Guidance for the Management of Medicines in Social Care Establishments

Aim:
To ensure medicines are managed appropriately in social care settings according to current legislation and guidance.

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Version 5

Guidance 1

Introduction

Background

This document provides procedural guidance on managing medicines, primarily within care homes, but the principles can be applied to any social care settings where medications are ordered, stored, and administered e.g., day services.

It has been developed to help service providers meet the requirements of current legislation, the Care Quality Commissions (CQC) five key questions and the National Institute for Health and Care Excellence (NICE) guideline on Managing Medicines in Care Homes (SC1). It also includes learning from medication incidents that have occurred and interpretation of common scenarios that staff may face when dealing with medication.

All providers and staff have a duty of care to ensure medication is managed properly to enable service users to take their medicines safely and to provide support if necessary. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that "Providers must make sure that medicines are supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe".

Care homes are regulated by the CQC, and medication handling is incorporated within the registration and inspection process. More information can be found on their website (www.cqc.org.uk).

The information in this guidance is believed to be accurate and true at the time of writing. It is acknowledged that this is an evolving document and that there may be changes in legislation and practice that may arise before its next formal review. Staff should therefore use professional judgement, be aware of their own limitations, seek advice and consult with senior staff where necessary if they are unsure of what action to take.

The authors accept no liability for loss of any nature to persons, organisations or institutions that may arise as a result of any errors or omissions.

For the purpose of this guidance the term 'service user' will be used, although other settings may use different terminology e.g., 'resident', 'patient' or 'client'.

1.1 Intention of this guidance

This guidance is split into sections and provides service providers with a medicines management document that they can adopt in full or use particular sections/aspects of it in the development of their own specific medicines policies and procedures.

It provides professional as well as practical guidance for service providers on how to manage medicines and is intended to be used in conjunction with relevant statutory legislation. It also provides templates and references for further information.

The guidance is designed to cover all situations and in particular where a service user is unable to take responsibility for administering their own medication and requires assistance. The assessment of a service user's ability to give consent to receiving assistance with their medication is covered below.

Guidance sections covered:

Guidance 1 – Introduction
Guidance 2 – Training & Competency
Guidance 3 – Consent & Capacity
Guidance 4 – Medicines Reconciliation & Transfer of Medicines
Guidance 5 – Ordering & Receipt of Medicines
Guidance 6 – Storage of Medicines
Guidance 7 – Administration of Medicines
Guidance 8 – Self-administration
Guidance 9 – Covert Administration
Guidance 10 – Non-prescription Medication
Guidance 11 – Record Keeping & MAR charts
Guidance 12 – Dose Changes & Verbal Orders
Guidance 13 – PRN Medication
Guidance 14 – Topical Preparations
Guidance 15 – Controlled Drugs
Guidance 16 – Disposal of Medicines
Guidance 17 – Medication Errors, Near Misses & Drug Alerts
Guidance 18 – Medication Review & Medicine Related Problems

1.2 Aims

The aim of all service providers will be to ensure that:

- Service users are supported to remain as independent as possible and to receive assistance with their medication only where necessary.
- Medicines are used to cure or prevent disease or relieve symptoms and not to punish or control behaviour.
- Medication assessments will be carried out and recorded at the commencement of the service to determine what assistance is needed, if any, and will be reviewed if the service user's medication or circumstances change.
- Errors, near misses and incidents involving medication will be reported, investigated, and reviewed to prevent recurrences with learning points shared with the appropriate agencies.

1.3 Roles & Responsibilities

All medicines are potentially harmful if not used correctly and care must be taken in their storage, administration, control, and safe disposal. Service users have the right to expect that any assistance offered is carried out in a professional manner by properly trained and competent staff.

The following document gives guidance to staff to ensure that any assistance given with medication is carried out in a professional manner, within the knowledge and competence of staff, and meets the aims of the service.

All registered providers are required to ensure that:

- There are local policies and operating procedures in place, which are regularly reviewed.

- Staff adhere to these policies and procedures for obtaining supplies, receipt, recording, storage, handling, administration, and disposal of medicines.

It is recommended that service managers evidence that staff have read and understood any policies, procedures, or guidance.

Only appropriately qualified staff who have the necessary knowledge and skills may carry out any invasive clinical procedure i.e., registered nurses, district nurses or in some cases appropriately trained care staff. Providers must ensure that staff are not only competent but appropriately insured for specific tasks they undertake.

1.4 Medicines Audit

There must be a complete documented audit trail from receipt through to administration and disposal of all medicines within the social care setting.

A medicines management audit should be carried out by the service manager on a regular basis (at least monthly). It is important that any areas that are identified as needing improvement have a clear rectification plan, documenting who is responsible and a time scale.

See Form 1a for an example of a medicines audit.

1.5 Confidentiality

It is important that service providers have a process for managing all confidential health and social care information.

All care providers and staff should be aware of the 5 rules set out in 'A guide to confidentiality in health and social care (2013)' (https://digital.nhs.uk) which are:

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

In relation to medicines, confidential information should only be shared with the health and social care practitioners who provide direct care to the service user if it is expected to result in better or safer care. This may include care home staff, social workers, doctors, nurses, those providing specialist care such as pharmacists, and administrative staff who support direct care. Staff should only ever share information if it is relevant and necessary (see rule 2 above).

It is important that all organisations send information via secure encrypted emails. Service providers are therefore strongly encouraged to obtain and use an nhs.net email account which facilitates this.

To obtain an NHS.net email account visit NHS England for details regarding the online application.

Example Form 1a

Monthly Medication Audit

Date Undertaken: _____

Completed by: _____ **Position:** _____

Date of last audit: _____

All previous actions addressed: **Yes** **No**

If no please detail reasons

Staff training & Support

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Is the current version of the homes medication policy available for staff to refer to?					
2	Is there evidence that staff have seen and read the current medication policy?					
3	Have all staff who are responsible for administering medication received suitable medicines training (annually – best practice)?					
4	Have all staff who are responsible for administering medication been assessed as competent within the last year?					
5	Are up to date copies of Patient Information Leaflets available for staff to refer to i.e., in original packaging or in a file if medicines supplied in MDS?					
Additional Comments:						

Ordering & Receipt of Medication

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Are records kept of the medicines that have been ordered (monthly's & acute)?					

2	Is each service user's prescription checked before being sent to the pharmacy so discrepancies can be picked up prior to receiving next cycle medicines i.e., prescriptions seen, tokens received/checked or online ordering system viewed?					
3	Is their evidence that medicines received have been checked and documented on the MAR chart (with quantity, initials and date received)?					
4	Do MAR chart directions and pharmacy labels match?					
5	Are all directions clear i.e., no 'as directed'?					
6	Is 'carried forward' medication recorded on the MAR chart including quantity?					
7	Have any missing items been followed up with prescriber/pharmacy in a timely manner?					
Comments:						

Storage

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Are the medication room, medication fridge, cupboards and/or trolleys locked at all times when not in use?					
2	Are medication keys kept in the possession of a responsible person and is there a procedure for keys at handover?					
3	Is the medication room clean, tidy, and organised?					

4	Is the medication room temperature checked and recorded daily and kept below 25°?					
5	Do all liquids, creams, eye preparations have a date of opening on them?					
6	Are expiry dates checked at least monthly and recorded (including those stored in service user's room)?					
7	Is there evidence of any medicines requiring fridge storage in cupboards or trolley?					
8	Is the fridge temperature (actual/minimum/maximum) checked and recorded daily and kept between 2-8°?					
9	Is there evidence that the thermometer has been reset after recording?					
10	Is the medication fridge cleaned and defrosted (if appropriate) regularly? Is this recorded?					
11	Is there a documented process for staff to follow if the temperatures go out of range?					
Comments:						

Controlled Drugs (CDs) (see additional audit sheet in Guidance 15)

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Is the CD cabinet attached to the wall with rag/rawl bolts?					
2	Is the CD register a bound book with numbered pages?					

