Safe Management of Medication Policy – NAS Adult Services

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Purpose

Medication management and training in all NAS Services will meet with current legislation and the relevant inspection standards for each type of service and will ensure the best outcomes are achieved for the people we support, with regard to their medication.

Scope

This policy deals with medicines for individuals at all Adult Services within the National Autistic Society.

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PART ONE - POLICY

1. LEGISLATION AND STATUTORY REQUIREMENTS

1.1. National Autistic Society (NAS) aims to ensure that all staff involved in the handling of medicines adhere to the appropriate legislation and guidance to provide person centered care and medication support where required

1.2. This policy is applicable to all staff providing care and support and their line managers and supervisors.

1.3. Medicines must be handled according to the requirements and recommendations as follows, depending on the type of service and location:

- Medicines Act 1968
- Misuse of Drugs Act 1971
- Misuse of Drugs (safe custody) Regulations 1973
- Mental Capacity Act 2005 (England and Wales)
- Adults with Incapacity (Scotland) Act 2000
- Royal Pharmaceutical Society guidelines “The Handling of Medicines in Social Care” (2007)
- NICE guideline “Managing Medicines in Care Homes” (2014)
- NICE guideline “Managing medicines for adults receiving social care in the community” (2017)
- Nursing and Midwifery Council “ Standards for Medicines Management”
- England - Health and Social Care Act 2008 CQC Fundamental Standards
- Scotland – National Care Standards
- Wales – Care Standards Act 2000 and National Minimum Standards
- Northern Ireland - DHSSPNI Care Standards

1.4. NAS will ensure individuals have their medicines safely and at the times they need them and in a safe way. NAS will ensure that the best outcomes are achieved for all individuals with regard to their medicines.

1.5. All NAS services will comply with the requirements of the appropriate regulator:

- England- (Adults) Care Quality Commission
- England (Children) Ofsted
- Wales – CSSIW
- Scotland – Care Inspectorate, Scotland
- Northern Ireland – RQIA (Regulation & Quality Improvement Authority)

2. PRINCIPLES OF GOOD PRACTICE

2.1. Our purpose is to ensure the safe handling of medication within the care and support services delivered by NAS.

2.2. NAS aims to ensure that individuals receive appropriate help and encouragement to manage their own medication. Where this is not deemed safe or appropriate, the policy aims to ensure that individuals receive a suitable level of support and assistance with their medication.

2.3. This medicines policy will be reviewed annually by OPUS and the National Lead for Health & Safety to ensure that it reflects current working practice within NAS and staff will be consulted on any changes made.

2.4. Everyone involved in an individual's care and support is responsible for ensuring that his/her medication is managed appropriately. However, the primary responsibility for the prescribing and management of medication rests with the individual's doctor in consultation with other members of the primary health care team and the individual.

2.5. NAS takes a person-centered approach to care /support planning. Individuals will be fully involved in the development of their support plan and this will include giving express consent concerning arrangements for the management of medication. The views of the individual must be respected and any refusal to take medication should be recorded and appropriate advice taken if this persists.

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

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

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

2.9. Individuals living in their own homes are responsible for managing their own medication if they are assessed as having "capacity". (See section 6 Choice & Consent.)

2.10. Individuals have the right to refuse medication. The views of the individual must be respected and any refusal to take medication should be recorded and reported to the GP.

2.11. Confidentiality must be observed regarding the individual's medical history and medication.

2.12. Medication should never be pre-dispensed or dispensed for another person to administer.

2.13. If there is any query or concern regarding an individual's medication, then that medication should not be given and the GP must be consulted immediately.

2.14. Medication may only be administered by designated, appropriately trained and competent staff.

2.15. All individuals taking medication should be monitored for changes in their condition, allergies etc, which may be medication related, and the GP kept informed.

2.16. All staff involved in medication related activities are required to read the medication policy and sign to acknowledge their agreement to abide by it (Appendix 1).

Residential Services

2.17. In **residential services**, the administration of medicines must be “protected time” and staff must be instructed not to disturb their colleague during the times that medication is administered to reduce the risk of medication errors.

3. SUPPLY OF MEDICATION

3.1. Staff will only administer medication from individual pharmacy-labelled containers or professionally-filled and sealed monitored dosage systems. These will be dispensed by the pharmacist and prescribed to the individual.

Residential Services

3.2. NAS **residential services** have designated members of staff who will be responsible for ordering medication from the GPs every four weeks, ensuring that required medication stocks are always available to individuals.

3.3. Prescriptions are ordered using the repeat prescription form and submitted to the surgery at the appropriate time. This timescale will be determined by the supply pharmacy's requirement for receiving the prescriptions for dispensing.

3.4. Liaison with the prescribing doctor is required for any changes or discrepancies in the medication. This should be done to enable the individual to receive the correct medication in time for the new start day of the 28-day cycle.

3.5. The supply pharmacy should be informed of any changes to medication during the month to ensure continuity of supply. This includes medication changes, discontinued items, new individual details etc.

3.6. On receipt of the prescriptions, these should be checked for errors and omissions and then sent to the supply pharmacy. The prescribing doctor must be notified immediately of any errors or omissions.

3.7. Medication will be delivered every four weeks by the supply pharmacy. Delivery of medication should be planned to arrive at least 5 days before its start date in order to resolve any queries (except in an emergency).

3.8. On the day of arrival, all medication should be checked in by the senior on duty and locked away immediately.

3.9. Any Controlled Drugs must be signed for, entered into the Controlled Drugs register and locked in the Controlled Drugs cupboard. This must be undertaken by two suitably trained people.

3.10. Any medication that requires fridge storage must be placed in the medicines fridge immediately.

3.11. Individuals who are new to the service are requested to ideally bring in a complete 28-day supply of medication on admission. The doctor's report form detailing their current medication must match the pharmacy labels on the medication before any medication is administered. If the doctor's letter and labels do not agree, a fax detailing the correct medication MUST be obtained from the doctor before any medication may be administered. It is essential that all medication brought into the service is signed in on admission, on the Medication Administration Record (MAR) sheet.

3.12. For interim or mid-month supplies, it may be necessary to handwrite a MAR sheet. A printed MAR sheet from the supply pharmacy is preferable but on occasions it may be necessary for a senior person to handwrite an item of medication on to an individual's MAR sheet. The appropriate procedure must be used (see procedure for dose changes).

Domiciliary / Day and Supported Living Services

3.13. **In domiciliary/ day and supported living services,** staff are not authorised to administer medication from family-filled dosette boxes. They may however occasionally "prompt" individuals to take their medication from a family-filled dosette box. If the prompt is required more than 2-3 times a week, a review should be undertaken .

3.14. Wherever possible, medication should be obtained by the individual or a family member or representative. If necessary, staff may take a prescription to the pharmacist and return medication to the individual. Where this occurs, staff must make a record of when the medicines were ordered, when they were supplied and check for any discrepancies between the medicines ordered and those supplied.

3.15. Prescription requests need to be completed by the individual, a member of their family, a representative or an authorised member of the primary health care team. In exceptional circumstances, the individual's regular support worker may undertake this task but only if authorised by the Registered Manager.

3.16. Where staff are required to transport medicines e.g. collecting or returning medicines from the pharmacy, an "Authorisation to Transport Medication" form should be completed (See Appendix 32).

3.17. For **day services**, all medication must be brought into the service in the original pharmacy-labelled container. To ensure this, it may sometimes be necessary to request a separate supply for the day service (Appendix 27).

3.18. Individuals and /or their advocates should be asked to complete a form detailing the medication brought into the day service. (Appendix 27).

3.19. To ensure families/carers send the individual's medication to the day service in the correct format, a template letter can be used (see Appendix 27). This requests the supply to be in its original container with the correct expiry date and containing only that medicine that is stated on the label (including the correct amount of tablets i.e. not some taken out for use at home / respite).

4. MEDICINES RECONCILIATION

4.1. The Manager is responsible for co-coordinating the accurate listing of an individual's medicines when they transfer to the service. This must occur in a timely manner to ensure the individual does not go without any medicines.

4.2. The following people may well be involved in the medicines reconciliation: the individual, family, carers, pharmacist, other health and social care practitioners as appropriate.

4.3. On the day an individual transfers into or from a service, the following information must be made available:

- Individual's details (full name, date of birth, address)
- GP details
- Details of other relevant contacts defined by the individual/family e.g. regular Pharmacist
- Known allergies and reactions to medicines and the type of reaction experienced
- Medicines the individual is currently taking
- Changes to medicines including medicines started, stopped, dosage changed, reason for change
- Date and time the last dose of any "when required" medicines was taken or any medicine given less often than once a day (e.g. weekly or monthly medicines)
- When the medicine should be reviewed or monitored
- Any support the individual needs to carry on taking the medicine
- What information has been given to the individual/family/carers

4.4. The person completing the medicines reconciliation (name, job title) and the date should be recorded on ….. [state where this is to be recorded – is there a specific form that needs to be completed?].

5 . S T O R A G E

Residential and Day Services

5.1. In **residential and day services,** all medication must be stored in lockable cupboards or in a lockable drug fridge or in individual lockable cupboards in the individual's room.

5.2. Internal (i.e. those medications taken by mouth) and external preparations (i.e. those medications not taken by mouth) should be stored suitably separated. Topical medicines e.g. emollients may be stored in the individual's room and applied by staff during personal care.

5.3. Items requiring fridge storage should be kept in a lockable drug fridge. The temperature of the fridge should be within the range 2-8 degrees Centigrade. A log of temperatures (maximum, minimum and ambient) must be recorded daily (Appendix 3) and any temperature that is out of range must be reported to the Manager who will take action to rectify it i.e. by defrosting the fridge or if not effective, calling the service engineer. The fridge should be defrosted and cleaned monthly (Appendix 28).

5.4. Room temperature for medication storage is generally between 15-25 degrees Celsius but this may be different for individual medicines – check the patient information sheet for required temperature storage. An increasing number of medicines are stating maximum storage temperatures below 30 degrees Celcius. A log of room temperatures should be recorded daily (see Appendix 16). The Manager must be informed if the room temperature exceeds this temperature.

5.5. Controlled Drugs must be stored in the approved CD cupboard i.e. metal lockable cupboard that conforms to the Misuse of Drugs (safe custody) regulations. It must be bolted to a solid wall. (See Section 14 for storage of Controlled Drugs by people who self-administer).

5.6. Oxygen cylinders – See section 20

5.7. Keys to the medication cupboards and medicines fridge should be held by the person in charge and passed to the next designated person at shift change. Keys must never be left in drawers, left unattended or taken home. Only staff members competent to administer medicines should have access to the keys.

5.8. Duplicate keys must be held in a secure location. Medication cupboards must never be left opened and unattended.

5.9. A lockable cupboard or drawer must be available in each individual's room for safe storage of medicines, if the individual self-administers following a risk assessment.

