of medicines in the dispensed packaging. **Such exceptional circumstances may include:**

4.28.6.1 Where a service user could safely take responsibility themselves for individual doses of medicines when away from the home if placed in a compliance aid, but is not able to manage this if the full quantity in the original packaging was supplied.

4.28.6.2 Where the service user, or person who will be responsible for the medicines whilst away from the home, is unable to access the medicines from the packaging as supplied by the pharmacy or does not understand the monitored-dosage system in use.

4.28.6.3 Where having the full quantity of medicines may present a risk to the service user or there is an established risk that the medicines will not be returned at the end of the period away, leaving the service user with no medicines.

4.28.6.4 **However,** controlled drugs must not be included within any part-packing or dispensing for short term leave and alternative arrangements with the supplying pharmacy must be sought.

4.28.7. The advice of the pharmacist should be sought and documented to confirm that the medicines will be stable in the compliance aid for the time it is to be stored there.

4.28.8. The compliance aid should be specific to the individual, robust and closable to prevent medicines falling out.

4.28.9. The service user (or the person responsible for the medicines whilst away from the home) must be advised to keep the medicines secure and to return the compliance aid to staff on return to the home.

4.28.10. Where possible, the service user themselves should be involved in transferring the medicines to the compliance aid with the support of a trained and competent member of staff. Otherwise, a nurse and a second trained and competent member of staff must prepare the compliance aid with the second member of staff checking each action.

4.28.11. Nurses should ensure that the compliance aid is labelled appropriately to the same standard as a pharmacy label as described in the NMC Standards of Medicines Management – standard 16.

4.28.12. If staff from the home are accompanying the person and responsible for the medicines, they should select the correct medicines themselves and prepare the compliance aid with the support of the nurse, as appropriate. The staff member should carry the medicines securely and on return to the home complete the MAR chart. Staff responsible for the administration of medicines when away from the home must have appropriate training to allow them to do this safely.

4.28.13. Any such arrangements must be agreed with the registered manager and the service user whose medicines it is and documented in the service user's care plan.

4.28.14. Staff must not sign the MAR chart for medicines which they have not administered. A code must be used, which is explained on the MAR chart, to indicate what has happened, for example, “medicines taken on social leave”.

4.28.15. The member of staff arranging the transfer of medicines must ensure that the person who will be responsible for the medicines has accurate, up-to-date information regarding:

4.28.15.1 The name, form and strength of the medicines taken with them.
4.28.15.2 Clear directions and advice on how and when the medicines should be taken and what dose to take.
4.28.15.3 The time of the last dose and time that the next dose is due for the medicines taken with them.
4.28.15.4 A contact number for the home/GP regarding queries about the medicines.
4.28.15.5 A copy of the current MAR chart and any relevant supplementary charts should be provided to the person who will be responsible for the medicines and the member of staff arranging the transfer should ensure that this person knows how to obtain information from the chart.

4.28.16. A trained and competent member of staff must check on the service user’s return to the home that any medicines which needs to be returned has been received and they must record the quantity of each medicines returned back to the home.

4.28.17. Any doses which should have been taken whilst the service user was away from the home, but which have not been taken, must be recorded in the service user’s records and disposed of in accordance with section 19. The advice of the GP must be sought by the nurse on duty regarding the missed medicines, as appropriate.

4.29. Transfers of medicines to new provider or hospital

When a service user transfers to a new provider or to hospital the following information must be sent with them by a trained and competent member of staff:

4.29.1.1 The service user’s details, including full name, date of birth, NHS number (if known), address and weight, where appropriate (for example, frail older people).
4.29.1.2 GP’s details.
4.29.1.3 Details of other relevant contacts defined by the service user and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse).
4.29.1.4 Known allergies and reactions to medicines or ingredients, and the type of reaction experienced where known.
4.29.1.5 The medicines the service user is currently taking, including name, strength, form, dose, timing and frequency and how the medicine is taken (route of administration).
4.29.1.6 Changes to medicines, including medicines started, stopped or dosage changed, and reason for change.
4.29.1.7 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).

4.29.1.8 Other information, including when the medicine should be reviewed or monitored, and any support the service user needs to carry on taking the medicine (adherence support).
4.29.1.9 A copy of the current MAR chart and any associated supplementary charts/protocols should be sent to provide the details of the current medicines.

4.29.2. The home must keep a complete record of the medicines transferred. The record must include:

4.29.2.1 Date of the transfer
4.29.2.2 Name, strength and form of medicine
4.29.2.3 Quantity transferred
4.29.2.4 Name of the service user for whom the medicine was prescribed
4.29.2.5 Where the medicines was transferred to
4.29.2.6 Signature of the member of staff who arranged the transfer of the medicine
4.29.2.7 Where appropriate, signature of a second member of staff witnessing the transfer

4.29.3. *This record should be made on the service user's MAR chart.* If the medicine is a controlled drug entered in the CD register, the transfer must be recorded in the CD register also.

4.30. Self-administration

Current NICE Quality Standard: Managing medicines in care homes overview states that "people who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk".

4.30.1. It is important for people living in care homes to maintain their independence, and that they have as much involvement in taking their medicines as they wish and are safely able to. However, when a person enters a carehome staff will often automatically assume responsibility for managing their medicines.

4.30.2. It should be assumed that people who live in a carehome can take and look after their medicines themselves, unless a risk assessment has indicated otherwise.

4.30.3. It is important to take into account a person's choice over whether or not they wish to self-administer their medicine and also to consider if self administration will be a risk to them or others.

4.30.4. Risk assessments are also important to determine what support a person needs to help them to self-administer different medicines (for example, a resident may be able to manage oral tablets but not eye drops), allowing care homes to ensure that necessary support is provided.

4.30.5. Risk assessment should be reviewed periodically, and whenever circumstances change, to address if any adjustment to support is needed.

4.31. General principles of self administration:

4.31.1. Self-administration is not an 'all or nothing' situation. Some people may keep and use their inhalers or external preparations (creams, ointments etc) but not their other medicines.

4.31.2. On occasions a service user may be able to exercise control over his/her medicines with some assistance from a trained and competent member of staff, for example;

4.31.3. A service user who has suffered a stroke and is unable to manipulate containers may choose to retain custody of their medicines and ask staff to assist at the time he/she chooses to take the medicines.

4.31.4. Alternatively, a service user might be able to manage their own medicines with support and prompting or self-administer insulin with supervision. If a resident self-administers insulin, they must dispose of the sharp themselves directly into the sharps bin. Where a resident is self-administering insulin or other medicines with a syringe a "sharps bin" must be provided. These are available on prescription.

4.31.5. The desire and ability to self-medicate will be considered as part of the process of admission to the home. Where it is felt that this would represent a risk to the service user or others in the service, this will be formally assessed and documented in the care record.

4.31.6. It is essential that where self-administration is introduced that the necessary safety, security and storage arrangements are in place and agreed procedures established. A lockable space in the service user's own room will need to be provided in order to ensure access is limited to that service user. Should medicines require refrigeration appropriate lockable facilities would also need to be available.

4.31.7. Certain conditions such as asthma and angina require immediate access to medicines to relieve symptoms, so self-administration of medicines to treat these conditions should be encouraged.

4.31.8. Staff must carry out a robust risk assessment with the service user to assess their ability to self-administer their medicines. It may also be appropriate to involve relevant health care professionals and family/carers (please see forms in Appendix 3).