3	Are all CDs requiring secure storage entered in the CD register and stored in the CD cabinet?					
4	Are only CDs kept in the CD cabinet?					
5	Are CD register entries signed and witnessed by 2 members of staff?					
6	Are entries in the CD register written correctly i.e., no crossings out/over writing? Have errors been documented correctly i.e., bracketed and rewritten?					
7	Does the quantity in the cabinet match the CD register balance?					
Comments:						

Self-Administration

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Do all service users who self-administer medicines (some or all) have a documented risk assessment in place? Is this reviewed?					
2	Is personal locked storage provided for service users who are self-administering?					
3	Have service users who self-administer signed a consent form?					
4	Have checks been undertaken to ensure medication compliance?					
5	Does the MAR chart indicate that the service user self-administers and is signed and dated when new supply issued to service user?					

Comments:

Homely Remedies & Self-Care

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Have homely remedies been authorised by service user's GP and documentation in place?					
2	Are homely remedies segregated and in date?					
3	If a homely remedy has been administered has this been recorded correctly on the MAR chart?					
4	Are self-care items documented on the MAR chart?					
Comments:						

Covert Administration

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Is there documented evidence of a multidisciplinary decision to administer covertly?					

2	Is information on how to administer medication recorded for staff and has this been agreed with a pharmacist?					
3	Has the correct paperwork been completed?					
Comments:						

MAR Charts

For large homes a selection of service users MAR charts should be viewed. Service users looked at:

1 …….. 2 …….. 3 ……..

4 …….. 5 …….. 6 ……..

7 …….. 8 …….. 9 ……..

10 ……..

		Yes	No	Any Action Required	Actions to be completed by (name)	Date Resolved
1	Is there an up to date list of signatures/initials in the pMAR (Paper MAR) folder of staff responsible for administering medicines?					
2	Do all service users have identification front sheets which include a dated photo, DOB, allergies, GP details and individual medication taking preferences?					
3	Have the pharmacy been made aware of all service users' allergies and these are recorded on the MAR charts?					

4	Are handwritten entries on pMAR clearly written, initialled, dated and countersigned by a second staff member (accuracy check)?					
5	Do medication changes on the MAR have date, staff signature and GP authorising name documented (has the change been reflected on the next month's MAR)?					
6	Are there any gaps seen on the MAR charts?					
7	Is non-administration documented correctly using the correct codes including a clear explanation?					
8	Is the quantity administered recorded on the MAR chart when there is a variable dose i.e., 1 or 2?					
9	Are PRN protocols in place for all 'when required' medication?					
10	Do the PRN protocols have a review date?					
11	Are the times PRN medications administered recorded?					
12	Are MAR/topical charts and body maps in place for creams and application recorded by staff as per prescribers' directions?					
13	Any 'out of stock' seen on the MAR chart?					
Comments:						

Disposal of Medicines

		Yes	No	Any Action Required	Action to be completed by (name)	Date Resolved
1	Is the disposal/return of medicines recorded in a specific book and include medicine, strength, quantity, name of					

	service user and reason for disposal/return?					
2	Is the returns/disposal process overseen by 2 staff who sign the record book?					
3	Is the disposed/returned medication appropriate i.e., not returning current medicines?					
4	Are medicines requiring disposal/return quarantined?					
Comments:						

Guidance 2

Training & Competency

Medicine administration must only be undertaken by staff that are appropriately trained in the handling and use of medication and have had their competency assessed. This is to ensure that medicines are given in a safe and legal manner.

Complying with this section will ensure that service providers are complying with section 1.14 & 1.17 of the NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

Along with training and competency all health professionals working within care services should be registered with the appropriate professional body and continue to meet the professional registration requirements e.g., Nursing and Midwifery Council

Details of the knowledge and skills required for medicine handling can be found at the Skills for Care website www.skillsforcare.org.uk

2.1 Training

It is the responsibility of the registered service manager to ensure staff who support with medication, employed to work within their service, receive appropriate safe handling and awareness of medicines training. This must meet the outcomes of people who use the service, the staff and regulators.

Staff must also have induction training that is relevant to the type of service they will be working in. It is recommended that all staff in the home (i.e., those who don't administer medicines) receive basic awareness of medicines training to include what they can and cannot do e.g., how to respond if a service user asks for paracetamol for a headache or if they appear unwell.

The training provided to staff must incorporate all aspects of this guidance. It is recommended that all training is accredited and assessed by an external assessor. Providers must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to service users.

For existing staff members trained in administering medication, it is recommended as best practice that a refresher course should be undertaken every year.

Care homes registered to provide nursing care must employ registered nurses. Where the delegation of administration/application of medicines is given to a carer that person must be trained and competent in medicines administration and records kept of the training competency received.

Specialist training on how to administer invasive medication is not required unless these techniques are to be used i.e., suppositories, pessaries, rectal diazepam, insulin injection, PEG, or oxygen. If staff are asked to administer medicines in this way specialist training must be undertaken by a qualified healthcare professional and the carer assessed as competent by this person. The carer must also sign to say that they agree to accept the

delegation; however, the carer can refuse to assist with any specialised techniques if they do not feel competent.

Training alone does not allow a carer to administer medicine. A formal assessment of competence to administer medicines must be undertaken following the training before they are allowed to administer medicines.

2.2 Competency Assessments

It is recommended that annual competency assessments in medicines administration are completed for all staff who support with medication (see Form 2a for an example). The competency assessment must be documented and signed off by both the staff member and the Registered Manager or nominated clinical lead. This training record must be made available for inspection upon request.

Competency assessments may need to be undertaken more frequently for new starters or those staff that have been involved in a medication error/near miss.

The person undertaking the assessment must also have been assessed as competent.

2.3 Records

The Registered Manager must ensure that a record of training and competency assessment for medication administration is available for every staff member who supports with medication. This must include the date the training was completed and when it is next due. This ensures a good auditable procedure is in place.

2.4 Incidents

If there are any medicines related safety incidents more frequent training and/or competency assessments may be required, in order to support any learning and development needs identified.

2.5 Agency workers & training

If agency workers are used, and will be administering medicines, it is important that a copy of their medicine's training/competency assessment is obtained prior to them starting work. The worker must receive a thorough induction to familiarise them with the services medication policy, procedures and the service users. It is recommended that a competent member of staff accompanies them initially when they are administering medication to ensure it is being given to the correct service user.

2.6 Access to medication and training reference material

It is important that staff have easy access to medication and training reference material. This will allow them to help answer any queries they may have regarding procedures or relating to medication such as side effects. It will also allow them to answer any queries from service users regarding their medication or service user's families or carers.

It is important however that staff recognise when they are outside of their competency and contact their manager, service user`s GP, district nurse or community pharmacist for further advice.

Copies of relevant information should be located in clinic areas where staff are able to access them easily, not locked in managers offices.