5.10. Medication should be date-checked on a regular basis and stored and used in date order. Expired medication should be returned for disposal via the pharmacy.

5.11. Medication storage areas including trolleys, cupboards and fridges must be cleaned regularly and checked on a monthly basis.

Domiciliary Care and Supported Living Services

5.12. In **domiciliary care**, all current medication should be kept together in a place of safety known and accessible to the individual if appropriate, and specified in the support plan. Where this is not appropriate, medication should be kept in a safe place where it is only

accessible to family, staff and other healthcare professionals. This should be agreed and noted in the support plan.

6. CHOICE AND CONSENT

6.1. All individuals should be given the choice to take or refuse medication and their dignity and independence should be maintained at all times.

6.2. Individuals should also be offered choice about where the medication is administered. Appropriate privacy and dignity should be maintained at all times. Individuals should be reassured about the medication that they are about to receive and told what is going to happen.

6.3. Medication may not be administered without consent. Where possible, the person should clearly provide informed consent, which should be recorded in the individual's support plan. If this is not possible, but there is a chance that the person can give consent, then the person should be given support to be able to make an informed decision. Full details should be recorded (Appendix 26). This is particularly important where mental capacity changes.

6.4. If it is not possible to obtain consent, key people acting in the best interests of the person can make a best interests decision. This includes a full assessment from a healthcare professional. Documentation of how and why the decision was reached must be made (refer to the Mental Capacity Act / Adults with Incapacity (Scotland) Act).

6.5. Where an individual does not have capacity to give consent, or where their wishes appear contrary to their best interests, instructions should be sought from the GP in conjunction with family members, carers as appropriate. In such cases, the individual support plan must be referred to. This should contain the person's views and preferences.

6.6. A individual will be said to have capacity to manage their medication if they can:

- Understand how to take their medication and understand in broad terms the nature of the medication and why it is being prescribed
- Understand the consequences of either not taking the medication or not following the GP's instructions
- Retain the information
- Understand the information
- Weigh the information
- Make choices and communicate them.

6.7. It is an individual's right to refuse medication.

6.8. Where the individual has capacity to self-administer but may need physical assistance, staff with the informed consent of the individual (or their relative or representative) will be asked to assist the individual as specified in their support plan. The individual retains responsibility for the administration of their medication. In emergency situations where circumstances change on a short term basis, to ensure the needs of the individual are met, full administration of medicines by staff may be necessary for a short period.

6.9. Where the individual lacks capacity and capability to self-administer, a risk assessment will be undertaken and a multi-agency best interest decision made following a capacity assessment. Following this, the decision regarding the most appropriate method of administration would be made.

6.10. The result of this assessment, including any medication support required, will be recorded as part of the support plan. Where it is necessary to administer medication to an individual, a MAR is required identifying the name of the medication, dose and times of administration.

6.11. Medicines are used to treat and prevent disease or to relieve symptoms. They must never be used as a form of punishment or for the convenience of professionals, staff or anyone else.

6.12. An advance decision or advance directive (Scotland) to refuse medication can be made by individuals. This enables the individual to make treatment decisions in the event of losing their capacity at some time in the future. *Please note that an advance directive is not legally binding in Scotland, unlike an advance decisions in England and Wales, however one of the general principles of the Adults with Incapacity (Scotland) Act 2000 is that if someone lacks capacity to make a decision for themselves and needs medical treatment, the wishes of the adult should be taken into consideration when making a decision on their behalf. Thus an advance directive should be taken into account.*

6.13. Evidence of any advance decision / directive made by an individual will be detailed in the individual support plan.

6.14. Please refer to the Mental Capacity Act 2005 (for England & Wales) and Adults with Incapacity (Scotland) Act 2000 for appropriate guidance around supporting adults without capacity to consent to medication

7. COVERT ADMINISTRATION

7.1. Disguising medicines in food or drink is generally **not** permitted.

7.2. In exceptional circumstances, covert administration of medicines (disguising medicines in food or drink) may be necessary but is only lawful (in accordance with the Mental Capacity Act 2005) where the individual lacks capacity and it is in the individual's best interest. Before covert administration of medicines can proceed, the Manager must have the written support of the multidisciplinary team. The best interest assessment and decision to administer medicines covertly should be clearly documented and a review date set.

7.3. Considerations for covert administration of medicines are as follows:

- The individual's best interests are considered at all times.
- The medication is essential for the individual's health and well-being
- The decision to administer a medicine covertly should be a contingency measure after an assessment of the individual
- Carers, relatives and the multidisciplinary team (including the prescriber and pharmacist) should be involved in the decision
- The method of administration should be agreed with the GP and pharmacist

7.4. The decision, action taken and details of all parties concerned should be documented in the support plan and reviewed at appropriate intervals (see Appendix 2).The process for covert administration is as follows

7.5. An assessment of the person's mental capacity should be undertaken to make a specific decision about their medicines

7.6. The Manager should seek advice from the prescriber about other options e.g. whether the medicine could be stopped

7.7. A best interest meeting must be held to agree whether giving medicines covertly is in the person's best interest

7.8. The Manager must record any decisions and state who was involved with the decision making process

7.9. The Manager must agree where the records of decision are kept and who has access

7.10. The Manager must seek advice from the Pharmacist to plan how the medicines can be given covertly

7.11. The GP must provide authorisation and the Manager must provide clear instructions in the support plan.

7.12. The Manager must ensure the staff are trained and assessed as competent to give the medicine covertly

7.13. The Manager must set a date to review the decision to give medicines covertly

7.14. In Scotland, covert treatment may only be considered for a person who lacks capacity to make decisions about treatment. In such cases, treatment may only be administered under a certificate of incapacity (Section 47, Adults with Incapacity (Scotland) Act 2000) or appropriate Mental Health (Care and Treatment) (Scotland) Act 2003 documentation.

7.15. It should be noted that if an individual requests that their medication is added to food or drink, this is not “covert” as they are fully aware. Advice should be sought from the Pharmacist to ensure it is appropriate to mix the specific medication in the proposed food/drink to ensure the delivery method will not alter the uptake, dosing or efficacy of the medication.

8. DOMICILIARY / DAY / SUPPORTED LIVING SERVICES

Domiciliary, Day and Supported Living services

8.1. In **domiciliary, day and supported living services**, staff may administer medication to individuals where this has been identified as a requirement in the needs assessment and support planning process.

8.2. The assessment of needs should involve a risk assessment of medication (Appendix 11) and the medicines support can be categorised as follows:

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

- An occasional reminder or verbal prompt*
- Requesting repeat prescriptions from the GP
- Collecting medicines from the pharmacy
- Returning unwanted medicines to the pharmacy
- Manipulation of a container e.g. opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the individual and when the staff member has not been required to select the medication.

The nature of the general support should be identified in the support plan.

* If a prompt is required more than 2-3 times per week, a review should be undertaken as a persistent need for reminders may indicate that an individual does not have the ability to take full responsibility for their own medicines or they may need regular reminders.

Administering Medication (Level 2) – this may include:

- When the support worker selects and prepares medicines for immediate administration, including selection from a monitored dosage system or compliance aid.
- When the support worker selects and measures a dose of liquid medication for the person we support to take
- When the support worker applies a medicated cream/ointment; inserts drops to ear, nose or eye; and administers inhaled medication
- When the support worker puts out medication for the individual to take themselves at a later (prescribed) time to enable their independence.

8.4. **Administering medication by specialised techniques (Level 3**) –this may include:

- Naso-gastric administration
- Rectal administration e.g. suppositories, enemas, diazepam (for epileptic seizure)
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG) tube
- Nebulisers

8.5. If the task is delegated to a support worker, an appropriate healthcare professional must train the support worker and be satisfied they are competent to carry out the task.

8.6. Other tasks may be undertaken as “level 3” tasks provided they have been agreed by the Registered Manager and are clearly documented in the support plan. The health professional delegating these tasks must have provided full instruction, training and a documented assessment of competence for the support worker.

8.7. Where a support worker administers medication, a record must be made on the MAR sheet (see section 11 on Record Keeping)

8.8. Different MAR sheets may be used according to whether the medication is supplied in a pharmacy-filled dosette box/ blister pack or in pharmacy-labelled bottles/boxes. For medication supplied in bottles or boxes, MAR sheet A can be used (Appendix 22). For medication supplied in dosette boxes or blister packs (also known as Monitored Dosage Systems), MAR sheet B can be used (Appendix 24). Some individuals may require both types of MAR sheet.

8.9. The Team Leader/Registered Manager should be informed of any changes to medication and the support plan amended with the individuals/ advocate’s agreement and signature. The Team Leader/Registered Manager will update the individual’s office based file.

8.10. Any changes or additions to the existing MAR sheet should be confirmed in writing ideally using the letter “Confirmation of Current Medication” (Appendix 21), by fax or by direct entry on the communication sheet by the GP or nurse prescriber. It may not be possible to get information about a change in medication from the GP immediately, therefore the Team Leader/Registered Manager should be responsible for ensuring a clear audit trail for confirming new/changed medication.

8.11. A Team Leader/Lead Support Worker will visit the individual, following changes confirmed (as in 8.10 above), to transfer this information to the MAR in the individual’s support plan. The Team Leader/Lead Support Worker will then check the MAR sheet entry for accuracy and auditing purposes during their next visit.

8.12. Any handwriting or amendments to MAR sheets should only be undertaken by staff trained and competent in this procedure. The entry should be copied directly from the medicine label and checked by a second person for accuracy. In the event of a second person not being available, the competent staff member should undertake a double check themselves for clarity and accuracy and as soon as a second person is available, they should undertake the checking procedure. Team Leaders/Lead Support Workers will check all handwritten entries during their visits. MAR sheets will be audited regularly. Regular assessment will identify the risks with this procedure, how to manage the risks and additional safeguards will be implemented if necessary.

8.13. The office must be contacted immediately if there is any discrepancy or query noted by staff regarding a change of medication.

8.14. Where queries arise over medication following hospital discharge, a healthcare professional must be contacted to confirm any decision regarding medication. If this occurs at a weekend or out of hours, contact should be made with the hospital / family/ NHS 111 / NHS24 or on-call GP as appropriate to obtain direction from a healthcare professional.

8.15. Where a staff member is required to administer warfarin, the current dose should be followed according to the yellow anticoagulant record book or patient record card issued by the hospital. If there is no yellow record book or patient record card available, the line

manager must be contacted for advice. The prescriber or duty doctor will then be contacted for clarification of the dose to administer and the advice given by the medical professional must be documented. The management of risk in the use of warfarin must be carefully considered. Where possible, a District Nurse should be involved in the process and be requested to sign off the task for support workers.

8.16. Staff should inform the office if they are unable to administer medication because the individual refuses, is asleep, absent, the medication is unavailable or if the support worker is late arriving at the individual's home which may impact upon medication dosage times. Any advice or action taken must be recorded in the daily record of care.