4.31.9. This assessment must be dated and signed by all parties involved and be reviewed on a monthly basis, and outside of this timeframe if the resident's condition changes. The completed form must be kept in the resident's file and a copy attached to the drug chart.

4.32. Facilitating self-administration

4.32.1. Self-administration of medicines must therefore be tailored to the individual patient. To facilitate self-administration, the following levels of self administration scheme need to be considered and explored with individuals.

- **Level 1** The Registered Nurse or designated competent staff member administers the medicines giving a full explanation as appropriate.

The service user's Medicines Administration Record (MAR) sheet will be used to order medicines and document receipt of medicines into the Home. The MAR sheet should be kept with the medicines in a locked cabinet, drawer or container in the service user's bedroom.

- **Level 2** The service user administers his/her own medicines under the supervision of the registered nurse or designated competent staff member from the locked cabinet or drawer in their bedroom but does not hold the key to the cabinet or the drawer.

At Level 2, the MAR sheet will be signed by the registered nurse to confirm supervised self-administration.

- **Level 3** The service user administers his/her medicines without supervision and has responsibility for the key to the lockable cabinet or drawer.

- At Level 3, the service user will assume full responsibility for self-administration. A photocopy of the MAR sheet may be provided as an aide to self-administration and for the service user to record self-administration if they so choose.

4.32.2. The carehome staff have the responsibility to ensure that the service user is competent to carry out the task and this will involve training, education and on-going assessment of the service user's capability and desire to self-medicate.

4.32.3. Information will be provided to the service user to ensure that they are aware of the nature and purpose of their medicine regime, special instructions and the consequences of failing to take a prescribed dose and of over-dosage.

4.32.4. If there is reason to believe that the service user is not adhering to the safe storage procedures or is felt incapable of managing his/her medicines safely then the assessment for self-administration should be reviewed and any changes documented in the care record.

4.32.5. The assessment form for self-administration is provided in Appendix 3 (this is to be completed for all service user's and to be reviewed on a regular basis as specified in the care plan for self-administration).

4.32.6. If the service user is to retain full control over their medicines, including ordering and collection of the medicines, then the home will need to keep an up-to-date record of the service user's medicines in their care plan. A MAR chart is not necessary.

4.32.7. Where a service user is only self-administering some of their medicines, these medicines must be included on the MAR chart and 'self-administering' written across the signature spaces for these items.

4.32.8. A service user who is self-administering their medicines does not have to complete a MAR chart. They may choose to do so as an aid to remembering the medicines, in this case a copy of the MAR chart should be provided for the service user to keep and complete themselves.

4.32.9. A copy of the assessment for self -administration should be kept in the MAR chart folder for reference and audit purposes

4.32.10. Where a service user has requested that the home arranges the ordering and/or collection of prescriptions and medicines, a trained and competent member of staff must keep a record of this to provide an audit trail. The record must contain the name of the service user; the name, strength and form of the medicine; quantity of each medicines ordered/received; the date of order/receipt and the signature of the member of staff. When the medicines is given to the individual, staff must record the name of the service user; the name, strength and form of the medicines; the quantity given to the service user; the date it was supplied and the signature of the member of the staff making the supply.

4.32.11. An agreement will be sought with the service user that allows nursing staff to monitor and review their on-going ability to manage their medicines (usually once a month unless concern).

4.32.12. There should be a 'stock take' of the service user's medicines with them on a regular basis, for example, when the medicines are due to be reordered. The record of the quantity of medicines received and supplied to the individual should be used to assess if the medicines appears to have been taken as prescribed and to establish if the medicines needs to be reordered. Monitoring of medicines use should not unduly compromise the service user's privacy.

4.32.13. Staff should report any concerns regarding a service user's ability to self-administer their medicines to the registered manager/clinical lead.

4.32.14. A lockable space must be provided in the service user's room for the storage of medicines. This must be big enough to store all the medicines appropriately (for example, bottles must be stored upright) and be accessible for the individual. Medicines requiring cold storage will be stored in the home's secure medicines refrigerator. Staff must ensure that the service user can gain access to this medicine on their request.

4.32.15. It is the home's responsibility to ensure that the service user understands that medicines must be kept safe and to ensure that this happens. If, despite discussion and the adoption of any reasonable measures which would allow the service user to keep the medicines securely, the service user is unwilling or unable to do this, and the safety of other people living at the home is compromised, then the home may insist that they store the service user's medicines securely for them. This protocol must be clear to the individual at the time they sign the agreement to self-administer their medicines.

4.32.16. If a service user is concerned about their medicines, a referral should be made to the GP or relevant health care professional.

4.32.17. A service user's ability to administer their own medicines must be reviewed at least every six months or sooner if there are concerns, and the review documented. Where necessary, a new agreement should be reached with the service user if their wellbeing or safety, or that of other people in the home, is being put at risk by the current arrangements. This should include an assessment of capacity if it is felt this has changed. For people who are receiving respite care or those who are admitted for short stays the service user's ability to self-administer their medicines should be assessed on each admission.

4.32.18. People should have the opportunity to involve others, such as family or friends, in discussions about their medicines if they wish to do so.

4.32.19. All discussions regarding medicines should be handled sensitively

4.33. Use of homely remedies

There is a recognised duty of care to be able to make an appropriate response to symptoms of a minor nature, for example, toothache. A decision may be taken by a nurse, using their professional judgement and in accordance with a homely remedies protocol, for minor ailments without necessarily consulting resident's GP.

4.33.1. The homely remedies protocol lists the conditions for which homely remedies can be used, and which medicines can be used. A copy of the homely remedies protocol must be kept with the MAR charts. The homely remedies protocol must be agreed with the GPs of the residents at the home before homely remedies can be used for them. Any exceptions for residents must be documented in the resident's care plan.

4.33.2. If a homely remedy is given, it must be administered from the original packaging as purchased from the pharmacy and in accordance with the dosage instructions on the packaging or patient information leaflet. The administration must be recorded on the resident's medicines administration record (MAR) chart.

4.33.3. Care must be taken to ensure that any homely remedies given are not contra-indicated and do not interact with the resident's prescribed medicines, nurses may wish to liaise with the supplying pharmacist.

4.33.4. Homely remedies must not be given for periods of longer than 48 hours without referral to the GP.

4.33.5. Homely remedies must be stored securely in a locked medicines cupboard, separate from prescribed medicines.

4.33.6. Medicines used as homely remedies must be purchased by the home for that purpose and must not be labelled for individuals. Medicines which has been prescribed for an individual must not be used as homely remedies stock.

4.33.7. An accurate record of stock must be maintained for all homely remedies. Each homely remedy must be recorded on a separate page. The record must include the full details of the medicines, the date it was received/disposed of and the quantity received/disposed of. Each administration should be recorded on the homely remedies record, including the date and quantity administered and the name of the service user to whom it was administered, as well as completing the service user's MAR chart. A running record of the stock balance should be maintained. A stock check, including checking the expiry date of the medicines, should be carried out at the end of each medicines cycle and the quantities reconciled with the running balance. Any discrepancies must be investigated immediately. The stock check should be documented on the record of homely remedies stock. Each entry should be signed by the person making it.

4.34. Alternative therapy treatment

A resident who is self-administering their medicines, who wishes to buy their own remedies for minor ailments or to use complementary medicines or supplements, should be encouraged to speak to a pharmacist or GP to ensure that there are no interactions between the bought medicines and their prescribed medicines. For the documentation and storage of the bought medicines see section 4 – self-administration.