The following is a list of resources that should be available to staff:

- **British National Formulary (BNF)**. This is published twice yearly in March and September. There is also an online version available which can be accessed at www.bnf.org or via NICE website. Access to the online version or a current paper copy must be available to staff
- **Patient Information Leaflets.** All medication dispensed by a community pharmacy or dispensing doctor must include a patient information leaflet for that particular medication. In some cases, if medication is supplied in e.g., mediwallet packs the pharmacy may provide the leaflets in a separate bag. Some larger pharmacy companies will provide copies of leaflets in a designated patient information leaflet folder.
- **Services medication policy and associated procedures**
- **NICE- Managing medicines in care homes (SC1), March 2014**
- **Guidance for the Management of Medicines in Social Care Establishments**

Additional websites that staff may find useful are:

NHS website - www.nhs.uk
Patient – www.patient.co.uk
Electronic Medicines Compendium - www.medicines.org.uk

Example Form 2a

Medication Competency Assessment

Name of care worker/nurse: _____

Key Area	Assessment Criteria	Achieved	Comments	Assessed by	
Main area	*The care worker/nurse can achieve this by*	*Yes/No*	*Any relevant additional information*	*Name*	*Date*
Training and Policy	Has the member of staff completed training on the safe handling of medicines? Record date completed				
	Has the member of staff read the medication policy and is there evidence that they have done so?				
	Does the member of staff know how to access the medication policy and other resources if they wish to check any information?				
Equipment preparation & Hygiene	Did the member of staff wash their hands before starting to administer any medication and follow appropriate hygiene measures throughout the medication round? E.g., wear gloves when applying creams.				
	Did the member of staff make sure that everything was properly prepared before starting the medication round, e.g., was there plenty of medication cups, jug of water, beakers etc?				
Consent	Before preparing or administering the medication did the member of staff obtain the person's consent?				
	If consent was not obtained was this part of a documented protocol for this service user, such as covert administration, and is the member of staff satisfied that the correct procedures have been followed in the best interests of the service user?				
Selection & preparation of medicine	Before selecting, preparing, or administering any medication did the member of staff read the MAR chart accurately?				
	Did the member of staff check whether a dose had already been administered or if the medication had been discontinued or previously missed?				

Key Area	Assessment Criteria	Achieved	Comments	Assessed by	
Main area	*The care worker/nurse can achieve this by*	*Yes/No*	*Any relevant additional information*	*Name*	*Date*
	If any directions are unclear or illegible on the MAR did the member of staff take appropriate steps to clarify the directions?				
	Was the medication selected checked against the correct MAR including checking the service user's name on the label and MAR? Was the expiry date checked and a date of opening added if opening a new pack?				
	If the directions on the MAR chart differed from those on the label did the member of staff take the appropriate steps to satisfy themselves as to the correct dose to be given?				
	Was the correct medication and dose selected at the correct time? Was consideration given to timing in terms of food or other directions on the label?				
	Was the medication prepared according to the directions and information on the MAR chart or any accompanying protocol?				
	Did the member of staff use the appropriate measure for any doses of liquid medication? E.g., oral syringe, graduated measuring cup?				
Administration of Medicine	Did the member of staff check that they had the right service user?				
	Did the member of staff check the records to see how the individual prefers to take their medication or demonstrate that they knew this information and administer the medication accordingly?				
	Did the member of staff offer information, support, and reassurance throughout to the service user, in a manner which encourages their co-operation, promotes dignity and which is appropriate to their needs and concerns?				
	Was the medicine administered correctly and a glass of water offered where appropriate?				

<table>
<tr><th>Key Area</th><th colspan="6">Assessment Criteria</th><th>Achieved</th><th>Comments</th><th colspan="2">Assessed by</th></tr>
<tr><td>Main area</td><td colspan="6">The care worker/nurse can achieve this by</td><td>Yes/No</td><td>Any relevant additional information</td><td>Name</td><td>Date</td></tr>
<tr><td rowspan="8"></td><td colspan="6">Please indicate with a W the items you have witnessed being administered or a D for those not witnessed but discussed.</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Tablets/capsules | | Liquids | | Sachets & powders |
Inhaler devices | | Eye Drops | | Eye ointment |
Ear drops | | Nasal Drops | | Nasal spray |
Creams & ointments | | Transdermal patches | | | </td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Was the security of all medication maintained throughout? E.g., Medication not left on the dining room table, medication trolley locked when staff not present.</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Did the member of staff visually witness the individual taking all their medication?</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">If the medication was not taken was the appropriate advice sought and documented, including checking information in the care plan if appropriate?</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">If the medication was not taken, was it dealt with as documented in the medication policy?</td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="4">Record Keeping</td><td colspan="5">Did the member of staff sign the MAR chart immediately after the medication was administered?</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">If the medication was not given was an appropriate code and reason entered on the MAR chart?</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td colspan="5">If the medication was a PRN medication or a variable dose was the MAR completed correctly with the time of administration, reason for administering and quantity administered?</td></tr>
<tr><td colspan="5">If the medication is a controlled drug did the member of staff ask a trained colleague to witness the entire process and sign the CD register?</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">If the medication is a controlled drug was the controlled drug register completed as well as the MAR chart?</td><td></td><td></td><td></td><td></td></tr>
</table>

Key Area	Assessment Criteria	Achieved	Comments	Assessed by	
Main area	*The care worker/nurse can achieve this by*	*Yes/No*	*Any relevant additional information*	*Name*	*Date*
	Were the pMAR charts returned to the proper place after the medication round?				
	If medication is to be given covertly is information on what to give and how to give available in the MAR folder and were these referred to?				
Stock Control	Did the member of staff check that there was sufficient stock in place to complete future medication rounds?				
	If there were shortages in medication noted did the member of staff take appropriate action to ensure the stock was replaced?				
	Was all medication returned to the secure storage area once the medication round was completed and placed tidily?				
Ordering, Receipt & Disposal of Medicines	Does the member of staff record any medication received into the home in a timely fashion using the correct documentation?				
	Does the member of staff order medication in accordance with the home's procedures after checking currently held stock?				
	Is any out of date medication or medication no longer required recorded on the appropriate documentation and stored securely, clearly quarantined from 'in use' medication until it can be safely disposed of following the homes procedures?				
Storage	Is the member of staff aware of the correct storage conditions for medicines and where to find this information?				
	Is the member of staff aware of the correct temperature range for the medication fridge and how to use the thermometer? Was the thermometer reset?				
	Does the member of staff fill in the fridge temperature records correctly?				
	If new medication is received is the stock rotated correctly so that older supplies are used first?				
Non-Prescribed Medication	Is the member of staff aware of what action to take if a service user wants to take 'over the counter' medication?				
	Is the member of staff aware of what to do if a service user has a minor ailment?				

Key Area	Assessment Criteria	Achieved	Comments	Assessed by	
Main area	*The care worker/nurse can achieve this by*	*Yes/No*	*Any relevant additional information*	*Name*	*Date*
	If a non-prescribed medication was administered was this from the original container as purchased and was the dose offered within the directions given on the packaging?				
	If a non-prescribed medication was administered did the member of staff record this correctly on the MAR chart?				
Accessing Advice & Information	Does the member of staff know who to contact if they need advice on medication?				
	Is the staff member aware of the information sources held at the home particularly patient information leaflets which should be available for the service user and staff?				
Dealing with Errors	Can the member of staff describe the correct process for what to do if they make an error?				
	Can the member of staff describe the correct process for what to do if they discover an error made by another member of staff?				

Any other information *Please record any discussions held with the member of staff*

Outcome of Assessment

Considering the information from the assessment the member of staff has been assessed as *(Please delete as appropriate)*:

- Demonstrating competence at this assessment to administer medication unsupervised.
- Requiring further supervision or training in order to administer medication unsupervised at this time.

Name of Assessor _____

Signature of Assessor _____

Job Title _____

Signature of Staff Member being assessed _____

Date of Assessment _____

This assessment must be reviewed by _____ or sooner if circumstances change

Guidance 3

Consent & Capacity

Making sure that there are good procedures in place for consent and capacity will ensure service providers are complying with section 1.2 of NICE guidelines – Managing Medicines in Care Homes which is supporting service users to make informed decisions and ensuring these are recorded correctly.