8.17. Each individual's support plan must be kept in an agreed, accessible place in their home in order to ensure effective communication with other agencies that may be involved in the individual's care and support. If a staff member needs to pass any information on, this should be recorded in the daily record of care, which may also be used by other agencies to communicate information.

8.18. The contents of the support plan and other records relating to medication should be fully up to date. Any information provided by other agencies must be forwarded to the office to ensure effective inter-agency working. Team Leaders/Lead Support Workers are responsible for auditing the content of the communication record.

8.19. Advice should be sought from the GP or District Nurse before any non-prescribed external preparations e.g. creams, ointments, lotions, gels are administered.

8.20. Assistance with the use of non-medical skin care preparations (e.g. baby oil, hand lotion) is acceptable provided the District Nurse has confirmed that there are no skin or tissue viability issues and as long as any change to the condition of the skin is reported immediately to the District Nurse by contacting the NAS office.

8.21. For individuals where there are no obvious skin problems and no contact with the District Nurse, the application of non-medical preparations at the request of the individual should be documented in the support plan.

8.22. Staff may assist with surgical stockings if the stockings have been prescribed, correctly fitted and issued with instructions from the appropriate healthcare professional.

9. ADMINISTRATION

9.1. Medication must be administered in accordance with the prescriber's instructions, as printed on the pharmacy label. Staff responsible for administration of medication will receive accredited training in this procedure.

9.2. If staff are in any doubt regarding medication, the relevant healthcare professional or Registered Manager should be contacted immediately.

9.3. If a medication is labelled "take as directed", the GP should be contacted for full instructions and a written authorisation of dose requested. It is not acceptable to administer from a container without full dosage instructions or without a written authorisation of the dose to be administered from the prescriber.

9.4. The label on the container provided by the pharmacist must not be altered under any circumstances. If the label becomes detached from the container or is illegible, medication must not be given until the advice of the supplying pharmacist is sought.

9.5. Before commencing administration of medication, hands must be washed with liquid soap to prevent contamination. This should be repeated if gloves have been worn. It is recommended that between individuals, staff clean their hands with the alcohol gel / liquid soap provided.

9.6. The 6 Rights of Administration must be applied.

- The identity of the individual must be ascertained. This must be checked with the name on the Medication Administration Record (MAR), the photograph on the MAR, the pharmacy label on the medication and by addressing the individual by name. (RIGHT INDIVIDUAL)
- The name, form and strength of the medication must be checked during the administration process i.e. the pharmacy label on the medication should be compared with the MAR sheet when the item is removed from the cupboard, before it is placed in the medicine pot and before documenting on the MAR sheet. (RIGHT MEDICINE)
- Medication should be given at the time indicated on the MAR sheet. If medication is administered more than one hour either side of the time stated, advice may need to be sought from the Manager or GP before the medication is administered. (RIGHT TIME)
- The dose of medication must be administered in accordance with the prescriber's instructions. Reference must be made between the MAR sheet and the pharmacy label to ensure this. If there is any discrepancy between the dose on the MAR sheet and that stated on the label, advice must be obtained from the Manager or GP before the medication is given. (RIGHT DOSE)
- Each medication must be administered in its prescribed form i.e. tablet, capsule, patch, inhaler etc and by the prescribed route i.e. oral, sublingual, topical etc (RIGHT ROUTE).
- The individual's RIGHT to REFUSE must be respected. See section 12 on Refusal.

9.7. Staff may not disguise medication in food or drink. In exceptional circumstances this may be agreed following a multidisciplinary authorisation (see section 7 on Covert

Administration). Full documentation would be needed to support this, including a risk assessment.

9.8. PRN (when required) medication must be given in accordance with the prescriber's instructions, details of which should be recorded in the support plan and on the PRN protocol. The PRN protocol should be person-centered and focus on outcomes (i.e. what the medicine is expected to do). Details should include the name and reason for the medication, dosage criteria i.e. how and when the medication should be given, how often it may be repeated and any maximum quantity that may be administered in a 24-hour period. Details should also include how the decision is reached about when and how to give, actions to be taken prior to administration, actions to be taken post-administration, expected outcomes and follow ups (see Appendix 9).

9.9. It is essential that administration of medication and subsequent signing of the Medication Administration Record sheet (MAR) is completed for one individual before selecting medicines for the next.

9.10. The MAR sheet will include the following information:

- Full name and date of birth of the individual
- Any known allergies to medicines/ foods (or "None Known" should be stated where this information is not known)
- Name, form and strength of medicine
- Dose
- Route of administration
- Frequency and time of each dose's administration
- Date of commencement
- Any special instructions e.g. one hour before food
- Name of the GP
- Codes for non-administration

9.11. A recent photo of the individual should be attached to the MAR sheet or divider card to aid identification when administering medication

9.12. The MAR sheet must contain an up-to-date record of all medications administered. After each administration, the support worker should sign the MAR sheet to verify that the medication has been administered. This must occur immediately after the medication has been administered but after witnessing that the individual has taken it. A code must be used for non-administration (see section 11 on record keeping).

9.13. For medication with a limited expiry, containers of medication should be marked with date of opening e.g. eye drops, creams, liquids.

9.14. During administration, medication must not be left unattended with the individual. It must remain in sight of the support worker. The support worker should remain with the individual until administration is complete. Staff should directly observe the taking of medication and medicines must not be left out "to take later". Staff should only sign the individual's medication chart after the medicines have been taken and if this has been directly observed.

9.15. For individuals who do not wish to be directly observed whilst taking their medication, but require staff to dispense the medications, a risk assessment should be undertaken to ascertain if they are competent and have capacity and capability to administer the medication themselves (see Appendix 17). This should be undertaken in association with the GP. If it is deemed appropriate for the individual to administer their own medication after it has been dispensed by staff, a disclaimer should be signed by the individual and a statement made in the support plan. The MAR sheet code must indicate that the signatures on the MAR sheet indicate "dispensing only" of the medication by staff and that the mediation has been "made available" for the individual to take themselves. The individual has undertaken "administration" in this instance.

9.16. Medication should not be opened or prepared until the individual is ready to accept it.

9.17. For application of creams and ointments, disposable gloves must be worn and disposed of appropriately after use.

9.18. Medication should not be given if:

- The MAR is missing
- The MAR is difficult to read
- The pharmacy label is difficult to read
- A significant change in the individual's physical or emotional condition is observed
- The 6 Rights of Administration cannot be verified
- The individual has queries about the medicines e.g. colour, size, shape
- There are any doubts or concerns

In these situations the medication should not be given until advice has been sought from the Registered Manager, Pharmacist or GP as appropriate.

9.19. Medication must not be crushed, broken or mixed with food and drink unless it is designed for the purpose or it has been specifically authorised in writing by a healthcare professional and documented in the support plan.

9.20. All liquids must be shaken prior to administration. Liquid dose measurements must be undertaken with accuracy. For doses of 5 or 10ml, the 5ml plastic measuring spoon should be used. For doses over 10ml, an appropriately graduated plastic measuring pot can be used. This must be held at eye level for accurate dose measurement. For doses of less than 5ml, an oral syringe may be provided for measurement of the dose.

9.21. Staff should not carry out skilled observation e.g. taking pulse before administration of medication.

9.22. Staff should not administer medication by injection, syringe driver or pessaries.

9.23. PEG feeds may only be administered by named staff and only in certain conditions, following specialist training, an assessment of competency by the District Nurse / healthcare professional and with the authorisation of the Registered Manager.

9.24. Eye drops, inhalers and transdermal patches may be administered by staff if they have undertaken the appropriate accredited training course, which details the techniques and issues involved with these procedures. If the administration of eye drops is complex and not straightforward e.g. post-op, the task will not be undertaken by staff.

9.25. Staff would only be expected to administer medication via nebulisers if they have had specialist training that is recorded, and the support worker is deemed competent by a District Nurse or appropriate healthcare professional.

9.26. Staff are not generally permitted to administer dressings. If a dressing becomes detached or soiled, the District Nurse should be contacted immediately for advice. Any action should be recorded in the daily record of care.

9.27. Blood glucose monitoring may only be undertaken with agreement from the Registered Manager and if there is a written protocol in place from the District Nurse. The support worker is only responsible for the recording of the value and reporting back to the District Nurse if necessary. Staff are NOT responsible for altering the dose of medication as a result.

10. CONTROLLED DRUGS

Residential and Day Services

10.1. In **residential and day services,** administration of Controlled Drugs should be undertaken by a suitably trained member of staff and witnessed by a second appropriately trained member of staff.

10.2. Administration of Controlled Drugs must be recorded and witnessed in the Controlled Drugs register. The name of the individual, time, date, medication (name, form and strength) and dosage must be recorded each time. In addition, the balance of stock remaining must be recorded. Any discrepancies must be reported to the Registered Manager immediately.

10.3. The member of staff who administers the Controlled Drug must make the entry in the Controlled Drug register and the witness must countersign.

10.4. Any complex dosage calculations should be double checked by a second member of staff.

10.5. Controlled Drugs for destruction should be returned to the pharmacy for disposal and the register signed by the person authorised to receive.

10.6. Controlled drugs should be audited weekly by a senior member of staff.

Domiciliary and Supported Living Services

10.7. In **domiciliary and supported living services**, if staff are required to administer a Controlled Drug to an individual, the same procedure for administration and recording should be used, as for any other prescribed medication. Staff must not administer injections of Controlled Drugs.

10.8. There is no additional requirement for Controlled Drugs used in the domiciliary / supported living setting. However, a risk assessment should be carried out to assess any potential problems with regard to storage, liquid dose measurement, build-up of stock and accessibility by the individual/others. Advice should be sought from the GP, pharmacist or District Nurse if necessary.

11. ANTIPSYCHOTIC MEDICATION

11.1 A person with a learning disability should only be offered antipsychotic medication to help with behaviour that challenges if other types of care and support have not helped to change their behaviour within a set time or treatment for another mental or physical health problem has not helped to reduce the behaviour or there is a serious risk of them harming themselves or others.

11.2 An antipsychotic should only ever be used alongside other types of care and support. It should be started by a specialist, who should regularly check if it is working and if there are any side effects. The specialist should be an expert in learning disabilities who is an adult psychiatrist.

11.3 The person supported should have a check-up after 3–4 weeks and the antipsychotic should be stopped after 6 weeks if it is not providing a positive outcome for the individual. It should also be reviewed again if their health or surroundings (for example, their care setting) change. If they carry on taking the antipsychotic, they should have a review of all their prescribed medication after 3 months and then at least every 6 months

12. HANDLING MEDICATION ON DAY TRIPS & SOCIAL LEAVE

12.1. Individuals will from time to time leave the service e.g. to attend hospital, visit friends or to go on holiday and may need to take their medication with them in order to ensure continuity of supply.

12.2. There is a range of options in the way medication is managed for individuals taking their medication out of the service .The most suitable option must be selected after consideration of the risks of the individual situation.