4.34.1. Where a resident request that staff administer a bought medicine (such as vitamin/mineral supplements, alternative or complementary therapies), the nurse must discuss this with the GP before administering any doses. The discussions must be recorded in the resident's care plan and signed and dated by the nurse making the record. Administration of these medicines must be recorded on the resident's MAR chart. See section 6.4 – medicines administration record.

4.34.2. These medicines are the property of the resident and are not part of the homely remedies protocol. They must only be used for the resident who has requested and purchased them. They must be stored in the locked medicines cabinet/trolley with the resident's prescribed medicines.

4.34.3. As with homely remedies, these medicines must only be administered in accordance with the directions on the packet or patient information leaflet from the original container as purchased. In no circumstances should more than the stated dose be administered.

4.35. Administration of medicines using specialised techniques

For medicines which is administered via a specialised technique, for example, via enteral tubes or syringe driver, the nurse must have up-to-date, documented training on that method of administration. Nurses must only administer medicines by routes in which they are competent.

4.35.1. A record of any training should be kept in the employee's training/personnel file.

4.35.2. Nurses can refuse to assist with the administration of medicines by specialist techniques if they do not feel competent to do so. Nurses **must** inform the registered manager if this is the case. Further training and development opportunities should be provided where appropriate.

4.35.3. Where medicines is to be administered by a method not covered in the patient information leaflet, such as via an enteral tube, the prescriber should be asked to confirm in writing that medicines should be administered by this method, for example, by adding 'via enteral tube' to the prescription. Advice must be sought from a pharmacist and documented, on the specific procedure to be used for each medicines.

4.36. Concerns about a resident's health

If there are any concerns raised regarding a resident's health (including concerns about possible side effects from medicines), the nurse on duty must assess the resident and contact the GP or out of hours service, as appropriate. Nurses may choose to treat minor ailments in accordance with the homely remedies protocol. The wishes of the resident must be taken into account.

4.36.1. A record must be made in the resident's care plan including the problem identified, the action taken and the advice and name of the health care professional contacted. The record must be signed and dated by the nurse making it.

4.36.2. Where agreed by the resident, their nominated representatives must be informed if a resident is unwell or has suffered side effects from a medicine. For a resident without capacity, the person with lasting power of attorney for health and welfare should be informed (if one exists).

4.36.3. Information on side effects of a medicines can be found in the patient information leaflet supplied with the medicines and can be checked by staff or the resident themselves.
Nurses must report adverse drug reactions to the MHRA via the yellow card scheme.(This can be accessed on line via https://yellowcard.mhra.gov.uk/).

4.37. Administration of emergency medicines

Emergency medicines is medicines which is required to be administered urgently to control the rapid decline of a resident's condition or in a life-threatening situation. Examples include the administration of buccal midazolam to stop seizures and adrenaline by injection in severe allergies.

4.37.1. The health care professional initiating the medicines should provide a health care plan with details of the name, strength, form and dose of medicines to be administered and the route of administration, the circumstances in which the medicines should be administered, details of the expected outcome of the medicine administration, what to do if the medicines does not work or cannot be administered and what further steps may be required if the medicines is administered successfully.

4.37.2. This plan will be specific for the individual. It must be included in the resident's care plan and be available to all staff who may need to administer the medicines.

4.37.3. Where the emergency medicines are administered via a specialised technique, the procedure in section 10.16 will also apply and must be followed.

4.37.4. If the administration of an emergency medicines is to be delegated to a member of care staff they must have received appropriate training and been assessed as competent by the

delegating nurse, including the use of any invasive or specialised routes of administration, if appropriate.

4.37.5. Written consent for staff to administer emergency medicines must be obtained from the resident. If the resident lacks capacity to give consent, the person with lasting power of attorney for health and welfare (if one exists) must be consulted, or a best interest decision should be made, in accordance with the principles and processes of the Mental Capacity Act. It is important to establish consent before the medicines is needed, as due the nature of the emergency the resident may not be able to give explicit consent at the time the medicines is needed.

4.37.6. Wherever possible, the home will have sufficient staff on duty who are able to administer the emergency medicines if needed. **In the event that there is no suitably trained member of staff available to administer the medicines, the emergency services must be called.**

4.37.7. Robust risk assessment must be undertaken for each individual requiring emergency medicines to establish the most appropriate storage and transport requirements for the medicines when at the home and when away from the home.

4.37.8. Every attempt must be made to respect a resident's dignity and privacy when administering emergency medicines especially if in a public place. If the situation is immediately life threatening, the emergency medicines must be administered, within the criteria set by the doctor, whilst providing the maximum privacy possible. In other circumstances staff may need to decide if calling the emergency services or going to the nearest accident and emergency department would be more appropriate.

4.38. Anticipatory medicines

There may be occasions where a resident is prescribed medicines which is only to be started in specific circumstances, for example, people who are nearing the end of life, residents prescribed antibiotics and/or steroids for recurrent severe chest infections due to an underlying medical condition.

4.38.1. If a resident has such medicines, there must be an accompanying management plan, provided by the health care professional, which covers the use of this medicines. A record should be made in the service user's care plan that the service user has anticipatory medicines prescribed. The medicines should be stored in the locked medicines cabinet but it should be clear that this medicine is only to be used in accordance with the agreed plan.

4.38.2. A separate MAR chart to cover any anticipatory medicines should be provided with the supply of medicines and started only when treatment is indicated.

4.38.3. Anticipated medicines regimes should be reviewed 6 monthly with the service user or nominated individual and GP.

4.39. Refusal of medicines and covert administration

It is an individual's right to refuse medicines and staff must never force a resident to take a medicine. Generally, it is worthwhile waiting for a short time before going back to the resident and re-offering the medicine. If the resident still refuses to take their medicine, this must recorded on the MAR chart, using the correct code, to indicate refusal has occurred. It may be necessary to contact the resident's GP for further advice, and their advice followed. The refusal and any advice received from the GP must also be documented in the care plan. The GP may also choose to undertake a review of the medicines, where it is frequently refused.

4.39.1 The resident must be asked if they would tell you the reason for their refusal to take any medicines. This may help in assessing potential options regarding the medicines.

4.39.2 If a resident is having difficulty swallowing their medicines, or wishes them to be administered other than as whole capsules or tablets, this must be discussed with the resident's GP or pharmacist, who may review the medicines, be able to prescribe more appropriate formulations or consider referral to a speech and language therapist for further assessment.

4.39.3 Tablets must not be crushed or capsules opened unless the advice of a pharmacist has been sought to ensure that the pharmaceutical properties of the medicines are not altered, and that it is safe to administer the medicines in this way. The method of administering the medicines must be documented and the approval of the GP obtained.

4.39.4 Covert medicines
Where there are ongoing concerns around patient refusal to take medicines, covert administration may be considered.

4.39.5 What are covert medicines? 'Covert' is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the service user receiving them.

4.39.6 Covert medicines must never be given to an individual who is capable of consenting to medical treatment. If a resident's decision is thought to be unwise or eccentric, it does not necessarily mean they lack capacity to consent.