3.1 Choice and consent

Each service user must be asked if they prefer the home to administer their medicines or whether they would like to be responsible for all or part of their medicines. Their care needs should be assessed on entering the service/care home. If the assessment indicates that they need assistance from staff with medication, the service user`s consent will be needed before this can be given.

If the service user has the capacity to consent to support being given, it is good practice to obtain in writing and include this as part of the care plan. A signature may not, however, be sufficient proof of valid consent. Consent should be seen more as a process, with the person being fully informed about their choices, risks and options for their treatment and care. They should be given easy to read information about the support available and time to think about and reflect on the decision.

A written consent form (see form 3a for an example) should be seen as confirmation that a discussion has taken place; it should fully record what was said and show how the service user was helped to make an informed decision.

Cultural requirements must be considered e.g. gelatin capsules are not suitable for vegetarians or service users of some religious faiths. Some religious festivals may also include fasting and may mean that service users prefer to have their medicines at certain times. In these circumstances the home should contact their community pharmacist who will be able to give advice on this. In addition, consideration should be given to service users who may prefer that medicines are given to them by people of the same gender.

If the service user chooses not to give consent staff must not administer medication. In these circumstances, if the person has mental capacity but staff remain concerned about the person's ability to take medication without support, staff should carefully explain any risks and together with the person and his or her doctor agree a plan to minimise the risks.

The service user`s consent or decision not to give consent must be noted in their care/support plan and reviewed regularly. Only the person receiving the treatment can legally give consent. A family member or someone acting as next of kin cannot give such authorisation, sign for it to happen or make the decision.

3.2 Capacity

The Mental Capacity Act 2005 is quite clear that all individuals are presumed to have capacity unless proven otherwise and everything possible must be done to help them make a decision. If there are doubts about whether a person has the mental capacity to give consent to receiving medication, a two-stage capacity assessment will need to be undertaken by a trained individual. If the assessment indicates a lack of capacity, it is the

responsibility of the staff under the services duty of care to use the best interest's checklist in accordance with section 4 of the Mental Capacity Act.

If the option of dispensing medication in a different form enables the person to retain their independence, the best interest's decision will be to make a referral to the persons GP and pharmacist. Other options may be partial or full assistance with medication.

The two-stage capacity assessment and best interest's decision should be recorded in the service user`s care/support plan. A copy should also be kept with the service users MAR charts. It should be remembered that capacity is not always static, i.e., a lack of capacity can be temporary, and assessments should be reviewed on a regular basis.

If a legal representative exists with the authority to make decisions about the service user`s health and welfare (a health and welfare attorney or health and welfare court appointed deputy where medication decisions are not excluded) he or she will need to make a best interest's decision in consultation with the persons doctor and care providers.

It must be established if an advanced decision to refuse treatment has been made, if so, staff must secure a valid copy of this for the individuals care plan.

Hints & Tips - Service users should be allowed to look after and administer their own medicines unless there are clear indications otherwise.

Learning Disability Services

The same standards and processes should apply, regardless of whether the service user has a learning disability or not. However, the only difference may be the extra support that may need to be given to people with learning disabilities to help them understand the information relating to the decision.

Example Form 3a

Administration of Medication Consent Form

I _____ *(Name)*

Will be staying at _____ as a *Permanent/Temporary resident

This signed consent form gives the Senior Staff at _____ authorisation to order and administer the prescribed medication as per my Medication Administration Record.

Signed _____ Date _____

(Resident)

Signed _____ Date _____

Name _____

(Staff member responsible)

**** Please delete as appropriate***

This form should be reviewed if circumstances/residents' decision changes

Guidance 4

Medicines Reconciliation & Transfer of Medicines

Making sure that there are good procedures in place for medicines reconciliation and the transfer of medicines will ensure service providers are complying with section 1.7 of NICE guidelines – Managing Medicines in Care Homes.

4.1 Medicines Reconciliation

On admission to a service provider/care home a named senior staff member should be responsible for coordinating an accurate list of all medicines the service user is currently taking. This should be done in a timely manner as **no** service user should be left **without** their medication.

The following people will need to be involved in medicines reconciliation:

- The service user
- The service user`s family or carers
- The service user`s GP
- The service user's usual community pharmacist
- The hospital discharge team
- Any other health or social care practitioners involved in the service user's care

It is important that the following information is available on the day the service user transfers into the service/ care home:

- Service user`s details including full name, date of birth, NHS number, address, and weight
- GP details (previous and new)
- Details of other relevant contacts defined by the service user and/or their family members or carers (e.g., consultant, regular pharmacist, specialist nurse)
- Known allergies
- Medicines the service user is currently taking (including any they buy over the counter) including name, strength, formulation, dose, timing, and frequency, how the medicine is taken (route) and what the medication is taken for (obtain this from previous GP surgery)
- Any recent changes to medicines including medicines started, stopped, dosage changed and reason for change (upon discharge from hospital)
- Date and time the last dose of any 'when required' medicine was taken, or any medicine given less often than once a day
- How the service user takes their medication for e.g., self-administer, are there compliance issues, is the service user having their medication crushed or given covertly.
- Other information including when the medicine should be reviewed or monitored (e.g., blood tests for warfarin) and any support the service user needs to carry on taking the medicine (part of initial needs assessment and development of care plan)
- What information has been given to the service user and/or family members or carers

Once this information has been verified by the nominated staff member, arrangements should be made to produce a new MAR chart (see Guidance 11 – Record Keeping) and arrange a further supply of medication. Particular attention should be made to ensuring it is fully documented who is responsible for arranging further blood tests for those medicines requiring regular monitoring e.g., warfarin. If any controlled drugs are received as part of a

transfer these must be entered into the services controlled drugs register and stored in the CD cupboard as soon as possible and fridge items placed in the medication fridge.

Do not administer any medicines that do not have an original pharmacy label e.g., those that have been packed by a family member or carer or bought over the counter.

4.2 Admission to hospital or transfer to another care setting

When service users are transferring to another service/care home it is important that **all** current medication is transferred with them to ensure that the nurses, pharmacists, doctors and social care staff know as much as possible about all the medicines they are taking and to aid continuity of care. This includes insulin, injections, patches, eye drops, inhalers, creams, suppositories, dressings and any other preparations (including vitamins and herbal).

If the service user is transferring to hospital via an ambulance, staff should ask ambulance staff for a 'green bag'. These have been designed specifically to transfer medication and MAR chart information into hospital safely. Ambulance staff are aware that they must be handed directly to the nurse in charge when they arrive. If the care home is in an area that has a red bag scheme the green bag should go within the red bag.

The service user`s MAR chart should be printed or photocopied to show all the medicines that the service user is currently prescribed, how often they are taken and when they were last administered. If there is more than one sheet, they should be numbered e.g. 1 of 2 so the hospital/ care home will know if they have anything missing. Any when required (PRN) protocols, topical and patch charts must also be included. It is important to ensure the MAR charts sent are:

- The most up-to-date version
- Contain all of the service user's current medicines
- The administration section of the MAR chart needs to be included and be the most up-to-date one
- Any medicines the service user no longer takes have been clearly crossed out

The member of staff handing over these medicines must make a list of all medicines that are handed over including the quantities and date of transfer and sign to confirm this and the person receiving the medicines must sign to confirm their receipt.

It is important to remember that controlled drugs must be signed out of the services controlled drugs register, when they are transferred to other services.

When a service user attends an appointment with a health professional outside of the care home (e.g., a hospital appointment), information about the service user`s medicines (including "when required" and any homely remedy use) should be made available during the consultation (see Guidance 1 regarding confidentiality issues).