12.3. The risks to be considered are:

- How long the individual will be out
- Who they are accompanied by and their competence
- The nature of the medication
- How much notice has been taken of the intention to go out

12.4. The following options for medicine handling should be considered:

- Missing the dose out altogether (after confirmation with the GP)
- Giving the dose early or late (after confirmation with the GP)
- Giving the original dispensed medicine to the relative/ carer/ individual (if competent to administer)
- Obtaining a separate labelled supply for “leave” (advance warning required to obtain a prescription and get it dispensed)
- Taking out the dose required and putting it in a labelled container (this is not applicable to Controlled Drugs – see section 12.8 below). If this option is used, the following protocol should apply
- This should be for a single dose only
- Only an authorised senior member of staff should undertake the task.
- A second member of care staff must be present to check and act as a witness and counter signatory
- The medication must be dispensed into a clean bottle or daily dosing aid and labelled with the name of the medication, strength, form, quantity, dose, name of individual and date. Any additional instructions e.g. take after food must also be added. These instructions should be copied directly from the original pharmacy-labelled container.

12.5. Information must be given to the individual/ family/ carers including details and directions about the medicine, the time of the last and next dose of each medicine and a contact for queries.

12.6. A log of medication taken out of the service should be completed using the in/out log. Any medication returning to the service should also be signed back in.

12.7. Details of the medicines taken with individuals should be recorded in the support plan.

12.8. If the medication is a Controlled Drug, a separate labelled supply containing only the quantity required should be obtained direct from the pharmacy.

12.9. Consideration must be given to the safe transport and storage of medication and risks assessed. A locked box or sealed plastic envelopes may be used.

12.10. Staff should record all medication administration during day trips/social leave. The same medication administration procedures should be followed as for on-site medication administration.

13. RECORD KEEPING

13.1. For occasional verbal prompts of medication (level 1), the date and time of the prompt must be noted in the individual's daily record of care.

13.2. For regular verbal prompts, these must be documented on the MAR sheet.

13.3. For administration of medicines (level 2) a record must be made on the appropriate MAR sheet including:

- Date
- Time
- Medication – name, form, strength
- Initials of support worker if medication is administered
- Appropriate codes should be used for refusal, absence, sleeping and other reasons such as medication unavailable, spillage, dropped tablets etc. Where the code for "other" is used, an explanation is required on the MAR sheet.

13.4. A separate record of current medication must be maintained for each individual.

13.5. All medication which is administered to an individual must be recorded on a MAR sheet. If it has not been possible to obtain a sheet printed by the pharmacy, then a senior staff member must handwrite the instructions as prescribed and printed on the medication label, and have it checked by a second member of staff.

13.6. All MAR sheets should be signed in black ink. Correction fluid or similar may not be used on the MAR sheets. If a mistake in recording is made, a single line should be made across the incorrect entry and a new clearly legible entry made.

13.7. Recording on the MAR sheet must occur immediately after the medication has been administered and the staff member has witnessed it has been taken.

13.8. A signature on the MAR sheet is required if medication is administered and a code used for non-administration.

13.9. An up-to-date sample signature and initials list should be kept for those staff eligible to undertake medication administration (Appendix 13)

13.10. For when required 'PRN' medication, full details should be entered on the back of the MAR sheet to enable monitoring of the medication usage. If a 'PRN' medication is not providing relief or is being requested frequently, this should be reported to the GP or Manager.

13.11. For medications that are administered regularly but infrequently e.g. monthly or every 3 months, a system must be in place to record when these medications are due. This may include marking the relevant box on the MAR sheet for monthly items and recording the date in the diary to remind staff for 3-monthly medicines.

13.12. Full details of the medication regime and treatment must be recorded in the individual's support plan.

13.13. The communication book should be used for the recording of any unusual incidents e.g. medication given out of the time frame, refusal etc.

13.14. Discontinued medication may only be documented on the MAR sheet by a senior member of staff.

13.15. Any changes to medication made by phone can only be accepted if it is supported in writing (by fax or email) before the next or first dose is given. The MAR sheet and support plan must be updated as soon as possible (usually within 24 hours).

13.16. Changes to medication or new orders may only be recorded on the MAR sheet by a senior member of staff. These changes must be copied direct from the prescriber's instructions e.g. from a GP letter, prescription, pharmacy label and be witnessed by a second member of staff. The MAR sheet entry should be signed by both the senior member of staff and the witness.

13.17. An audit trail of medication needs to be maintained i.e. a record of all medication received, medication administered and medication returned.

13.18. Records must be kept of all medicines leaving and returning to the service with individuals for the purposes of day trips, social leave etc. An in/out log should detail date, quantity, medication name, form and strength and individual's details (Appendix 6) Information must be provided to the individual/family/carers when the individual is temporarily away from the service. This includes the medicines taken with the individual, clear directions, time of the last and next dose and a contact for queries.

13.19. MAR sheets should be retained for a minimum of 7 years and thereafter destroyed securely.

13.20. A gap monitoring system (Appendix 4) should be in place to ensure medication has been administered and signed for and action taken if a member of staff consistently fails to record the administration of medication. Any discrepancies and the remedial action taken must be documented (see section 23 Medication Errors and Safeguarding).

13.21. For individuals whose topical medicines are stored in their room and applied by trained and competent care staff, a TMAR (Topical Medicines Administration Record) will be set up. This will list all creams and ointments to be applied and will include a body map and individual-specific directions (Appendix 8).

13.22. The TMAR must be completed immediately after topical preparations are administered. The body map will indicate where the cream/ointment should be applied.

13.23. The TMAR will be transcribed monthly from the original MAR sheet by a senior appropriately trained member of staff, at the time of changeover of medicines.

13.24. The Controlled Drugs register must be used whenever Controlled Drugs are received into the home, administered or returned to the pharmacy. The remaining balance in the register must always reflect the current stock held in the home.

Residential Services

13.25. In **residential services**, the record of medication received and administered can be kept on the MAR sheet and the record of medication returned may be kept in

the Returned Medication Record (see section 13 on disposal). Stocks which are carried forward from the previous month should have the quantity carried forward written on the current MAR sheet and be added to the quantity received, to give the total quantity in stock.

13.26. In residential services, any allergies to medication must be documented on the MAR sheet or “none known” entered if appropriate.

Domiciliary, Day and Supported Living Services

13.27. In **domiciliary, day care and supported living services**, the MAR sheet should be kept in the individual’s support plan. Team Leaders/ Lead Support Workers are responsible for ensuring that new MAR sheets are provided monthly.

13.28. Used medication sheets should remain in the individual’s support plan until the current month end before being returned promptly to the office. Team Leaders / Lead Support Workers will be responsible for collecting and returning the used MAR sheets each month. This will be audited regularly.

13.29. A blank MAR sheet should be available in all individuals support plans ready for written entries and authorisation to be made by the prescriber at the time of a home visit.

13.30. Medication risk assessments should be kept in the individual’s support plan and copies maintained in the office based file.

14. REFUSAL OF MEDICATION

14.1. An individual has the right to refuse medication, even if a refusal may adversely affect their health.

14.2. When an individual has capacity, staff must respect the individual's refusal to take medicines.

14.3. If an individual refuses to take their prescribed medicines, the reason for refusal should be recorded on the back of the MAR sheet and a code used for non-administration, on the front of the MAR sheet.

14.4. The information relating to the reason for refusal can then be discussed as part of a medication review with the individual's GP.

14.5. Where a medication has already been removed from its container and is then not taken by the individual, it should not be replaced in the container but dealt with via the disposal procedure and recorded accordingly.

14.6. Where an individual consistently refuses to take their medication, staff should consider the following:

- Making an attempt to find out why the person is refusing the medicine
- Considering whether the individual would benefit from more information about their medicines, including information about the risks of not taking it
- Suggesting an alternative empathetic member of staff to explain and reassure the individual
- Considering whether the medication could be offered at a different time to aid compliance
- Giving consideration to the form of the medication e.g. whether the individual requires a liquid or soluble preparation to aid swallowing

14.7. For any ongoing refusal, if the individual agrees, staff should inform the GP who prescribed the medicine and inform the supplying pharmacy, to prevent further supply and overstock.

Residential and Day Services

14.8. In **residential and day services**, the individual will be given a second opportunity to take their medication from a different member of staff after a suitable time interval of 15 - 30 minutes.

14.9. In domiciliary services, where an individual declines to take their medicines, the staff member should consider waiting a short while before offering it again.

15. DISPOSAL

15.1. Disposal of medication will be necessary when:

- The expiry date of the medicine is reached
- A course of treatment is completed, discontinued or no longer required
- The individual has refused to accept the medication
- The individual for whom it is prescribed, dies
- The medicine has been "spoiled".

15.2. A record should be made in the Returned Medication Record (Appendix 14) at the time when they are placed in the area for disposal. Details should include date, quantity, name, form and strength of medication, name of the individual for whom it was prescribed plus the staff member's initials or signature.

15.3. Odd tablets that have been refused by the individual after having been removed from their container should be placed in an envelope and returned as per 13.2 above. The envelope should bear the same details as those required for the Returned Medication Book.

15.4. No medication may be destroyed in the service. Unwanted medication may not be placed in sharps boxes or down the sink or toilet. The only exception to this is for small doses of liquids which have been measured out for the individual, but which the individual refuses. In this case, as the volume of liquid is small, it may be poured down the sink and a record of its destruction made on the back of the MAR sheet.

15.5. Syringes and needles must be disposed of by placing in the "sharps" box.

15.6. When an individual dies, their medication must be retained in the service for sufficient time (upon a release notification from the Coroner/GP/medical professional) following death, in the event of it being required by the coroner. After this period, it may be returned to the pharmacy for destruction.

Residential Services

15.7. In **residential services**, medicines for disposal must be removed from the cupboard and placed in a separate locked labelled area, for subsequent return to the pharmacy for disposal

15.8. Controlled drugs (CDs) for destruction in a **residential service** must be stored in the CD cupboard until collected by pharmacy staff and handed separately to the person collecting, for signature.

Domiciliary, Supported Living and Day Services

15.9. In **domiciliary, supported living and day services**, it is expected that relatives or representatives of the individual will make arrangements for the return of all unused medication to the pharmacist for safe disposal. Where there is no one able to do this, consent should be obtained directly from the individual/advocate and Registered Manager. Medication for disposal should be returned as soon as possible to the pharmacy and a record made – see 15.10.

15.10. A form (Appendix 25 - Permission to Remove Unwanted Medicines) should be completed for any medication that requires disposal. This should detail the name of the medication,

quantity, date and reason for return. The form should be signed and dated by the individual/advocate where possible, and an authorised member of the office team. The pharmacist receiving the medication should be requested to sign and date the form and return it to the individual for its subsequent retention in the individual's support plan.