4.39.7 There may be certain circumstances in which covert administration may need to be considered to prevent a resident missing out on essential treatment. This may only be done where the resident **lacks capacity** as defined by the Mental Capacity Act or under the conditions defined by the Mental Health Act (MHA). An assessment of capacity must be undertaken, in accordance with the Mental Capacity Act, and the discussions (including who was involved) and conclusions reached recorded in the resident's care plan.

4.39.8 If a service user is lawfully detained under a section of the Mental Health Act, some forms of forced or disguised medicines are recognised in law for medicines. However, it must be recognised that such administration under the Act will only apply to treatment for psychiatric

conditions **and not for physical health conditions.** *The impact on the therapeutic alliance must also be considered and how the resident will perceive their recovery.*

4.39.9 Disguising medicines in order to save life, prevent deterioration, or ensure an improvement in the resident's health, cannot be taken in isolation from the recognition of the rights of the resident not to give consent. It may, in such circumstances, be necessary to administer medicines covertly. If a deprivation of liberty safeguards (DOLS) authorisation is in place, the covert administration of medicines must be clearly identified within the authorisation. Applying for a DOLS authorisation, or the permission of the Court, should also be considered if covert administration is being considered, particularly if that medicines will affect a resident's behaviour, mental health or act as a sedative. In such circumstances the Service Manager or the resident's consultant should consider obtaining further advice from the Trust solicitor.

4.39.10 If the resident has capacity and the MHA does not apply, the resident cannot be compelled to take their medicines even if this is likely to affect their health or wellbeing. **Administration of medicines in this instance against a service users wishes may be deemed unlawful.**

4.39.11 An appropriate assessment must be performed by a medical practitioner to establish whether the resident lacks mental capacity. If it is determined that the resident does lack mental capacity to consent, a multidisciplinary best interests meeting must be held to establish whether covert administration is in the patients best interest. Any decision must be documented clearly in the notes.

4.39.12 In deciding what treatment may be reasonably considered as being in the best interests of a resident who lacks capacity to consent, the General Medical Council recommends that the following be taken into account:

- Options for treatment which are clinically indicated.
- Evidence of the service user's previously expressed preferences, including any advance statements or directives (see **Consent** below).
- Knowledge of the service user's background, including their cultural and religious beliefs.
- Third-party views about the service user's preferences given by those who may have other knowledge of the service user, e.g., partner, relative, carer or advocate.
- Where more than one option (including non-treatment) seems reasonable and in the resident's best interest, consideration should be given to that which least restricts the resident's choice.

4.40 Consent

4.40.1 All adults must be presumed to have the mental capacity to consent or to refuse treatment, including medicines, unless they:

- Are unable to take in and retain information about their treatment and given by the treating staff, in particular with regard to the consequences of refusal or non-treatment.
- Or are unable to understand the information.
- Or are unable to properly consider the information before making a decision.

4.40.2 Assessing this capacity must be undertaken using a mental capacity decision making checklist, e.g. FACE and is primarily a matter for the responsible clinician and the MDT with input from carers if available, but other practitioners, clinicians and authorised employees may all usefully contribute to discussions about this assessment.

4.40.3 When service users are capable of giving or withholding consent, no medicines may be given without their agreement *unless a medicine is needed for their mental health condition and they are under the MHA.* If withholding consent, staff must ensure that the service user has been given sufficient information in a suitable format about the nature, purpose, associated risks and alternatives to the proposed medicines.

4.40.4 *Unless a medicine **is** needed for their mental health condition and they are under the MHA,* a competent adult has the right to refuse treatment, even if refusal will adversely affect their health or shorten their life. Registered nurses and authorised employees must respect a competent adult's refusal in the same way as their consent.

4.40.5 Service users who lack capacity may have indicated consent or refusal at some previous time whilst competent, in the form of an advance statement, advance directive or living will. Where these wishes are known, all staff must respect them, provided these advance decisions are still clearly applicable to the service user's present circumstances and there is no reason to believe that the service user has changed their mind.

4.40.6 The ultimate decision to administer medicines covertly must be fully informed and agreed by the multi-disciplinary team caring for the service user *at a 'best interests' meeting.*

4.40.7 No one, not even a spouse or parent can lawfully give consent on behalf of another adult. However, the views of relatives, carers, relevant service user's representatives, advocates and close friends may be helpful in clarifying the wishes of the service user and establishing what action is in their best interest.

4.40.8 In service users who lack the capacity to consent and who are physically unaware that they are taking medicines (e.g. unconscious service users), the administration of medicines will not need to be carried out covertly. However, if these service users recover awareness their consent must be sought at the earliest opportunity.

4.40.9 It is important to recognise that mental illness might often cause temporary or fluctuating incapacity. In such cases, regular assessment (and record) of capacity will be required if *in truly exceptional circumstances covert administration has been agreed.*

4.40.10 Crushing medicines and mixing with food or drink to make it more palatable or easier to swallow when the resident **has consented to this**, should only be considered as a last resort but does **not** constitute covert administration. However, it is important that other forms of medicines are considered first such as liquids, dispersible or soluble tablets. Before altering the medicines in any way always check and take advice from the pharmacist to ensure that this is appropriate, and gain consent from the GP. The advice given by the pharmacist and subsequent method of administration (if appropriate) must be documented (see Appendix 4).

4.41 Process for covert administration of medicines

4.41.1 Covert administration is only likely to be necessary or appropriate when service users actively refuse medicines and are judged not to have the capacity to understand the consequences of their refusal.

4.41.2 There are certain exceptional circumstances in which covert administration may be considered acceptable in order to prevent a service user from missing essential treatment. In these circumstances and in the absence of informed consent, the following must apply:

- The best interests of the service user are considered at all times and the medicines is considered essential for the service user's health and well-being, (or for the safety of others).
- All alternative means of administration have been explored and similarly refused.
- The decision to administer a medicine covertly must not be considered routine but should be considered a contingency or emergency measure. Any such decision must be reached after assessing the care needs of the service user specifically and individually in order to avoid the ritualised administration of medicines in this way.
- There must be a 'best interest' meeting convened for the multi- disciplinary team and if engaged, the service user's relatives or carers, or if appropriate the relevant service user's representative, and agreement reached that this approach is required in the specific circumstances. Family and/or carer involvement in the care process should always be encouraged when the initial decision is made and at full reviews.
- The actual method of covert administration must be agreed and full and mini reviews of the decision must be undertaken regularly and recorded on a 'Covert administration of medicines form' (Appendix 4).
- Covert administration reviews should be undertaken at least every three months and full reviews at least annually. These reviews must be recorded on the covert administration form and outcome in the patient notes. Where covert administration is either no longer deemed necessary or patient is deemed to have capacity, review of covert arrangements should be made a priority.

- The advice of pharmacy should be sought to determine the means of administering medicines covertly – i.e. if medicinal products are to be crushed, dissolved or otherwise administered in a way in which they were not intended. In such instance administration will be considered "off licence". Registered nursing staff must remain aware of the NMC guidance on the administration of unlicensed and off-licence medicines.
- The MAR chart should be annotated to indicate that medicines is being covertly administered to the service user. Following covert administration, the administration record should be annotated with the appropriate coding, alongside the initial of the practitioner administering the medicine.
- If the administration is going to be undertaken for the long-term and/or is in the context of any other measures which may be deemed to deprive the service user of their liberty, an application to the depravation of liberty safeguards (DOLS) for an authorisation should be sought.