A covering sheet, "about my medicines – Identification sheet" is included (see Form 4a). Services may wish to use this to provide supporting information as part of the transfer process.

Hints & Tips - Ensure all medicines and devices e.g., inhalers, spacer device etc. are labelled with the service user`s name.

4.3 Administration of medication away from the service

It is important, to ensure continuity of care, that service users continue to receive all their medicines wherever they are. It may be necessary for service users to take medication with them when they attend Day-Care, go on outings, have leave with their families or go on holiday etc. In all circumstances forward planning is always advisable.

Medication leaving the home must have their dispensing label attached, and be in suitable containers, child-resistant where appropriate. Medicines **must not** be transferred to another container/envelope for use when away from the home (this is classed as secondary dispensing).

Medicines should be counted and signed to say they have been taken out of the home and counted and signed back in on return (see Form 4b for an example). The MAR chart should be coded accordingly, whilst the service user was not on site, to indicate that the service user was not present in the home.

Day Leave

For those service users that leave a care home/service on a regular basis (e.g., to day care services and require lunchtime medication) the GP and /or pharmacist should be asked to review the service user`s situation. For example, a medication may be changed or given as a different formulation so that it does not require to be given at lunchtime.

If medication is required and it is not appropriate to take the homes supply of medication (i.e., if in a Monitored Dosage System (MDS)) an additional supply of medicines must be organised with the GP/Community Pharmacist and transferred on a daily basis with the service user. Alternatively, a specific supply for that service user could be kept at the day services centre.

Day Care Services

All medicines entering the service need to be booked in and booked out when the service user leaves. It must be documented who has been given the medicines prior to leaving. It is also important that information of any medicines given during the service users stay is fed back to staff at the service user's residence or care provider (particularly important for when required (PRN) medicines). It is recommended that day services have a MAR chart system for service users they administer medication to.

Weekend/ Holiday Leave

If service users are leaving the home for a specific length of time e.g., holiday with relatives then a specific supply should be ordered from the GP to cover that time period.

When service users are going on holiday with relatives, the relatives **are not required** to complete administration records but may do if they prefer. Relatives should be encouraged to return unused medication to the home. It is advisable for relatives to be given a contact for queries regarding medication whilst away, such as the home, supplying pharmacy or GP.

If a number of service users from the home/service are going on holiday together then the medicines should be transported in a locked facility e.g., a case.

4.4 Post hospital discharge (read in conjunction with section 4.1)

All service users returning from hospital should have a discharge note listing all their current medication at the time of discharge. The hospital should also inform the service user`s GP.

Upon discharge the service user's medicines will be dispensed in original containers rather than a Monitored Dosage System (MDS), unless specifically requested.

The following process should be followed:

- Check the medication against the medicines that the service user may have had previously and the MAR chart (ensure information is available on dosage regime if service user is on warfarin)
- Separate and quarantine any medicines that are not to be used for safe disposal
- If the discharge note is unclear or there is any doubt that the medicines that have been brought in by the service user are current (i.e., the date of dispensing of the medicine is not within the last 28 days) contact the discharging ward or medicines helpline (NUH) to clarify before administration
- Do not administer any medicines that do not have an original pharmacy label e.g., those that have been packed by a family member or carer (secondary dispensing)
- Request a new prescription as soon as possible to prevent the patient running out of any medicines
- Inform the supplying pharmacy so that they know any changes as soon as possible
- Be aware that when residents return from hospital medication will be in original packs (unless arranged with hospital due to resident self-administering). This supply should be used before ordering a further supply in a MDS from usual pharmacy if used by the home.

4.5 Communication between care home/service staff

Staff coming on duty should be made aware of any changes to service user's medicines that have taken place and any on-going monitoring requirements. There needs to be a robust hand-over process in place e.g., a hand-over meeting supported by processes such as a communication book and /or notice board.

Particular attention should be made to any administration gaps on the MAR charts, information about PRN medication, medicines that the service is awaiting delivery of, or medicines that the home needs to order.

Additional information that staff should be made aware of are those service users who are due to be administered medications that need to be given at set times e.g., diabetic medication, Parkinson's medication, antibiotics and once weekly medication e.g. alendronic acid or transdermal patch changes.

4.6 Respite service users

Any service provider who provides short term or respite care needs to ensure that they have a robust procedure in place to ensure medications are received, administered, and documented safely and correctly.

This should include:

- How the service will obtain a supply of medications for the duration of the service user`s stay.

- For planned respite the service could consider asking the service user`s family or carers to arrange for the service user`s GP to write a prescription for a medicines supply to cover the period of respite. The service could then arrange to have these medicines dispensed in advance by their local pharmacist.

- Where a service user brings their own medicines into the service, staff must check on admission, that there is a sufficient quantity of everything to cover the respite period.

- Family or carers must be asked to supply medicines in the original containers supplied and labelled by the pharmacist or dispensing doctor. Staff must check to confirm that they are in date and have not expired; in particular, care should be taken with liquids, creams and eye drops. Staff should ensure that any insulin and inhalers are also left with them.

- If there is any confusion or ambiguity about what current medication or dosages are to be administered to the service user, then the service provider must make every effort to clarify the details with the service user`s GP. Advice can also be sought from their pharmacist or other health care professionals involved in the service user`s care. The service may wish to ask for a copy of the service user's current prescription or hospital letters to confirm the service user's current medication regime.

- Particular attention should be taken with any PRN medication regimes, as these may have changed since the service user was last admitted.

- A MAR chart must be produced for the service user. If medication has not been dispensed by the home's usual community pharmacist, then the service may have to transcribe the medication onto a blank MAR chart. This should be done using the information on the medication labels by two trained members of staff, one to transcribe and one to countersign for accuracy.

Example Form 4a

NHS

ABOUT MY MEDICINES – IDENTIFICATION SHEET

Please ensure an up to date copy of the service user's medication is attached to this sheet and keep both copies with the current medication

Name of service user:	Photograph (if available)
Address:	
Date of Birth:	
GP contact details:	
Allergy information:	
Pharmacy contact details:	
Preferences for taking medication:	
Special instructions:	
Name & contact details of provider:	
Key worker/carer contact details:	
Reviewed by: Date reviewed:	
HOSPITAL STAFF: Please keep this form with the drug chart and contact the keyworker and community pharmacist to ensure that any medication changes are monitored after discharge	

Example Form 4b

Holiday or Day Leave Medication Tracker											
Name		**Date of Birth**			**Room Number**			**Date of Leave**			
Medication	**Strength**	**Form**	**Dose**	**Quantity**	**Signed out by**	**Date**	**Handed to (signature)**	**Quantity Returned**	**Date**	**Signed in by**	

Ordering & Receipt of Medicines

Making sure that the ordering and receipt of medicines is done correctly will ensure service providers are complying with section 1.10 & 1.12 of NICE guidelines – Managing Medicines in Care Homes.

5.1 Ordering Medicines

Repeat Prescriptions

Repeat prescriptions are for medications that service users take on a regular basis and are normally issued with a 28/30-day supply of medication.

Staff who are given the responsibility for ordering repeat medicines should be allowed protected time to undertake this task. It is important that there are at least 2 members of staff who are competent to order medicines to cover holidays and sickness.

The ordering process for the service must take into account the time required to generate the service users' repeat prescriptions at the GP practice/s and the timescales agreed with the community pharmacy or dispensing doctor to ensure they have enough time to dispense items. It is the homes responsibility that service users are not left without medication. Medicines that are supplied are the property of the service user and must only be used for the service user whose name appears on the label.