16. SELF-ADMINISTRATION

16.1. It is assumed that an individual can take and look after their medicines themselves unless a risk assessment has indicated otherwise. A medication risk assessment (Appendix 11) should be undertaken to ascertain how much support an individual needs. The responsibilities of staff should be written in the individual's support plan.

16.2. The Manager should co-ordinate the risk assessment and should help determine who should be involved to enable the individual to self-administer e.g. individual, family, other healthcare professionals and social care practitioners. This must be person-centered.

16.3. Records of medication prescribed and supplied for individuals to take themselves must be kept. A record of when individuals are reminded to take their medicines themselves should be noted in the daily notes.

16.4. Individual risk assessments must be reviewed regularly and reassessment undertaken based on individual need, using the Self Administration Monitoring Form (Appendix 17).

16.5. Discreet supervision and monitoring of secure storage and correct personal administration may be necessary for some individuals. This may be in the interests of the welfare and health of not only the individual but others in the service.

16.6. Although MAR sheets are produced for individuals who self-medicate, there is no necessity for staff to sign these charts as they are not responsible for administration however any support given must be noted in the support plan and daily notes.

16.7. If an individual wishes to self-administer a Controlled Drug, an individual medication risk assessment should be carried out by the Manager, taking into account obtaining, reminders, ordering, supply, storage and disposal of the Controlled Drug.

16.8. A record should be kept of all medicines received into the service before they are distributed to individuals for them to self-medicate.

Residential Services

16.9. In **residential services,** a lockable facility should be provided in the individual's room for those who wish to self-administer. Storage for an individual will be determined by risk assessment. Individuals should have access to any medicines that need special storage at a time when they need to take them or use them.

Day Services

16.10. **In day services**, additional monitoring for individuals who self-administer may be necessary. Appendix 27 can be used for this purpose.

17. ADMINISTRATION OF INSULIN

17.1. For any individuals prescribed insulin, there should be an individual support plan detailing the checks, treatment and responsibilities of all those involved in this support. Also identification of what action should be taken in the event of the individual having a hypoglycaemic attack. The support plan should also incorporate information about the relative importance of mealtimes and foods that should be avoided.

17.2. Individuals requiring insulin can be assisted but are responsible for their own administration. Specific training on the practical aspects of supporting individuals with diabetes and correct preparation of the prescribed dose must be provided to staff who are willing to assist with insulin. This training must follow Nursing and Midwifery Council (NMC) guidelines and be via an approved trainer e.g. community nurse. Training for named staff must be fully documented and should incorporate an assessment of competence together with subsequent reassessments.

17.3. The overall responsibility for an individual with diabetes requiring support with insulin would remain with the District Nurse.

17.4. The Registered Manager must have evidence of the support worker's competence before the support worker can assist with insulin.

17.5. Staff may undertake blood glucose monitoring if requested by the GP or District Nurse. The responsibility of the support worker is purely to obtain the reading and document it and not to adjust the medication or alter treatment as a result. This must only be undertaken by the prescriber. A record of the blood glucose readings should be sent to the GP regularly at the timescales agreed.

17.6. Sharps Safety - Glucose monitoring and insulin administration may involve the use of sharps i.e. lancets, needles, etc. There are a number of precautions that should be adopted to reduce the risk of injury from sharps:

- Used sharps must be disposed of immediately after use by the person who has used it. This may not be possible for some individuals and the required support should be documented on their support plan
- A risk assessment must be carried out for activities where NAS staff assist individuals with insulin and/or glucose monitoring. Safer sharps must be used if the activity presents a risk of needle-stick injury
- Sharps devices must never be passed from one person to another. If you are supporting an individual you must not pass sharps devices directly to individuals and they must not pass sharps directly to you. Use a 'receiver' if the passing of a sharps device cannot be avoided – This practice must only be adopted for one-off exceptional circumstances. A receiver is an inanimate object such as a hard surface or tray. The sharps device should be placed on the 'receiver' rather than be passed directly from one person to another. The device must then be disposed of in an approved sharps container. If this occurs it should be reported as a near miss event and the individual's support plan must be reviewed to reduce the risk of recurrence
- All near-miss events or sharps injuries must be reported in accordance with the accident reporting and investigation policy

- It is important that you take the necessary action in the event of a needle-stick injury. You must familiarise yourself with the 'Exposure Incident Procedure' set out in the NAS 'Infection Control Policy' if you provide support to individuals who monitor glucose and/or use insulin.
- Approved sharps containers - Sharps containers are available on prescription from the individuals GP. Healthcare professionals involved in the individuals care must advise the individual how they obtain, use and arrange collection of sharps containers
- Disposal of sharps bins. Used sharps are Hazardous Waste and as such must not be disposed of via the domestic waste stream. Individuals who reside in assisted living premises are considered to live 'at home' and as such may have arrangements in place for the collection of their sharps containers via their local authority. Advice on arrangements can be sought from the individual's healthcare provider and/or the local authority
- If the individual's place of residence provides any level of healthcare services then the waste will be considered healthcare waste and will need to be disposed of in accordance with the 'Safe Management of Healthcare Waste'. Please contact the Health and Safety team for advice if this is the case.

18. ADMINISTRATION OF RECTAL DIAZEPAM / BUCCAL MIDAZOLAM

18.1. An individual may be prescribed rectal diazepam or buccal midazolam in the treatment of epilepsy. There should be an individual support plan detailing the treatment and responsibilities of all those involved in this care. Also identification of action required should the individual have an epileptic seizure. The manager will ensure that staff will have received required training and deemed to be competent to administer these medicines before accepting an individual into an NAS service.

18.2. **Administration of rectal diazepam** by staff may only proceed with the express recorded agreement of the individual and the staff member must be competent and willing to undertake this task.

18.3. There must be a valid prescription with clear written instructions regarding the dose to be administered. The MAR sheet should reflect this.

18.4. Specific training must be given to the staff member on the practical aspects of caring for individuals with epilepsy and administration of a rectal solution. This training must follow NMC guidelines and be via an approved trainer e.g. community nurse. The support worker must then demonstrate competency.

18.5. Training must be fully documented and incorporate an assessment of competency together with subsequent reassessments.

18.6. Clear, accurate and unambiguous records must be maintained for rectal diazepam on the individual's MAR sheet and in the support plan.

18.7. The trained and competent member of staff must familiarise themselves with the individual's support plan and protocol for administering rectal diazepam.

18.8. The trained and competent member of staff will carry out the instructions as detailed in the support plan and protocol and will record the time, duration of seizures and the intervals between seizures.

18.9. If having followed the guidelines, the seizures continue, an ambulance must be called. The appropriate paperwork must be completed and handed to the paramedics on arrival.

18.10. If an individual requires administration of rectal diazepam and there is no trained staff member available e.g. whilst out on a trip, an ambulance must be called.

18.11. Consideration should be made to how best transport these medications when the individual goes out, since they should have their medication with them at all times. The pharmacy–labelled supply should be taken by the individual/accompanying carer in a suitable robust container that affords appropriate protection and security. (See Section 11 Handling medication on Day Trips/Social leave)

18.12. It should be noted that **administration of buccal midazolam** is a "level 2" task (as opposed to administration of rectal diazepam which is a "level 3" i.e. individual and care worker specific) however training must be undertaken on the correct usage and handling of the product.

18.13. All training for both rectal diazepam and buccal midazolam must be fully documented. Due to the nature of the medication and when it is required, practical competency assessment checks are not always feasible. Knowledge checks must therefore be

undertaken every 6 months to ensure staff are confident to administer these medicines should the need arise.

19. SPECIALIST TASKS

19.1. On occasions, staff may be requested to administer medication by a specialised technique. Examples include: administration of suppositories, nebulisers etc.

19.2. Administration of such medication requires specific training in the use of the product and the training should be fully documented and be via an approved trainer. An assessment of competence should be incorporated into the documentation for any support worker who has been trained in the procedure.

19.3. There should be a specific individual support plan detailing the treatment and responsibilities of all those involved in this care.

19.4. Administration of a medication by a specialised technique may only proceed with the express recorded agreement of the individual.

19.5. Authorisation for a support worker to undertake this responsibility must first be obtained by the Manager.

19.6. Visiting healthcare professionals who undertake specialist tasks in NAS services should be requested to document on the MAR sheet, in addition to their own records.

20. OXYGEN MANAGEMENT

An individual may be prescribed oxygen as part of their treatment programme. This section details the arrangements for the use of prescribed oxygen in cylinders only.

Where services administer oxygen they must have documentation covering the arrangements for ordering, receipt, storage, administration and removal of oxygen. This will be developed in conjunction with the supplier.

Only those authorised support workers who have undergone specific training should be allowed to assist in the administration of oxygen to the individual.

The Registered Manager/ Team Leader must ensure that the relevant training, support and supervision are available and accessible.

Staff who have been trained and who are deemed competent are permitted to administer oxygen in line with the specific task in the support plan. All oxygen administration must be recorded in the individual's daily record of care for each occasion.

Safety advice from the supplier must be available for all staff and must be followed. A documented risk assessment must be in place for the use and storage of oxygen.

Oxygen safety risks

- Increase in the air oxygen concentration (oxygen enrichment) - Even a small increase in the oxygen level of air can create a dangerous situation where it becomes easier to start a fire which will burn hotter and more fiercely than in normal air and reduce the efficiency of fire-fighting equipment
- Cylinders containing pure oxygen under high pressure – Oxygen can react violently with common materials such as oil and grease resulting in explosion. Other materials such as plastics may catch fire spontaneously
- Cylinders may explode if heated

Risk controls

Use

- Keep equipment in good condition – secure during storage, use and transit to reduce risk of damage
- Ensure good ventilation during use
- Only use tubing and other peripheral equipment supplied as compatible with your cylinder type
- Ensure you know the correct flowrate as prescribed

- Check the supply in the cylinder by looking at the gauge
- Open valves slowly
- Never modify or tamper with oxygen cylinders or associated peripheral equipment. Equipment designed to be used with oxygen under pressure will have been tested to ensure safety. Any problems should be reported promptly to the supplier
- Smoking MUST NOT be allowed during oxygen administration. This also includes E-cigarettes. Naked flames e.g. candles, open fires should not be allowed near oxygen. Failure by the individual or any other person to comply with this requirement may result in the withdrawal of the service.
- Oxygen cylinders should be upright during use and secured to prevent them falling over
- Oxygen equipment should be kept clean using the method recommended by the supplier
- Tubes and masks should be kept clean and in good condition and checks should be made to ensure that tubing is not crushed or kinked.
- Tubing and masks should be replaced on a regular basis as advised by the supplier.
- Documentation must be in place covering the administration details of the oxygen. This must include flow rate and length of time the oxygen should be used for and the prescriber's details.
- If an individual is self-administering the oxygen, a documented risk assessment must be in place and regularly reviewed to assess their ability to do so correctly.
- Oxygen and associated equipment (e.g. masks/ nasal cannula, tubing) must only be used for the person for whom it was supplied.
- Oxygen cylinders have an expiry date and this must be checked on a regular basis to ensure that out of date oxygen is not used.
- Hands should be washed before handling the equipment to ensure no grease is present on the hands. If alcohol gel is used on the hands you must ensure that it has fully evaporated BEFORE handling oxygen cylinders or supporting an individual. Do not use or handling the equipment if your hands are contaminated with oil based crams or moisturisers.
- Close valves after use and when cylinders are empty

Transportation of oxygen cylinders in vehicles

- Oxygen may only be transported in vehicles where it is deemed necessary for the preservation of life of an individual who is also in the vehicle. Transporting cylinders

between sites where the individual is not present is considered to be a delivery activity and is forbidden to be carried out by NAS staff.