4.42 Professional conduct

4.42.1 All practitioners must reflect on the treatment aims of disguising medicines and be absolutely confident that they are acting in the best interests of the resident. The treatment must be considered necessary in order to save life, prevent deterioration in health, or ensure an improvement in the resident's physical or mental health status.

4.42.2 Registered nurses involved in covert administration of medicines must be fully aware of the aims, intent and implications of such treatment. If an authorised employee is involved in covert administration, it is the responsibility of the appointed practitioner in charge to ensure that they are fully aware of their own responsibilities arising from this practice. The administration of covert medicines can also present practical problems in that a resident may not fully ingest the substance that carries the medicines. This fact is acknowledged in this guidance to recognise the difficulty that nursing staff may encounter using this method of administration. In the event of the resident not fully ingesting the substance containing the medicines for a variety of reasons, the nursing staff should make medical and pharmacy colleagues aware and a note made in the resident's clinical notes.

4.43. Record keeping

The standard of record keeping should ensure that records are properly completed, legible and current and provide a complete audit trail of medicines. All records relating to medicines should be signed and dated by the member of staff making them.

4.43.1. The records should be factual, clear, accurate and respectful. The service user, or their nominated representative, may request to see the records, so they should be easily understood and avoid jargon or abbreviations.

4.43.2. A list should be maintained of the names, signatures and initials of all staff authorised to administer medicines and updated at least 6-monthly. This should be kept in the front of the MAR chart folder and updated to reflect staff changes.

4.43.3. A separate list should be maintained of the names, signatures and initials of all staff authorised to administer controlled drugs. This should be kept with the CD stationary on the ward.

4.43.4. Records must be maintained of all medicines brought into the home, for which the home is responsible, from whatever source; all medicines administered; all medicines disposed of or transferred from the home and any medicines carried forward from one cycle to the next. Collectively these should allow the quantity of medicines available for each service user to be easily determined at any time.

4.43.5. Record keeping for a service user who is self-administering their medicines is covered in section 4.

4.43.6. The Registered manager has a duty to ensure that appropriate medicines records are maintained. In incidences where other health care professionals are involved in the administration of medicines at the home, they must be asked to sign the home's records, as well as their own paperwork, to ensure that the home has a complete record of medicines administered. If the medicine is a controlled drug, the health care professional must be asked to complete the MAR chart **and** the controlled drug register.

4.43.7. If the medicines have been administered at a hospital or GP's surgery or similar, a code must be used on the MAR to indicate that the service user has attended the appointment and the medicines has been reported to have been given.

4.44. Document retention and disposal

4.44.1. It is a legal requirement for care home records to be retained within the home even when a service user has left the home. Records must be retained securely in a place where only authorised staff have access. In accordance with CQC guidance, social care records must be kept for **three years** after the date of last entry. After this time, the records must be reviewed and only retained while it is necessary or relevant to do so, for example, the records are relevant to the service user's current care.

4.44.2. Confidential records must not be disposed of with the normal waste. They should be shredded, so that they cannot be retrieved or a confidential waste disposal company must be used.

4.45. Management of medicines errors and incidents

It is recognised that, despite high standards of good practice and care, mistakes may occasionally happen. The mistake must not be hidden or ignored. If a member of staff is found to have hidden or ignored the mistake this will be considered gross misconduct and disciplinary action will be taken. For registered nurses this will include referral of the incident to the Nursing and Midwifery Council. In the event that a medicines error or incident has occurred the procedure below must be followed:

4.45.1. Ensure the service user is safe

4.45.2. Nurses should use their professional judgement and knowledge, including available reference resources, to assess the service user and the potential consequences of the error or incident. The nurse should contact the GP/out of hours service and outline what has happened. The instructions should be confirmed with the GP/out of hours service and followed, including any monitoring required. The instructions should be recorded in the service user's care plan and include the name of the health care professional spoken to and the time and date the conversation took place.

4.45.3. If the nurse does not contact the GP/out of hours service, the reason should be documented in the service user's care plan. The nurse is professionally accountable for this decision.

4.45.4. Explain to the service user what the error was and any possible side effects and reassure at all times, as appropriate for the individual.

4.45.5. Report the incident to the registered manager.

4.45.6. Inform the service user's family or person with lasting power of attorney for health and welfare, as appropriate. If the service user has capacity and does not wish you to report it to their family, this must be respected. If the service user does not have capacity, then the best interests process will need to be followed. Document who you have informed and any consent given.

4.45.7. The error must be recorded in the service user's care plan, in detail. The information should also be passed over at shift changes, an incident form must be completed and the on call clinician for the Lindridge Care Home must be notified.

4.45.8. If the error is the administration of the wrong service user's medicines, ensure that the service user who should have had the medicines has had their correct medicines and that arrangements are in place to obtain replacement medicines for this individual to replace the dose(s) wrongly given to a different service user.

4.45.9. The incident must be recorded via the SPFT safeguard incident reporting system. The severity of the error will determine the level of alert raised – i.e. it may be of a serious incident nature (guidance can be provided by the home manager or risk and safety team if staff are unsure)

4.45.10. An internal review of how the incident occurred undertaken by the registered manager (or his/her designated deputy) and documented. Any actions identified to prevent reoccurrence should be put in place.

4.45.11. Consideration should be given as to whether a safeguarding alert needs to be raised with the local authority regarding the incident.

4.45.12. The registered manager in conjunction SPFT risk and safety team must ensure that CQC are informed if the error/incident could or has resulted in significant harm to the servicer user or the incident has been reported to the police.

4.45.13. Consideration must be given to the need for further action in relation to supporting the member of staff involved. This will depend on the nature of the incident and could include for example: providing extra training, reassessment of competence, whether there is a need to stop the staff member from undertaking medicines duties and/or suspend them from all duties. This should be done within the bounds of relevant employment law. In cases of negligence or repeated poor practice by a registered nurse, referral to the Nursing and Midwifery Council may be necessary.

4.46. Medicine alerts and safety warnings

4.46.1. These are sent via e-mail and the home must ensure that Medicines and Healthcare Products Regulatory Agency (MHRA) has the correct e-mail address.

4.46.2. E-mails must be checked daily by the designated person and on the receipt of a safety warning/drug alert the e-mail should be printed out and the nurse on duty should check if there is any stock of the named medicine/medical device within the home.

4.46.3. The advice and timescales on the safety warning/drug alert must be complied with and the actions taken recorded. This could include removing any affected medicine or medical device from use. Where necessary, the nurse should make arrangements for a replacement supply of medicines.

4.46.4. Where the drug alert requires the batch number of a medicine to be checked, this must be done. If the batch number of a medicine is not available at the home, the advice of the supplying pharmacist should be sought.

4.46.5. If there are no medicines/medical devices specified in the notification at the home, this must be recorded on the safety warning/drug alert along with the nurse's signature and the date and this must be placed in the appropriate file. Drug alerts/safety warnings must be kept for two months from their date of receipt.

4.47. Disposal of medicines

The home has a duty of care to ensure that all waste is disposed of safely. This includes disposing of medicines safely.

4.47.1. Medicines that are no longer required, including refused and dropped/damaged doses of medicines, should be disposed of via a licensed waste handling company. Medicines may no longer be required because the expiry date is reached, treatment is completed or discontinued or the service user dies. Bought medicines (whether homely remedies stock or a service user's own) should also be disposed of via the licensed waste handling company when no longer required.