Prior to ordering medication, a check should be performed to highlight which medicines are required, by confirming the amounts currently held within the home and checking the expiry dates of current medicines held. If the service user has enough supply of medication to last until the next time the service places an order, then it should not be requested. 'When required' (PRN) medicines, such as pain relief medicines or inhalers, that are still in situ and in date should be carried forward. They should not be returned for destruction each month and then re-ordered as this is a waste of NHS money (see Table 5b for hints and tips to reduce medication waste).

Hints & Tips –

- Ensure nutritional supplements are checked for expiry dates and only ordered when needed.
- Check stocks of insulin syringes as it is easy to forget to check stock levels of fridge medication.

If medications are noted to have not been given on a regular basis, then these should be flagged for review by the GP.

A written record should be completed to show what has been ordered from the GP Practice. NICE recommend that service providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy, as they may not be aware of any recent additions or deletions to the prescribed medication.

The service needs to consider what processes it needs to put in place if they have service users who are registered to different practices. Consideration also needs to be given to those service users who may have their prescription transmitted electronically to the community pharmacy of their choice.

The repeat prescription request records should be taken to the relevant GP practice/s without delay by the care home/ service. In some cases, a community pharmacy may do this on behalf of the care home/service.

Prescriptions issued by the GP practice must then be checked against the order record. This should be done before the prescriptions are submitted to the pharmacy for dispensing:

- To ensure that all medication ordered has been correctly prescribed
- To ensure that no new medication has been added by mistake

Any queries must be raised at this stage with the GP Practice.

Prescriptions should then be photocopied as a record of the GP's authority to administer and kept with the MAR charts for reference.

If the GP surgery also dispenses the medicines (a dispensing doctor surgery), the service may not have the original written prescription to check. It is therefore very important to keep records of what the service has requested the GP to prescribe for each service user. If the medication the service receives is different from what you expect, check with the GP before you give it.

The generated prescriptions must then be delivered to the community pharmacy for dispensing without delay, in some cases the pharmacy may collect the prescriptions from the home /service directly (if resident is under 60 years of age the declaration on the reverse of prescription will need to be signed).

See Table 5a for a summary guide for ordering repeat medication.

Electronic Prescriptions

If the GP surgery uses EPS (Electronic Prescription Service) ensure the pharmacy supplies copies of prescriptions prior to delivery using a token on the EPS system.

More information can be found at:
https://digital.nhs.uk/services/electronic-prescription-service

Online ordering

Online ordering is recommended as the most appropriate way for care homes to order medication for their residents where the GP practices involved have moved to an Electronic Prescription Service (EPS).

It is important that the care home is able to check that what they requested on the repeat has been issued on the prescription before it is dispensed. This check allows the care home to follow up any issues / discrepancies with the practice before the pharmacy dispense the medication. However, when the prescriptions are sent electronically without online ordering this process often does not happen as GP practices & pharmacies are sometimes unwilling to print off 'tokens' for the care home to check against.

With online ordering GP practices or pharmacies do not need to print a 'token' for the care home to use for the check. The check can be undertaken online within the care home.

Benefits to online ordering include:

- Care home has more control over the ordering process of medication.
- Good audit trail of what has been requested and actioned.

- Helps improve communication between the care home and the GP practice(s).

Care homes will need to obtain permission from the residents for them to order medications online via proxy access on their behalf.

A secure email account i.e., an nhs.net email address will be required.

More information on setting this up can be obtained from GP practices or by contacting taniacook@nhs.net

Acute prescriptions

When a prescription is written for a medicine that the service user has not had before or does not take regularly, it is often referred to as an 'acute' supply. Acute medication is usually for a limited time such as five or seven days (e.g., antibiotics). It is important therefore that the prescription is taken to a pharmacy to be dispensed as soon as possible, within 24 hours.

The services usual dispensing pharmacy should be contacted immediately to arrange supply, however if this is not possible the prescription should be taken to an alternative pharmacy. NHS 111 or the out-of-hours service should be contacted if there are issues in obtaining the medicines e.g., if the services usual pharmacy is closed, as they will be able to direct you to the nearest pharmacy that is open. Photocopy the prescription as a record.

If the prescription is to be sent to the pharmacy via EPS, it is important that the home contacts the pharmacy to highlight this and arrangements made to collect or deliver.

Ensure a record of these medicines is made in the service user's care plan.

5.2 Receipt of Medicines

All medicines received into a care home/service must be checked and recorded. This includes monthly repeat medicines, acute prescriptions, following discharge from hospital, after holiday/weekend/day leave, if transferred from another care home/service, homely remedies and supplementary medicines. It is good practice for staff to check with the recent GP of service users who have been admitted from their own homes into the care home/service that the medication brought in with them is correct and current. Staff who are given the responsibility of receiving medicines should be allowed protected time to undertake this task. Care Homes/ services must ensure that more than one person can perform this task (to cover holidays and sickness)

On arrival medicines should be handed to the designated person and medicines should be stored securely until the medicines are booked in (ensure fridge items and CDs are stored appropriately). For acute prescription medication this process should take place straight away so there is no delay in the service user receiving their new medication.

It is best practice that medication is booked in by two members of staff as this ensures a good audit trail and that checks are in place.

The following process needs to be completed (this also applies to eMARs (electronic MARs):

- Check all medication ordered is received and any anomalies should be followed up immediately
- Check that all medication is labelled with a service user's name, if not, then that medication must not be used, it should be returned to the pharmacy/dispensing doctor and then re-ordered.

- Check medication names. Some medicines have both a brand and a generic name. In general medications should be referred to using the generic name to prevent confusion. If there are any concerns about the name of the medication the pharmacy/dispensing doctor must be contacted. The MAR chart should reflect the name on the medication container.
- Check expiry dates and note any short expiry dates
- Check medicine labels have clear instructions. If the label states 'as directed' it must be referred back to the prescriber for clarification
- Record quantities received on the MAR chart and record any quantities of medication carried forward. Remember to sign also. Check the quantity transferred is correct.
- Ensure stock is rotated so old stock is brought forward

Most pharmacies will produce MAR charts. If an item is requested mid-cycle or from a different source there may not be a MAR chart. In these circumstances the medicine will need to be handwritten/entered manually onto the MAR chart ensuring that all information is transcribed from the medicine label to the pMAR or eMAR. The entry should be signed/entered by the staff member transcribing and countersigned by another member of staff who has checked for accuracy.

It is the homes responsibility to ensure that the date of opening is recorded clearly on all liquids, creams, ointments, insulin, ear/eye/nose drops and nasal sprays. Expiry dates of all medicines should be checked on a monthly basis. It is good practice to record that expiry dates have been checked.

Day Services

It is recommended to find out in advance what medication is going to be brought into the service and whether these are to be administered by staff or self-administered. Any medicines coming into the service with the service user should be in their original container and have their dispensing label on them. All medication coming into the service should be booked in. It should then be stored in a secure place.

5.3 Receipt of MAR charts

All medication received in the home needs to be accounted for; therefore, it is important to keep a record of the stock levels, prior to commencing, preferably on the MAR chart in the boxes provided. To ensure this happens all medicines received should be recorded on the residents MAR chart. It is important that during the booking in process the MAR charts are checked for accuracy by referring to a copy of the current prescription or prescription slip used for ordering the medication. Medication directions should also be checked to ensure they are unambiguous.

All medication quantities received should be entered onto the MAR chart along with the date of receipt and initials of the person receiving the medicine. For electronic systems check the quantity transferred is correct. Care staff must check all aspects correlate with each other before they sign and date the MAR chart.

Any medication that is still in use and in date should be carried forward from one month to the next and the amount carried over recorded on the MAR chart each month. Medication does not need to be returned to the pharmacy for destruction each month and a new supply requested as this is wasteful. Using the carried forward box on the MAR chart ensures it is possible to audit the quantities of medicine.