- Keep the vehicle well ventilated by opening a window and setting the car ventilation to take air from outside rather than circulating.
- Safely secure oxygen cylinders in the boot, behind the front seats or strapped in the back seat of the vehicle.
- Protection should be placed around cylinders to ensure that they do not move around in the boot of the vehicle
- Never transport oxygen cylinders unsecured in the front or rear passenger seats
- Individual portable oxygen cylinders should be kept in the carry bag provided and secured using the rear seat belts
- Never use oxygen in a fuel station
- Never smoke while using oxygen in the car
- Do not store oxygen cylinders in your vehicle
- If you have to leave oxygen cylinders unattended in the car, keep them out of view in the boot.

Handling

- Oxygen cylinders should only be moved using the appropriate cylinder trolley as advised by the supplier, unless they are designed to be portable.
- Portable cylinders should be carried in a purposely designed bag/rucksack.

Storage

- Oxygen cylinders should be stored securely in a dry, secure, clean well-ventilated environment below 50 degrees Celsius
- Cylinders should be stored upright
- Valves must be closed when cylinders are stored
- Full and empty cylinders should be segregated to avoid confusion in selection.
- The storage area should be free from combustible material and the cylinder must not be stored in direct contact with a source of heat (e.g. radiator, fire) or combustion (flammable liquids).

- A warning sign should be displayed on the door indicating the presence of oxygen
- A procedure in each service should be in place for informing the emergency services of the location of oxygen if they are required to attend in the event of a fire or fire alarm. The location and maximum quantity of oxygen cylinders must be clearly identified on your fire risk assessment
- In the event of fire you must notify the 999 operator of the presence of oxygen cylinders within the building

Disposal

- Cylinders remain the property of the supplier and should be returned to the supplier when they are no longer required and/or empty.
- Do not dispose of cylinders waste holding areas
- Cylinders must be kept in a secure location, separate from full cylinders until such time that they are collected.

21. HOMELY REMEDIES AND NON-PRESCRIBED MEDICATION

Residential Services

21.1. Homely remedies are defined as over-the-counter medicines, authorised by the doctor and held by the **residential service** for the treatment of minor ailments. A sample policy is shown in Appendix 20. Each residential service should draw up a homely remedy policy in conjunction with the GP (Appendix 5).

21.2. For the purpose of this policy, non-prescribed medicines are defined as those over-the-counter medicines brought in or purchased by family or the individual e.g. daily supplements.

21.3. **Homely Remedies for Residential Services**: Only staff named in the process (Appendix 6) are allowed to administer homely remedy medication. These staff members should sign the process to confirm they have the skills to administer the homely remedy and acknowledge that will be accountable for their actions. This must be verified with a signature by the Manager.

21.4. Administration of homely remedies in line with the Homely Remedy policy should be recorded on the back of the individual's MAR sheet and on the Homely Remedy Record (Appendix 19).

21.5. Homely remedies may only be administered to individuals covered by the policy and may only be administered for up to 2 days before calling the doctor.

21.6. Stocks of homely remedies should be counted and checked monthly and recorded on the Homely Remedy Record.

21.7. **Non-prescribed medicines**: Individuals and their families are requested to inform the service of any non-prescribed medicines that are purchased or that individuals wish to take. This includes herbal, homeopathic and vitamin preparations. The service must then check with the GP that these preparations are suitable and if so, the individual or family may purchase these items and they may be administered by staff on the GP's written authorisation. The administration of these preparations should be recorded on the current MAR sheet.

All Services

21.8. **For all NAS Services,** non-prescribed medicines may only be administered to individuals on the written authorisation of the doctor. Their administration should be recorded on the back of the MAR sheet.

21.9. If an individual requests a support worker to administer or purchase an over-the-counter preparation, staff must first refer this back to their line manager. The manager will contact the GP or relevant healthcare professional for authorisation, to ensure there is no risk of drug interaction or contra-indication.

21.10. If an over-the-counter medication is recommended by the individual's GP, dentist or other appropriate healthcare professional, staff may only purchase the medication once checks have been made to ascertain there is no interaction with other prescribed medication. The name of the individual must be written on the container and an entry made on the MAR

sheet. Directions for use must include the name of the medication, dosage and length of treatment.

21.11. Staff should not offer advice to an individual about over-the-counter (OTC) medication or complementary treatments. Examples of this include homeopathic preparations, vitamins, minerals and supplements that have not been prescribed, painkillers, cough linctus, cold and 'flu remedies etc. This list is not exhaustive.

21.12. Staff are not permitted to take any individual's non-prescribed medicines (the same is true for prescribed medicines) in the service for their own personal use and they may not be administered to another member of staff.

21.13. For any requests for non-prescribed medication that are made at the weekend or out of normal working hours, the out-of-hours duty doctor, NHS 111/NHS24 or Pharmacist should be contacted for advice.

22. HOMELY REMEDIES AND NON-PRESCRIBED MEDICINES – RESPITE SERVICES

Homely remedies and non-prescribed medicines must be stored in line with product instructions the same way as prescribed medicines

22.1. For hospital discharge admissions, individuals will be discharged from hospital with a discharge summary listing the medication and a 4-week supply of medicines.

22.2. The senior on duty should co-ordinate admissions and check that the medicines tally with the summary and that individuals' bags are checked for any other medication.

22.3. The senior on duty should handwrite a MAR sheet from the discharge summary or labelled supply and initial the entry. A designated, suitably trained, authorised member of staff should double check the entry and countersign for accuracy.

22.4. If there are any discrepancies or concerns, the discharging ward should be contacted immediately.

22.5. All entries must be written clearly and with no abbreviations.

22.6. All medicines should be counted and recorded on receipt as part of the audit trail.

22.7. For respite admissions from home, individuals should be requested to bring their medicines in, in original pharmacy- labelled containers. Unlabelled supplies must not be used. In the event of an unlabelled supply being brought in, the individual's GP should be contacted to arrange a new labelled supply. If this occurs at a weekend, the individual's family should be requested to come in and administer the medication until a labelled supply is received.

22.8. Relatives should be advised that they should not bring in any other prescribed or non-prescribed medicines without telling the senior on duty.

22.9. Any dose changes for medication should only be accepted in writing from the GP or other healthcare professional. Dose changes of warfarin require an up-to-date letter from the clinic.

22.10. A running balance should be maintained for "high risk" medications e.g. warfarin, Controlled Drugs and for any medications where there have been errors.

22.11. The senior on duty is responsible for assessing if the individual is capable of self-administration or requires additional support.

22.12. Each individual's supply should be checked on a weekly basis, in agreement with the individual, to ensure continuity of supply.

22.13. Individuals for respite will leave the service with their remaining medication. A check should be made to ensure there is sufficient supply. They or their relative should sign in acceptance of the medication.

23. SHARING INFORMATION

23.1. All staff must follow the rules of the NAS Confidentiality Policy.

23.2. It is important that information about medicines is shared with the person and their family members or carers and between health and social care practitioners.

23.3. Staff must be aware of the need for sharing accurate information about an individual's medicines, including what is recorded and transferred when an individual moves **from** the service to another setting e.g. hospital.

23.4. When an individual transfers **to** the service, a discharge summary should be sent with the individual.

23.5. The transfer of information about an individual's medicines at shift handovers must be recorded e.g. new medicines, dose changes etc.

24. AUDITING OF MEDICATION

24.1. Medication audits should be undertaken on a rolling basis by a designated senior member of staff and documented.

24.2. The audits should include the following topics, which will be carried out at appropriate times depending on the service:

- MAR sheet signatures and gap monitoring
- Checks of dose changes and handwritten entries
- Loose medication counts
- Labelling of creams / ointments
- Date of opening on eye drops and liquid medications
- Date checks of “PRN” (when required) medication
- Fridge temperatures
- GP reviews
- Stock control
- Controlled Drugs
- All forms and paperwork
- Staff competency checks
- Medication training of staff team

24.3. A suite of audit tools can be found in Appendix 12. These can be adapted to meet the needs of each individual service.

Domiciliary and Supported Living Services

24.4. For **domiciliary services**, audits will involve visiting the individual’s home to undertake an audit of their medication and records

24.5. Monthly desktop audits of MAR sheets will be undertaken by the Team Leader/ Lead Support Worker.

24.6. A regular review of individuals’ records and documentation should be undertaken by the Registered Manager/ Team Leader e.g. Risk Assessments, PRN protocols, Confirmation of Current Medication forms, Medication Error Report forms etc.

24.7. An annual medication audit will be conducted by a member of the Operations Team.

25. MEDICATION ERRORS AND SAFEGUARDING

25.1. NAS recognises that despite the high standards of good practice and care, mistakes may occasionally happen for various reasons. If a mistake occurs, this must IMMEDIATELY be reported to the person in charge who will contact the Registered Manager / On-call manager, so as to prevent any harm to the individual. There must be no concealment or delay in reporting the incident.

25.2. At the time that the error is discovered, the support worker must stay with the individual and the person in charge / on-call must contact the GP immediately and seek advice. The person in charge/ on-call must record all medical advice given. This advice must be actioned immediately. The individual must be observed and monitored for any obvious side effects in line with information on the patient information leaflet and emergency action taken as advised by the patient information leaflet or if required. The family/ next of kin should be informed if appropriate. Patient information leaflets for all medications must be readily available.

25.3. The above procedure also applies to errors recognised by the support worker but for which they have not necessarily had any direct involvement.

25.4. A medication error form (Appendix 8) must be completed including details of whether the individual came to any harm as a result of the error and what action was taken as a result of this. Copies of the completed medication error forms should be sent to the Nominated individual and to the NAS Care Standards Officer.

25.5. A medication error may consist of any one of the following. The list is not exhaustive.

- Administering medication to the wrong individual
- Administering the wrong dose of medication
- Failing to administer the medication
- Administering medication at the wrong time
- Failing to sign for medication administered
- Administering the medication via the wrong route
- Controlled Drugs do not balance

25.6. All medication errors, incidents and “near misses” must be fully and carefully documented as individual safety incidents. These should be investigated to determine the root cause and action taken as appropriate. Detailed audits must be carried out on a regular basis and used in team meetings to improve practice.

25.7. The Registered Manager should encourage staff to report errors. They should be dealt with in a constructive manner that addresses the underlying reason for the incident and prevents recurrence.