4.47.2. Following the death of a service user the medicines must be retained for at least seven days in case the Coroner's Office requires them. In the case of an active investigation the Coroner may request that medicines are kept for longer periods. Such medicines should be kept securely, separate from in use medicines, clearly marked as 'Retained at Coroner's Request' until permission is given to dispose of the medicines. If the medicines is requested to be given to the Coroner's Court or police as part of the investigation, a complete record of the medicines transferred must be kept at the home.

4.47.3. All medicines disposed of (including doses left in the MDS system) must be recorded to ensure a fully accountable system.

4.47.4. Staff with medicines management responsibilities must be familiar with the process for destroying controlled drugs.

4.47.5. The record of disposal must detail the following:

- Date of disposal
- Name, strength and form of medicine
- Quantity disposed of
- Name of the service user for whom the medicine was prescribed
- Reason for disposal
- Signature of the nurse arranging the disposal.
- A second nurse or suitably trained and competent member of care staff should check the record and sign as a witness.

4.47.6. Medicines should not be removed from the packaging for the purposes of disposal. For example, liquids should be disposed of in the bottles (ensuring that the bottle will not break); solid dosage forms should be left in the blister packs. It is acceptable to remove the outer cardboard packaging or the reusable components of a MDS system. Controlled drugs can be removed from all packaging for denaturing. Any information which could identify the service user whose medicines it is should be removed or deleted before placing in the medicines waste bins.

4.47.7. Waste medicines must be stored in a locked cupboard, separated from the medicines in use, in the waste medicines bins provided by the licensed waste handling company.

4.47.8. Some medicines are classed as hazardous waste and nurses should ensure that waste medicines are segregated correctly. Advice should be obtained from the licensed waste carrier, documented and followed.

4.47.9. Waste medicines transferred to the licensed waste handling company must be accompanied by the appropriate waste transfer note or waste consignment note, as appropriate. The home must retain copies of this documentation for at least two years for a waste transfer note and three years for a waste consignment note. It is the home's responsibility to ensure that the documentation is completed correctly but advice should be sought from the licensed waste handling company.

4.47.10. The home should also conduct an internal annual audit to ensure the requirements are being met and identify any changes.

4.47.11. It is the responsibility of the home to ensure that waste disposal requirements are complied with. Further advice can be found in the Department of Health document: Environment and sustainability. Health Technical Memorandum 07-01: Safe management of health care waste.

4.48. Disposal of controlled drugs

4.48.1. When a CD is disposed of, a record must be made in the home's record of disposal and, where the CD is included in the register, the CD register must be also be updated.

4.48.2. The record in the CD register must be made on the page which details the name, strength and form of the medicines being disposed of for the correct service user. It must state the date the medicines are disposed of and the quantity disposed of. It is essential that the running balance is updated to reflect the destruction of the CD, including zero balances where appropriate.

4.48.3. Disposal must be undertaken by a nurse or pharmacist, and a trained and competent member of staff both of whom must sign the entry detailing the disposal of the CD.

4.48.4. Before destruction, controlled drugs requiring safe custody must be stored in the CD cabinet, separated from the medicines in use, and clearly marked as "awaiting disposal do not use".

4.48.5. Before transfer to the licensed waste handling company the medicines should be denatured using a CD denaturing kit purchased for that purpose. The directions on the kit should be followed. Depending on the kit used, there may be a time period required to denature the CD completely. The kit should be stored in the CD cabinet until denaturing is completed. If the nurse is unsure of how to dispose of a specific controlled drug the advice of a pharmacist must be sought and documented.

4.48.6. The organisation should have a T28 exemption registered with the Environment Agency for this activity. Advice should be obtained from the Environment Agency.

4.48.7. *The designated organisation that is responsible for the removal/disposal of clinical waste from Lindridge is PHS Tel: 01204 704633*

4.49. The rehabilitation unit

4.49.1. There are some units within Lindridge that operate as rehabilitation beds (previously known as step-down beds). Patients occupying these beds are transfers from acute hospital who require a small period of enhanced care prior to full discharge to their pre-admission accommodation.

4.49.2. The basic principles of medicines management adopted by Lindridge and laid out in this code shall also apply to the rehabilitation units. Extra consideration must be given to the following areas:

4.49.3. Admission to rehabilitation

- New patients must have their current GP SCR obtained on admission BEFORE they are temporarily registered with the GP service that has clinical responsibility for the rehabilitation patients whilst at Lindridge. This is (an-remove) important to ensure medicines accuracy during the admission medicines reconciliation.
- A medicines reconciliation must be completed on admission – this can either be performed by the nursing team or the pharmacy team (for the medicines specific side) and should use the pre-acute admission GP SCR and the discharge summary from the transferring hospital as the minimum information sources. Any discrepancies should be queried with the transferring hospital and escalated to the incumbent GP for consideration.

4.50 Training

4.50.1 Medicines must only be administered by registered nurses or by designated and appropriately trained staff who have had their competency assessed and to whom specific tasks have been delegated.

4.50.2 The registered manager (or designated deputy) is responsible for ensuring arrangements for training staff are in place and ensuring that regular reviews of competency are carried out.

4.50.3 Regular reviews of competency should be undertaken at least annually or more frequently, if necessary. Nurses must keep their skills and knowledge up to date and must provide evidence of on-going professional learning and development.

4.50.4 All nursing staff must attend the Trust Nurse Medicines Management day training every two years as part of their mandatory training.

4.50.5 As part of the induction training, new care staff members will be informed that they cannot administer any medicines until they have received training and had their competency checked for the tasks to be delegated to them by the responsible nurse.

4.50.6 Newly appointed nurses must receive training on the use of the medicines administration system used in the home and the documentation and recording used at the home.

4.50.7 All staff administering medicines, including care staff to whom specific tasks have been delegated, will need to have read and understood the homes medicines protocol and procedures. Staff must sign the signature record sheet to indicate that they have read and agree to comply with the medicines protocol and procedures.

4.50.8 The home will provide regular refresher training for staff in order to ensure that skills are up to date and reflect current best practice.

4.50.9 Nursing stations have a folder of “bite-sized” training that can be utilized at any time to refresh staffs’ knowledge on particular topics relevant to the home e.g. Safer transcribing, Controlled Drugs, medicines and falls risk.

4.50.10 The home will provide up to date reference sources including the following:

- A copy of the Handling of Medicines in Social Care RPSGB 2007
- A copy of CQC Essential Standards of Quality and Safety
- A copy of the NICE guidelines: Managing Medicines in Care Homes
- A copy of the current BNF or access to the online version of the BNF
- A copy of the NMC Standards of Medicines Management

5.0 Development, consultation and ratification

5.1 This policy was written by the Deputy Chief Nurse in collaboration with the Associate Director of Operations Lindridge Care Home and the Deputy Chief Pharmacist.

5.2 This policy was ratified by the Drug and Therapeutics Group and Professional Policy Forum.

6.0 Equality and Human Rights Impact Analysis (EHRIA)

- Undertake an equality and human rights impact analysis.
- Where an impact analysis is deemed unnecessary, record the decision

7.0 Monitoring Compliance

7.1 Regular audits (held in audit file and on the shared drive) must be carried out by the registered manager, pharmacy team or an appropriate person nominated by the registered manager, to ensure that processes for medicines management are being followed correctly including documentation and recording, and storage of medicines.

7.2 There is a monthly medicines management audit which can be used in conjunction with 6 monthly Q&S style medicines audit and the 6 monthly CD inspection audit.