MEDICATION PROFILE				COMMENCING	WEEK 1							WEEK 2							WEEK 3							WEEK 4						
				TIME-DOSE																												
Paracetamol 500mg tablets Take ONE or TWO tablets up to FOUR times a day when required. Do not exceed 8 in 24 hours																															
Dr Sig		Carried Forward	20																												
Commenced		Route		Rec'd	100		quant			120		By		LR/CO		Returned/ Destroyed					quant			By							

5.4 Changing pharmacy supplier

Most residential care services receive dispensed medication from a single community pharmacy. When a service decides to change supplier there can be a risk to the care and continuity of medicines supply to users of the care service.

The care service should give careful consideration to the reasons for wanting to change supplier, and the potential problems associated with the change.

From any community pharmacy you should expect medicines of appropriate quality and suitably labelled for the intended recipient. Dispensing services should be:

- Accurate
- Accessible
- Prompt

When the care service operates a synchronised supply cycle, the medicines are requested every 28 days and all the new supplies are started on the same day. As repeat medicines for all residents are requested at the same time a changeover is simplified. It is more difficult to organise the change when the service has operated a non-synchronised repeat medication system and plans to move to a synchronised cycle.

The essential steps are:

- Agree the date for change with the new pharmacy and each GP practice involved
- Agree the method for requesting repeat prescription orders and any new paperwork involved with the new pharmacy and each GP practice
- A few weeks prior to commencement of the new supply, the service initiates the order for prescriptions. This is a good time to request a medication review for residents. The service should also ensure that any excess stocks of current medicines are used up before arranging for reordering.
- Dispose of any medication from the previous supplier that is no longer required by residents before the changeover date. Remember to get the resident's permission to do so.

It may seem a good operational measure to clear out everything, return it all to the old pharmacy and start afresh with the new one, but this will increase medication waste and is an unnecessary cost to the NHS.

Table 5a

Good Practice Summary Guide for Ordering Repeat Medications in Care Homes

A monthly stock check of all medicines must be conducted at the point of ordering further supplies

- Check the fridge
  e.g. insulin
- Check individual patient rooms for current stock
  e.g. inhalers
  e.g. topical preparations creams and ointments
- Only order regular medication when there is not enough medication left until the date the next supply cycle starts
  Carry over any part-remaining stock if in date *
- Only order 'when required' medication where this is not adequate stock being carried over based on the patients' usual requirements.

Check the MAR chart at the point of ordering further supplies.

- If regular item not routinely being taken as prescribed
  - Request GP to review
- If 'when required ' item regularly not required / administered (but still occasionally required) has significant quantity remaining at end of each month
  - Request the quantity to be reviewed
- If 'when required' medication is no longer required by a patient
  - Request the GP to r/v to discontinue and take off repeat
- If you have any concerns about a patient and their medication (that is not clinically urgent)
  - Request a medication review by the GP
- If a medication has started / changed / stopped during the month, ensure the pharmacy supplier is informed at the point of ordering to ensure the new MAR chart can be updated accordingly.

Use the prescription counterfoil / EPS token to order further supplies of ongoing items

(if not ordering on-line)

- If an item is not on the repeat prescription counterfoil / EPS Token it is most likely an acute prescription item.
  Request the GP to review and add to repeat if appropriate to continue, and further supplies are required.

*Refer to Expiry Date Recommendations for Care Homes

Table 5b

Hints & Tips for Reducing Medication Waste

Many factors can contribute to medicines waste in social care settings and a joint effort involving all e.g., care homes, GPs, community pharmacies and GP practices is required.

The research report *Evaluation of the Scale, Causes and Costs of Waste Medicines*, highlighted the residential and care home sector as a significant contributor to medicines waste in the NHS in England, suggesting the systems and processes used in the sector account for around £50m of the estimated £300m annual total medicines waste.

Waste medicines include medicines disposed of as well as dropped or spilled medicines.

The following *Top Tips* have therefore been developed to assist staff to manage medicines safely whilst reducing unnecessary waste.

General advice to reduce waste when ordering medicines

- The service should retain responsibility for ordering medicines. The responsibility should not be delegated to the community pharmacist.
- Services should ensure that at least 2 members of staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.
- It is important that the member(s) of staff responsible for ordering medicines only requests items that are needed after checking the stock. Do not routinely clear medicine stocks at the end of the month only to re-order new stock.
- Ensure any medicines that have been discontinued are not re-ordered. There should be a written procedure for managing medicine changes and a robust process for ordering medication which includes using the current MAR chart.
- The prescription produced by the surgery should be checked against the prescription request before it is sent to the community pharmacy to ensure there aren't any discrepancies. It is best practice that a photocopy is taken of the prescription, for audit purposes. If an item on the prescription is not required or has been prescribed in error, it can be crossed through. This must be documented, and the GP surgery informed so the electronic records at the surgery can be updated. If the prescriptions are sent electronically from the surgery to the pharmacy, the dispensing token (copy of the prescription) can be used to check against the prescription request. The community pharmacy can provide care homes with tokens prior to the delivery of the monthly medicines.

Other ways to reduce waste and promote good practice include the following:

Prescribed Regular Medicines	Ensure that there are adequate amounts of medication available in order to meet the needs of the service user without overstocking.
	Liaise with the prescriber if there are drugs that are dispensed in original packs of 30 days rather than 28. This means that there will be regular excess at the end of each month, e.g., macrogol sachets are available in packs of 30, the medication cycle is 28 days therefore if the dose is one daily, there is the potential for 2 sachets to be wasted each month.
	Medicines such as inhalers, insulin, GTN spray and glucagon should be carried forward and not re-ordered each month if not needed. When carrying forward these medicines ***always check the expiry date on the packaging*.**
	Regular review of medication should be prompted as deemed necessary, to ensure appropriateness of prescribing and to minimise waste resulting from patient refusal or non-adherence.
	Ensure that there are adequate procedures and staff are suitably trained to deal with discharge medication. On discharge from hospital service users may be provided with a supply of medicines (sometimes in original packaging), use these medicines rather than discarding them.
	If the service user has been prescribed a special–order product which has a short shelf life once manufactured, liaise with the community pharmacy or dispensing practice to ensure it is received just in time for the start of the cycle to minimise any waste.
Interim prescriptions	Ensure medicines started during the cycle are in line with the current cycle, e.g., if a new regular medicine is started on day 13 of the cycle, 15 days' supply should be prescribed so it is in line with the other medication. If the monthly prescription request has already been submitted a prescription for the next cycle should also be generated and sent to the community pharmacy explaining clearly that an interim prescription has been issued for immediate delivery and the other prescription is for the next medication cycle.
Prescribed "when required" (prn) medicines	Where medicines are prescribed as 'when required' there should be systems in place to ensure that stock is kept at adequate levels and that medication which has expired is not administered.
	Whilst it is difficult to predict how much 'when required' medication a patient will need in the 28-day cycle, care should be taken when ordering. Sometimes significant amounts of medication are destroyed, only for a replacement supply to be reordered for the following month. It is acceptable for homes to retain 'when required' medicines and carry these forward onto the next MAR each month provided that it is administered for the original condition for which the prescription was initiated and the storage conditions are appropriate.
	If 'when required' medicines are dispensed into an MDS (tray) then the stability is reduced, after which the medicines will need to be re-ordered and replaced, if still indicated. NICE recommends that 'when required' medicines are kept in their original packaging.
	Medicines which have been dispensed for service users in the original packaging may be retained until the expiry date printed on the pack or strip, providing that the 'when required' medication is administered for the original condition for which the prescription was initiated, and the storage conditions are appropriate.
	GP review of analgesics and laxatives should be prompted. A research report identified that the most commonly wasted medicines in care homes were laxatives and paracetamol containing analgesics.