25.8. If the line manager believes the error/ incident could be a safeguarding issue as defined below in 23.9, they should report to the local safeguarding team as per the NAS Safeguarding Policy and Procedures.

25.9. A safeguarding issue in relation to managing medicines could include

- Deliberate withholding of a medicine without a valid reason
- Incorrect use of a medicine for reasons other than the benefit of a individual

- Deliberate attempt to harm through use of a medicine
- Accidental harm caused by incorrect administration or a medication error

This list is not exhaustive.

25.10. Accurate details of any medicines-related safeguarding incidents must be recorded as soon as possible so that the information is available for any investigation and reporting. The reports must be monitored for trends.

25.11. The local safeguarding process, with details of office hours and out-of-office contacts can be found in the NAS Safeguarding Policy.

25.12. A medication error or any notifiable safeguarding concern must be reported to the appropriate regulator (England (Adults)-Care Quality Commission (CQC), England (Children) – Ofsted, Scotland – Care Inspectorate Scotland, Wales- CSSIW, Northern Ireland - RQIA) without delay if it leads to a serious injury to any person who uses the service or an injury requiring treatment by a healthcare professional to avoid death or serious injury. Reports of “near-misses” which could have led to injury or harm should also be reported to Care Inspectorate Scotland. All medicine errors should be reported to CSSIW in Wales.

26. RAISING CONCERNS

Staff should raise concerns about a person's medicines with their line manager. These concerns may include:

- The person declining to take their medicine
- Medicines not being taken in accordance with the prescriber's instructions
- Possible adverse effects
- The person stockpiling their medicines
- Medication errors or near misses
- Possible misuse or diversion of medicines
- The person's mental capacity to make decisions about their medicines
- Changes to the person's physical and mental health

27. MEDICATION AWARENESS AND TRAINING

27.1. All NAS staff who administer medication must have completed an accredited Safe Handling of Medicines foundation training course and must attend a refresher medication course every year. Competency of staff must be assessed yearly or more frequently if required, as determined by the manager (Appendix 15).

27.2. Retraining and further competency assessment will be undertaken for any staff member who has been involved in a medication incident or error.

27.3. All Agency staff should be provided with skills as requested by the NAS. If medication is an activity they will be carrying out, then the necessary competencies should be requested in order to ensure that suitable staff are provided.

27.4. The NAS needs to be confident that all staff (including agency staff) have the necessary competencies to work safely and as such, a competency test would be a minimum requirement for agency staff required to carry out any medication activities. As such, Managers and senior staff are responsible for identifying and checking the skills and qualifications required to do the job safely and for the provision of training to ensure that competencies are met and maintained.

27.5. Managers and senior staff must complete an accredited Assessors Workshop for Medication Handling to evidence their ability to assess the competence of their own staff. A refresher course and update will be undertaken every 2 years.

27.6. Records of medication training and staff competence should be accessible and kept up to date by the Manager or Team Leader.

27.7. Staff must be aware of the medications they are administering and the consequences of administration and non-administration. Full consideration must be given to whether the best outcomes are being achieved for individuals.

27.8. Staff must ensure prescriptions are up-to-date and are reviewed and changed as the individual's needs change. Medication reviews will be performed by the GP or other healthcare professional every year and staff must be aware of potential changes to an individual's medication regime.

27.9. Staff are responsible for monitoring the effects of medicines and taking action if the individual's condition changes.

27.10. Advice on medication issues, policies and procedures should be sought from a pharmacist.

28. REFERENCE SOURCES

28.1. Patient Information Leaflets will be supplied with most medicines. These also provide a useful reference source for staff. Where appropriate, relevant information about the medicine being prescribed should be made available to individuals or others acting on their behalf.

28.2. Useful links:

- England: www.cqc.org.uk; Fundamental Standards
- Wales: www.cssiw.org.uk; National Minimum Standards for care
- Scotland: www.careinspectorate.com; www.nationalcarestandards.org. National Care Standards.
- Northern Ireland: www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/sqsd-standards-care-standards.htm. Care Standards.
- NICE Guidance - Behaviour that challenges and learning disabilities

Residential Services

28.3. In **residential services,** staff should have access to a copy of the British National Formulary (BNF) which is less than 2 years old, to use as a reference source.

29. DRUG RECALLS

Residential Services

29.1. In **residential services,** on occasions, drug recall alerts are issued from the Central Alerting System and will be cascaded by the Nominated Individual via email to registered managers. On receipt of the drug recall, the designated senior person in charge should take responsibility for actioning the recall.

29.2. The senior person should read the recall alert, action as appropriate and sign and date the recall notice. The notice should then be circulated to all relevant staff involved in medication administration, if appropriate. Each staff member should sign and date the recall once read.

29.3. Any medication which is required to be recalled should be removed from stock by the designated senior person, labelled as such e.g. “For Return- Drug Recall” and locked away, separated from medicines in use, until it has left the premises.

29.4. The signed and dated recall alert notice must be filed for safe keeping in a dedicated “Drug Recalls” file.

29.5. Arrangements must be made by the senior person actioning the recall to obtain new medicines / replacements as appropriate and contact the GP if necessary.

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PART 2 PROCEDURES

PROCEDURE FOR ORDERING, SUPPLY AND STORAGE-RESIDENTIAL

1. Repeat prescription request forms are completed on week 2 of the monthly cycle by a designated person.

2. Repeat request forms are then sent to the surgery.

3. A record must be kept of all medicines ordered.

4. Prescriptions are either sent directly from the surgery to the pharmacy or collected from the surgery by a designated person. The pharmacy should supply copies of the monthly prescriptions which should be seen and checked to ensure that all required medication has been prescribed before dispensing.

5. It is the responsibility of the designated person, to indicate to the pharmacy if there have been any changes with regard to medication. The monthly prescriptions should be checked before dispensing to prevent wastage.

6. The new supply of medication is delivered every 28 days and stored in an empty locked room until the medication is checked in.

7. Once received, the medication is checked off against a record of the order, by the designated person and recorded on the MAR sheet. Any “carried forward” stock must be recorded and added to the quantity received.

8. Any discrepancies must be indicated to the pharmacy immediately and before the start date of the new cycle.

9. Any fridge items or Controlled Drugs must be put away in the appropriate storage area immediately. Controlled Drugs must be entered into the Controlled Drugs register.

10. All other items of medication must be stored in the appropriate locked cupboard.

11. All monthly medication orders will arrive with a printed Medication Administration Record (MAR) produced by the pharmacy. Medication not

required this month but still requiring administration will be recorded on the MAR sheet but will indicate a “nil” quantity supplied. Upon receipt of medication, items should be checked against the information on the MAR sheet i.e. name of drug, strength, form, dosage, route, amount received, time of administration and individual’s name. Each item must be signed and dated to confirm receipt and quantity entered. Any discrepancies must be queried immediately with the pharmacist and/or prescribing doctor.

12. Interim or mid-month supplies of medication may be obtained either from the local pharmacy or the monthly pharmacy supplier. In both cases, an audit trail of medication is required and medication should be signed in on arrival e.g. antibiotics.

Local Arrangements	
Interim supplies are usually obtained from:	Pharmacy: Address: Tel. No:
Pharmacy delivers to service?	Yes/No
Designated person is required to collect medicines from the pharmacy?	Yes/No

PROCEDURE FOR REQUESTING REPEAT PRESCRIPTIONS- DOMICILIARY

This procedure should only be adopted when there are no family members, friends or representatives to undertake the task.

1. The support worker should notify the office of the need for a repeat prescription.
2. The support worker will complete a prescription request form (the tear-off portion attached to the prescription).
3. The support worker will take the repeat slip to the surgery.
4. The support worker will document in the individual's daily record of care that a prescription has been requested and when it is ready to be collected.
5. A support worker will be assigned to collect the prescription. The date the supply was collected should be documented and any discrepancy between the ordered medicines and received medicines checked and actioned where appropriate.
6. If an individual has completely run out of medication, the manager or team leader will ring or fax the surgery immediately.

PROCEDURE FOR COLLECTING PRESCRIPTIONS - DOMICILIARY

1. This procedure should only be adopted where there are no family members, friends or representatives to undertake the task. A support worker may be required to collect a prescription from the surgery and /or to pick up medicines from the pharmacy. The dispensed medication should be collected and taken to the individual at the next visit (on the same day as collection).The individual's daily record of care must detail what medication the support worker has collected. This must be completed by the support worker. The date the supply was collected should be documented and any discrepancy between the ordered medicines and received medicines checked and actioned where appropriate. It is the responsibility of the individual or family to ensure continuity of supply of medication. In exceptional circumstances, where there is no one able to do this, it is the responsibility of the support worker to ensure continuity of supply by submitting the prescription request to the surgery.

PROCEDURE FOR ADMINISTRATION

Administration of medication to an individual

1. Check the identity of the individual to whom the medication is to be administered. A photo should be present to aid identification.

2. Check the MAR sheet

3. Check that the medication has not already been administered*.

4. Check that the name, form, strength and dose of the drug on the label correspond with the medication chart. If there is any discrepancy, refer to the line manager/ pharmacy immediately.

5. Ask the person if they are ready to take their medicine before removing it from its packaging, unless other arrangements have been agreed and recorded in the support plan

6. Administer the medication according to the dosage form. Witness that the individual takes the medication.

7. Record the administration of medication by initialing the correct date space on the Medication Administration Record (MAR).

8. Record if medication has not been administered, by using the appropriate codes on the MAR sheet.

9. Record any additional information on the back of the MAR sheet or in the daily record of care as appropriate.

*If a support worker believes the individual has already taken a dose of the medication, medication should not be given and advice should be sought from a line manager.

PROCEDURE FOR ADMINISTRATION OF CONTROLLED DRUGS - RESIDENTIAL

1. **Residential Services**: The individual's MAR sheet must be taken to the Controlled Drug cupboard and the instructions for administration checked by two medically trained members of staff.

2. The Controlled Drug cupboard should then be opened and the appropriate container removed together with the Controlled Drugs register.

3. The individual's name must then be checked on the medication container, the amount of medication remaining noted and compared to the corresponding page in the Controlled Drugs register. The amounts should match. Any discrepancies should be reported immediately to the Manager.

4. Both members of staff take the medication to the individual. The prescribed amount should be taken from the container after the appropriate checking of the label and MAR sheet, administered and then details must be recorded in the Controlled Drugs register.

5. Both members of staff are then required to sign the register. The member of staff administering the Controlled Drug must make the entry. The second member of staff acts as a witness to the whole procedure.

6. The remaining balance must be checked and recorded in the register

7. The remaining medication must then be returned to the Controlled Drug cupboard and the cupboard securely locked.

8. Controlled Drugs must be checked each week by the senior person and monthly by the Registered Manager. A full record of these checks must be maintained.