7.3 Where a discrepancy is found in the audit that indicates that a medicines error has been made, which has not been previously identified, the procedure in section 18.2 should be applied. If the error is not recent and there are no current urgent concerns about the relevant service user's health, there may be no need to contact the out of hours GP; however the service user's GP must be informed as soon as possible.

8.0 Dissemination and Implementation of policy

- Following ratification of this procedure, the sponsor will ensure the document is forwarded to the Health & Social Care Governance Support Team who will allocate an official document number and log the document on the Trust central database.

- The Health & Social Care Governance Support Team will inform the sponsor and document author of the official document number allocated.

- The Health & Social Care Governance Support Team will place this guidance on the central database and will upload it to the Trust website for staff access.

- Further dissemination will be agreed between the authors and the Executive Sponsor and compliance against specified training will be monitored through the audit process.

9.0 Document Control including Archive Arrangements

The Health & Social Care Governance Support Team will maintain an archive of previous versions of the non-medical prescribing procedure / policy and will update the central database and website. Archived documents will be listed on the database, with details of the date they were archived and removed from the website and a link to the superseding document if appropriate.

The Health & Social Care Governance Support Team will also store electronic copies of the non-medical prescribing equality impact assessment, dissemination plans, and review and approval checklists.

Requests from staff to access archived procedural documents can made to the Health & Social Care Governance Support Team (for all documents dated April 2006 onwards) Requests from other organisations or individuals outside of the Trust must be made in accordance with the Freedom of Information Act.

10.0 Reference documents

The following documentation has informed this policy. Staff are encouraged to be familiar with these documents, especially those staff who are registered practitioners.

- **Standards for Medicines Management** (2017) published by The Nursing and Midwifery Council available: https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-medicines-management/

- **NICE Social Care Guidelines (SC1): Managing Medicines in Care Homes** (2014). Published by the National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/Guidance/SC1

- **NICE Quality Standard: Medicines Management in Care Homes** (2015). Published by the National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/guidance/qs85/resources/medicines-management-in-care-homes-pdf-2098910254021

- **NICE Guidelines (NG27): Transition between inpatient hospital settings and community or care home settings for adults with social care needs** (2015). Published by National Institute for Health and Care Excellence (NICE), available: https://www.nice.org.uk/guidance/ng27/chapter/Recommendations

- **The Handling of Medicines in Social Care (2007).** Published by the Royal Pharmaceutical Society of Great Britain, available: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/handling-medicines-socialcare-guidance.pdf?ver=2016-11-17-142751-643

- **CQC – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment – section 2 g/f provides** compliance guidance for care home providers against what Care Quality Commission inspectors are looking for when they visit carehomes.

11.0 Bibliography

In addition, this policy is intended to ensure that medicines are handled appropriately, in accordance with the following legislation and guidance as relevant to the setting:

- Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities)
- (Amendment) Regulations 2015
- The Medicines Act 1968 and the Human Medicines Regulations 2012
- The Misuse of Drugs Act 1971 and associated regulations
- Guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Pharmaceutical Society.
- Equality Act 2010
- Mental Capacity Act 2005
- Nursing and Midwifery Council (NMC) Standards for Medicines Management 2007

12.0 Glossary

- MAR- Medicines Administration Record. The legal record of a medicine being administered or not administered.
- OTC- Over the counter in reference to medications/supplements that can be obtained without a doctor's prescription.
- POD- Patient's Own Drugs in reference to the POD locker where they would be stored.
- CD- Controlled Drug.

13.0 Cross reference

- Safeguarding Adults Policy
- https://policies.sussexpartnership.nhs.uk/clinical-3/safeguarding-adults-at-risk-policy?highlight=WyJzYWZlZ3VhcmRpbmciXQ==
- Medicines Management Update for Qualified Nurses - Training Schedule (accessed via 'My Learning')
- Information Governance Assurance Policy
- https://policies.sussexpartnership.nhs.uk/corporate/information-governance-policy
- Clinical Risk Assessment and Safety Planning: https://policies.sussexpartnership.nhs.uk/clinical-3/clinical-risk-assessment-safety-planning-risk-management-policy-and-procedure
- Mental Capacity Act Policy: https://policies.sussexpartnership.nhs.uk/mental-health-act-and-mental-capacity-act-policies

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14.0 Appendices

Appendix 1 **Month:** …….. **Year:** ……

Medicines Refrigerator & Clinic Room Temperature Log

The clinic medicines refrigerator and room temperature should be recorded every day to ensure the medicines are stored appropriately. The refrigerator temperatures should be between **2°C and 8°C**. Room temperature should be **25°C or less**.

DATE	TIME	CURRENT TEMP (°C)	MIN TEMP (°C)	MAX TEMP (°C)	ROOM TEMP (°C)	SIGNATURE	ACTIONS
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							
13th							
14th							
15th							
16th							
17th							
18th							
19th							
20th							
21st							
22nd							
23rd							
24th							
25th							
26th							
27th							
28th							
29th							
30th							
31st							

Specific considerations and required actions:

- After recording refrigerator temperatures, ensure the thermometer is reset.
- Unless a frost-free model, monitor any build-up of ice. Defrost when ice is visible in the fridge and at least annually. Ideally, defrost when the refrigerator is empty; alternatively store any content in another refrigerator temporarily.
- **If medicines are, or have been frozen (<0°C), medicines must not be re-used. Inform the pharmacy team and local estates as a matter of urgency. Use another refrigerator until the issue is rectified for any replacement stock.**
- **If the refrigerator temperature is outside the required temperature range (between 2°C to 8°C)** seek urgent advice from pharmacy staff. If this issue recurs, inform Estates and do not use the refrigerator until resolved.
- If the ambient temperature exceeds 25°C for a short period during a heatwave, this will not have an overall damaging effect on the medicines. However, if the temperatures above 25°C are recorded for any other reason or continually recorded, the reason should be investigated immediately and the advice of the local pharmacy team sought.

Refrigerator content

- All medicines should be stored in the original packaging as this is printed with the expiry date and batch number, contains a patient information leaflet and administration instructions and protects products from light and damage.
- Fridge contents should be evenly distributed to allow air to circulate around items and shelves.
- Medicines should be stored in the main body of the fridge, not in the bottom drawer or door where the temperature can be higher. Storage adjacent to a freezer compartment or freezer packs should also be avoided.
- Stock must be rotated according to expiry date and older stock placed at the front of the fridge to be used first.
- Expired stock must be removed as soon as possible and safely destroyed
- Fridge contents should not occupy more than 50% of the volume of the main body of the fridge i.e. the fridge must not be overfilled so that air flow is not compromised. An overfilled fridge can also create potential for freezing and lead to poor stock rotation.

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Appendix 2 Checklist for the registered manager to assess the competence of healthcare assistants to check the administration and recording of Controlled Drugs (CDs) in the absence of a second registered nurse

This checklist has been developed to help the Lindridge registered manager to assess healthcare assistants to be able to second check when CDs are administered in the absence of a second qualified member of the nursing team. They are not expected to have any clinical input into the process. They are only being asked to initial/sign that they have witnessed that the correct medicine and dose was selected, they saw it administered to the correct patient and the proper recording took place on the drug chart and in the CD register. Due to the limited use of CDs on most wards, some of the assessment can take place using non-CD medicines as the process of identification, watching the administration and recording on the drug chart applies equally to all medicines. Additional training on how to record in a CD register will need to be undertaken.

The Lindridge Healthcare assistant's name: ……..…… Registered manager's name:…….....

The healthcare assistant is able to demonstrate that:	**Date demonstrated**
They can read drug names on a drug chart, but are confident to refuse to be a witness if they cannot read them?	
They can correctly select a range of medicines from the drug trolley, including the correct dose?	
They know how liquid medicines are correctly measured using oral syringes and measuring cups?	
They know how to witness the administration of medicines, including unusual formulations like fentanyl patches?	
They know how to record the administration on the drug chart, including when special administration or omission codes need to be used?	
They know how to match the page in the CD register with the CD administered?	
They know how to record a dose administered in the CD register?	
They are aware of the guidance in the front of the CD register how to record CDs and what to do if an error is made recording?	
They know how to check the CDs stock level after administration and what should happen if there is a discrepancy found with the register?	
They know that if at any point they are unsure that everything was done correctly, they can refuse to witness the administration?	
Depending on local circumstances, they know who should be called for advice if they feel they cannot witness the administration?	

I confirm that I am competent to take on the role of second checker when CDs are administered:……..... (Healthcare assistant signature)

…….. (date). I confirm that …… (Healthcare assistant's name) has successfully demonstrated to me that they can undertake the role as second witness when CDs are administered…… (registered manager's signature)..……(date)

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Appendix 3

Service agreement for service users who self-administer medicines

Level 3

I …… (name of service user), wish to administer my own medicines. I understand that I will be responsible for taking and the safe keeping of my medicines once it has been supplied to me by a member of staff.

My medicines have been explained to me i.e. its therapeutic purpose, the dosage, the times to be taken, any side-effects and who to ask if there are any concerns.

I do not need supervision to take my medicines and will take responsibility for its administration and, I will comply with the following:-

- I will keep all my tablets, medicines and creams locked in a locked drawer, cabinet or cupboard in my room.
- I will ensure that the key is kept on my person at all times.
- I agree for staff to regularly check that my medicines are stored safely and correctly, and agree to them carrying out a check of the stock balance.
- I will ensure that I give any medicines that have been discontinued by my doctor to a staff member for safe disposal.
- I understand that if there are any concerns expressed by staff that they will talk to me about this and if necessary consult with the Doctor and/or Pharmacist.

Signature of service user	
Signature of nurse assessor	

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Self-administration aide memoire

Service users name: Unit: Week commencing:

Put a tick or enter your initials in the correct box each time you take your medicines at the correct time each day

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Lunch time							
Tea time							
Night time							

- If there is a time when you do not take your medicines as you should have done, please be sure to tell a member of nursing staff as soon as you can.

If you require this document in an alternative format i.e. easy read, large text, audio, Braille or a community language, please

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Service user self-administration assistance sheet

Service user name…… **Unit**……..

Name of medicine	Prescribed For…	When to take it				Other Information
		Breakfast	Lunch	Teatime	Bedtime	

Completed by…….... **Designation**…

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Daily Self-administration Progress Record – Stages 1 & 2

Service user's name: Unit : Week commencing:

Date →																												
	B	L	T	N	B	L	T	N	B	L	T	N	B	L	T	N	B	L	T	N	B	L	T	N	B	L	T	N
Requests medicines at correct time																												
Reads instructions on bottles																												
Selects correct doses																												
Takes medicines																												
Returns meds to appropriate container																												
Leaves medicines secure? Is the locker secured (stage 2)																												
Initials																												

Key: √ = Independently performs task, **X** = Needed prompting **O** = Not applicable

Comments on how well the service user is coping and on their insight and attitude to medicines: (Please continue overleaf if necessary)

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Appendix 4

COVERT ADMINISTRATION OF MEDICINES
RECORD OF DECISION & REVIEW

This form must be completed in full and attached as part of the service users medicines profile (MAR chart folder)

Name of service user	
Date of Birth	
Nursing unit	
Date of MDT decision	

ASSESSMENT CRITERIA	**RECORD OF MDT RESPONSE**
Has the prescriber performed a capacity assessment and determined the service user lacks the capacity to consent? *The law assumes all adults to be capable of giving consent unless demonstrated otherwise.* *Assessment of capacity to consent should be subject to continuous review*	**YES / NO** *(delete as appropriate)* Surgery Name:_____ Prescriber's Name:_____ Date of Assessment:_____ ***Decision MUST be recorded in the medical notes***
Is there a person available with power to consent on behalf on the service user? E.g. Welfare guardian *Covert administration can only be given if consent is gained from this person unless this is impractical* *If consent is sought but NOT given, the reasons for refusal should be clearly documented.*	**YES / NO / IMPRACTICAL** *(delete as appropriate)* Name of Person:_____ Consent given: YES / NO *(delete as appropriate)* ***OR*** Reason contact impractical:_____

List of mediciness to be given covertly *Any specific advice around covert administration received from the consulting pharmacist should also be clearly stated beside the appropriate medicines e.g. "do not mix with tea/coffee"*	_____ _____
Which methods will be used for administering the medicines? *E.g. mixed in yoghurt, mixed with jam, in a cup of squash* *Be mindful of any advice given by the consulting pharmacist*	
Why is this medicines necessary? All medicines should be reviewed prior to covert administration and rationalised	
What alternatives were considered by the MDT and why were these rejected? *E.g. non-pharmacological treatment options, medicines holiday, alternative administration routes*	
Why is covert administration considered to be the least restrictive way to treat the service user?	

Has the service user previously expressed views on the current/proposed treatment that would be relevant? *e.g. stated that opioids make them feel uncomfortable and itchy, has previously rejected specific treatments*	**YES / NO** *(delete as appropriate)* If YES, state:	
Staff members permitted to covertly administer these mediciness *Staff involved in preparing and giving medicines MUST have received appropriate guidance in covert administration of medicines*	**NAME and DESIGNATION** *(list staff below)*	
How will the covert administrations be recorded on the MAR chart? *Covert administrations should be clearly identifiable*		
When will the need for covert administration be reviewed? *FULL reviews must take place at least annually.* *MINI reviews must take place at least every 3 months.*	Date of next FULL review :_____ Minimum frequency of MINI reviews:_____	
MDT team members consulted during this covert decision *Includes healthcare professionals, carers, advocates, family members etc*	**NAME** _____ _____ _____ _____ _____ _____ _____	**DESIGNATION** _____ _____ _____ _____ _____ _____ _____
Name of **pharmacist** consulted about medicine covert suitability and administration advice	**NAME**	**DATE CONSULTED**
Do any of the MDT team ***disagree*** with proposed treatment? *If YES, they must be informed of their right to challenge the treatment proposed*	**YES / NO** *(delete as appropriate)* Date informed of right to challenge:	**IF YES....Name & Reason(s):**

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MDT review log of continuation of covert administration

Name of service user	
Date of Birth	
Nursing unit	

Any "No" answer should prompt an immediate full review of capacity and suitability for covert administration.

DATE	Is medicines still necessary? Y/N	Is covert administration still needed and appropriate? Y/N	Is capacity assessment paperwork still valid and available to view? Y/N	Names of reviewing members	Designation of reviewing members

DATE	Is medicines still necessary? Y/N	Is covert administration still needed and appropriate? Y/N	Is capacity assessment paperwork still valid and available to view? Y/N	Names of reviewing members	Designation of reviewing members