9. NOTE: In **domiciliary services**, the procedure for administration of a Controlled drug is the same as for any medicine. See "Administration procedure.

PROCEDURE FOR RECORD KEEPING

Records need to be kept of the following:

1. Medication ordered - including copies of prescriptions and records of ordering.

2. Medication received and administered –this should be documented on the MAR sheet.

3. Medication for disposal – this should be documented in the “Returned Medication” book.

4. Individual’s support plan, risk assessments and assessment of capacity to consent

5. Medication profile detailing how an individual prefers to take their medicines

6. Correspondence and messages about an individual’s medicines e.g. letters, transcribed phone messages etc.

7. Transfer of care letters, summaries about medicines, in/out log - when an individual is away from the service for a short time

8. Used MAR sheet records - should be retained for a minimum of 7 years. They should be filed in the individual’s records at the end of each month. They are then archived.

9. PRN protocols, homely remedy policies, non-prescribed medication authorisations

10. All forms as detailed in the appendices.

PROCEDURE FOR DISPOSAL-RESIDENTIAL

Medication may need to be disposed of in the following circumstances:

- Medication that has been refused
- Medication that has been stopped by the prescribing doctor
- Medication that has passed its expiry date
- Medication which remains following an individual's death
- Medication which has been spoiled

1. All medication should be disposed of promptly, except in the event of death, whereby "sufficient time" must elapse before medication is disposed of (timeframe will be determined by coroner, GP or other medical practitioner), in the event of it being required by the coroner.

2. Medicines should be returned to the pharmacy for disposal. A record should be made in the Returned Medication Book at the time when they are placed in the area for disposal. Details should include date, quantity, name, form and strength of medication, name of the individual for whom it was prescribed plus the staff member's initials or signature.

3. Controlled Drugs must be returned to the pharmacy. These must be signed out of the Controlled Drug register by the person authorised to receive.

4. Odd tablets that have been refused must be placed in an envelope and recorded in the Returned Medication Book. The envelope must be labelled with the name of the medication (if known), the name of the individual, the date and time (if known). The envelope must then be returned to the pharmacy for destruction.

5. Unused dispensed liquid medicines can be returned to the pharmacy for destruction

6. Used Controlled Drug patches on removal from the individual should be folded in half to inactivate them. They may be returned to the pharmacy for destruction.

PROCEDURE FOR REMOVAL OF MEDICATION- DOMICILIARY/DAY SERVICES/SUPPORTED LIVING

Any unwanted, discontinued or expired medication must be returned to the pharmacy as soon as possible. Ideally, this will be done by a family member, friend or representative.

If a support worker has to remove medication, the following procedure should be followed:

1. The individual must consent to the removal of the medication
2. The support worker must contact the office who will deal with the arrangements for removal.
3. The support worker should label the medication 'for removal' and place the medication in a place of safety so it cannot be administered by mistake.
4. The form 'Permission to Remove Unwanted Medicines' (Appendix 25) must be completed by an authorised member of the office team and the individual.
5. Medication must be returned to the pharmacy as soon as possible and a signature obtained from the pharmacy as evidence of its receipt.
6. The signed and dated form 'Permission to Remove Unwanted Medicines' must then be returned to the individual's support plan.
7. In **day services**, all medication for disposal should be returned to the individual or their carer for subsequent return to the pharmacy for disposal.

PROCEDURE FOR SELF ADMINISTRATION- RESIDENTIAL

1. An individual risk assessment will determine how much support an individual needs to carry on taking and looking after their medicines themselves

2. The risk assessment should consider:

    - Individual choice
    - If self-administration will be a risk to the individual or to others
    - If the individual can take the correct dose at the right time and in the right way (consideration of mental capacity and manual dexterity)
    - How often the assessment needs to be repeated
    - How the medicines will be stored
    - Responsibilities of staff

Where individuals are assessed to have capacity to self-administer the following arrangements will be implemented:

3. Lockable cupboards/ drawers will be provided in individuals' rooms for storage of their medicines and the individual will hold the key.

4. The MAR sheet can be endorsed "Self-Administering" and no other recording is required on the MAR sheet for those items.

5. Details of when the medicines were supplied to the individual and any reminders or support given should be recorded in the support plan.

6. Discreet compliance checks and monitoring should be undertaken every month (with the option to increase the frequency of these in order to ensure continuity of supply and increase independence). Particular reference should be made to

"when required" (PRN) items and medication such as inhalers etc to ensure continuity of supply but not excess.

7. Reassessment dates for self-medication should be set based upon individual need in order to monitor the support required and any changing needs of the individual.

PROCEDURE FOR TAKING VERBAL ORDERS

To reduce the risk of errors, the following procedure should be adopted for a dose change or addition/ discontinuation to medication:

1. Verbal orders should not be accepted for a dose change or new medicine unless it is supported in writing by the prescriber via a fax or email, before the next or first dose is given.

2. In emergency/ exceptional circumstances, the Manager may accept a verbal order. The details of the message should be recorded in the support plan and read back to the prescriber to confirm understanding. A fax or written order should be requested to follow as soon as is practicable.

3. An entry on the MAR sheet and in the support plan should be made by the senior on duty as soon as possible (within 24 hours), who should sign the entry and reference it back to the original authorisation.

4. If possible, a second person who has witnessed the verbal order and the repeating back of the instructions to the prescriber, may act as a counter signatory.

PROCEDURE FOR HANDLING MEDICATION ERRORS

1. On discovering the error, the line manager / person on-call should be notified immediately.

2. The support worker should stay with the individual and the person in charge / on-call should contact the GP immediately for advice. This must be documented and the advice actioned.

3. The individual should be monitored closely and observed for any obvious side effects of the medication and emergency action taken if required.

4. The family / next of kin should be contacted if appropriate.

5. The medication error report form should be completed. Copies of the completed medication error forms should be sent to the nominated individual and to the NAS Care Standards Officer.

6. The Manager should conduct an inquiry and initiate any actions necessary to prevent reoccurrence.

7. The appropriate regulator / safeguarding team should be informed where appropriate.

8. A regular audit of medication errors, incidents and “near misses” should be implemented and shared with staff in team meetings.

PROCEDURE FOR MEDICATION HANDLING FOR DAY TRIPS/SOCIAL LEAVE

Individuals will from time to time leave the service e.g. to attend hospital, visit friends or to go on holiday.

There is a range of options in the way medication is managed for individuals taking their medication out of the service

The most suitable option must be selected after consideration of the risks of the individual situation.

Risks include:

- how long the individual is out for
- who they are accompanied by and their competence
- the nature of the medication they are taking
- how much notice has been given of the intention to go out

The following options should be considered:

- Missing the dose out altogether (after confirmation with the GP)
- Giving the dose early or late (after confirmation with the GP)
- Giving the original dispensed medicine to the relative/ carer/ individual (if competent to administer)
- Obtaining a separate labelled supply for “leave” (advance warning required to obtain a prescription and get it dispensed)
- Taking out the dose required and putting it in a labelled container. If this option is used the following protocol must apply:
- This should be for a single dose only.

- Only an authorised senior member of staff is authorised to undertake the task.
- A second member of care staff must be present to check and act as a witness and counter signatory
- The medication must be dispensed into a clean bottle or daily dosing aid and labelled with the name of the medication, strength, form, quantity, dose, name of individual and date. Any additional instructions e.g. take after food must also be added. These instructions should be copied directly from the original pharmacy-labelled container.
- Information must be given to the individual/ family/ carers including details and directions about the medicine, the time of the last and next dose of each medicine and a contact for queries.
- A log of medication taken out of the service should be completed using the in/out log. Any medication returning to the service should also be signed back in.
- Details of the medicines taken with individuals should be recorded in the support plan.
- If the medication is a Controlled Drug, a separate labelled supply containing only the quantity required should be obtained direct from the pharmacy.

PROCEDURE FOR DOSE CHANGES

1. **For warfarin dose changes** – the yellow book/ letter supplied by the anticoagulant clinic is the definitive instruction for the new dose. This should be placed in a plastic wallet next to the MAR sheet.

2. A second member of staff should check the MAR sheet entry against the yellow book and sign also.

3. All staff should be briefed on the procedure of how to manage a new warfarin dose i.e. the yellow book / letter should be read first before administration. Staff must be aware of when the next blood test is due and hence the possibility of another dose change.

4. The senior should annotate the MAR sheet with the new dose ensuring the entry is clear and legible and corresponds to the new instruction. Their signature and the date should also be added.

5. **For all other dose changes/ interim supplies** – a senior designated member of staff should copy the new instructions directly onto the MAR from the fax or pharmacy medicine label. This person should sign to take accountability for the transcription then a second suitably trained member of staff should witness both the new entry and the original fax or label. If both agree in all details, then the witness should countersign. The MAR should also be annotated to indicate where the authorisation for the dose change or addition has come from.

PART 3 APPENDICIES - SEE SEPARATE APPENDICES ON NASNET

Appendix Number	
SO-0169-001-0617	Agreement to Abide by Medication Policy
SO-0169-002-0617	Covert Administration Agreement Form
SO-0169-003-0617	Fridge Temperature Record
SO-0169-004-0617	Gap Monitoring Record
SO-0169-005-0617	Homely Remedies Policy
SO-0169-006-0617	Homely Remedies Authorised Staff List
SO-0169-007-0617	Medication Error Form
SO-0169-008-0617	Topical Medicines Administration Record (TMAR)
SO-0169-009-0617	PRN Protocol (Medicines as needed)
SO-0169-010-0617	Medication Risk Assessment - Level of Support
SO-0169-011-0617	Daily Audit Tool
SO-0169-012-0617	Weekly Audit Checks
SO-0169-013-0617	Monthly Audit Checks
SO-0169-014-0617	Managers 6 Monthly Audit Review
SO-0169-015-0617	Competency Assessment
SO-0169-016-0617	Returned Medication
SO-0169-017-0617	Room Temperature Record
SO-0169-018-0617	Self Medication Monitoring Form
SO-0169-019-0617	Medication Made Available to People Supported
SO-0169-020-0617	Home Remedy Record
SO-0169-021-0617	Confirmation of Current Medication
SO-0169-022-0617	Medication as Required Sheet A Front Page (MAR)
SO-0169-023-0617	PRN Protocol (Medicines as needed)
SO-0169-024-0617	Medication as Required Sheet B (MAR)
SO-0169-025-0617	Permission to Remove Unwanted Medicine
SO-0169-026-0617	Consent for Staff to Administer Medicine
SO-0169-027-0617	People we Support Bring Medication into Day
SO-0169-028-0617	Cleaning Schedule
SO-0169-029-0617	Letter to GP re Separate Supply
SO-0169-030-0617	Observation of People Supported Self Administering
SO-0169-031-0617	Letter to Family re: Original Supply
SO-0169-032-0617	Authorisation to Transport Medication
SO-0169-033-0617	Staff Signature
SO-0169-034-0617	Sample Homely Remedy Policy