Prescribed liquids, creams and ointments	It is good practice to record the 'date opened' on all liquids, creams and ointments. GPs to review the quantity prescribed as it might be possible to change to a smaller pack size, e.g., generally only a fingertip amount of barrier cream is required when it is used; therefore, a smaller pack size may be more suitable.
	If you notice that there is a lot of excess at the end of the month, please arrange a GP review.
	Creams containing active constituent's, e.g., steroid creams, antifungals, should be used in accordance with the prescriber's instructions.
Oral nutritional supplements	On-going need should be reviewed periodically, and the current weight, BMI and MUST score should be communicated to the prescriber on a monthly basis.
	Check that the service user finds the flavours and consistency of the product acceptable. If a starter pack is used to identify flavours that are palatable, subsequent prescriptions should be for the chosen flavours, e.g., a choice of 2 or 3 flavours.
Inhalers	Review or ask for inhaler technique to be checked by an appropriately trained health care professional.
	Check that the dose and number of inhalers prescribed synchronise with the monthly cycle, e.g., Seretide Evohaler® contains 120 doses, therefore if the dose is 2 puffs twice a day, 112 doses will be needed so **one** inhaler would be sufficient for a month's supply
	If there is damage to the device or you suspect it is not working properly, please request a new one. The device may require an occasional clean to ensure it works correctly. Ensure you follow manufacturers guidance for individual devices (see patient information leaflet in box)
	Reliever inhalers intended to be used on a when required basis will not need to be automatically re-ordered every month. The resident may have one spare inhaler available; a new prescription can be ordered when the one in use runs out. Check expiry dates regularly.
Dressings and wound management products	Check that the quantities requested reflect the number of wounds and the frequency dressings are changed. Most dressings are changed every three days; therefore 5 dressings (per wound) should usually be sufficient for two weeks. Fewer dressings will be required if the wound is being regularly assessed. Wound care products should not be routinely ordered in monthly quantities. Do not use on other service users. Each should have their own supply.
	Make sure the correct size is ordered (not too large).
	Request the exact number of dressings required, do not request "1 pack".
	Do not use dressings intended for primary use as a secondary dressing, e.g., Aquacel used on top of another dressing.
General advice to reduce waste when storing medication	Ensure the storage areas are kept clean and tidy and the temperature of the room is maintained below 25°C.
	Monitor the fridge daily and ensure it is regularly cleaned and defrosted in accordance with the manufacturer guidance. The fridge temperature should be maintained between 2°C and 8°C.
General advice to reduce waste when	Ensure measuring spoons, cups or syringes are used to measure liquid medication. Similarly use the scoop provided to measure powdered thickeners. Follow infection prevention and control guidance for correct cleaning advice.

administering medication	Do not prepare medication for administration until you have identified the resident's willingness or ability to take the medication.
	Do not prepare 'when required' medication for administration to the resident in advance of assessing their needs.
	Ensure the correct inhaler technique is used, it may be necessary for a spacer device to be used, liaise with the prescriber.
Method for carrying forward medication from one cycle to the next	There should be a process in place for communicating to the community pharmacy which items are to remain on the MAR chart for the next cycle.
	If the entry is to be handwritten/manually input onto eMAR system, the name, strength, formulation and dose of the medication must be copied onto the new MAR chart, refer to the photocopy of the original prescription (where available), the labelled product and previous MAR chart. If there is a difference in the directions check the resident's notes to verify the change. If it is still unclear, check with the prescriber before a dose is administered. The entry should be signed and checked by a suitably trained witness who should also sign the entry or input ID code.
	The quantity of medication carried over must be written onto the new MAR chart to enable audit to take place (for liquids an estimate is acceptable).
Other processes and procedures	Review service policies and procedures to ensure that they don't contribute to medicines waste.
	Audit the waste records, these may provide useful information on how efficiently medicines are being managed in the service.
	Reflect on how service user instances of refusal or non–adherence are dealt with. Learning to deal with refusals such as returning after a short interval (without affecting the service user's right to refuse medicine) or identifying alternative formulations which are acceptable to the service user can help to reduce waste.
	When a service user dies, the community pharmacy or dispensing practice should be informed in a timely manner to prevent medicines for the next cycle being dispensed.
Expiry dates	Most medicines can be used until their expiry date.
	Some have a shortened expiry once opened, check the medicine label or label on the container for further details.
	Liaise with the community pharmacy or dispensing practice and agree the minimum expiry date that medicines supplied in amber bottles will have.

Guidance 6

Storage of Medicines

Making sure that the storage of medicines is done correctly will ensure service providers are complying with section 1.12 of NICE guidelines – Managing Medicines in Care Homes.

All medicines must be stored securely at all times. All health and social care organisations are accountable for ensuring the safe storage of medicines. This will ensure that medicines are always fit for purpose and help to prevent accidental use or theft.

All medicines should be stored so that:

- they are not damaged by heat or dampness (i.e., not in kitchens, bathrooms, toilets, above or near radiators or on windowsills)
- they remain sealed, to prevent infection control issues
- they cannot be mixed up with other service user's medicines (this could cause medicine errors)
- they cannot be stolen (filing cabinets are not suitable places for storing medicines unless they are secured to a solid wall or floor and kept locked)
- they do not pose a risk to anyone else

6.1 Room Requirements

Medicines should be stored securely in a locked room. The room storing the medicines should be discreet so that they are not "advertised" to anyone who should not have access to them e.g., frosted glass or blinds in windows, no signs on doors and cupboards and trolleys stored so they are not visible from the front door.

Medication delivered to the home prior to the next monthly cycle should be stored securely.

There should be sufficient workspace to prevent incidents and hand washing facilities to avoid infection control issues.

The keys to the room and cupboards should be carried on the person authorised to administer the medicines. There should be a system of recording who has the keys at any time e.g., a signature sheet on shift handover. If a set of keys are lost, then the locks should be changed immediately.

The temperature of the room should be recorded once a day, at the hottest time of the day to show that the room does not exceed 25°C (see Form 6a for an example). 25 degrees is the maximum safe storage temperature for medicines that do not require refrigerated storage. If the storage area becomes too hot, then extra ventilation or an air-conditioning unit may be required to keep the temperature down.

Hints & Tips -

- If an air- conditioning unit is being used the temperature displayed on the unit may not be the actual temperature of the room, it may be the temperature that the unit was set to. Readings must therefore be taken off a separate thermometer.

6.2 Cupboards & Trolleys

All medicines should be stored securely in locked cupboards or a locked trolley which can be secured to a solid wall. Medicine cupboards and trolleys must be big enough so that each service user's medicines can be stored separately (to prevent medicine errors), be well-constructed and have a good quality lock. Medicine cupboard or trolleys should contain only medicines (they are not for valuables or foods). Filing cabinets are not suitable places for storing medicines.

See 'Guidance 8 - self-administration' for storage requirements for those service users who self-administer their medicines.

See 'Guidance 16 - Controlled Drugs' for storage requirements for these medicines.

Each service user's medicine should be stored separately within the cupboard or trolley to reduce the risk of selecting the wrong service user's medication. It is also recommended that internal and external medications are also stored separately. It is important to ensure that stock is rotated, and expiry dates checked regularly. It is advised to record when expiry dates are checked for auditable purposes.

At all times medication must be kept in the original containers in which they were dispensed. Pharmaceutical preparations must not be decanted from one container to another for the purposes of storage. This also applies to medications that remain from the current supply when the new supply is received; the original supply should be finished first.

Nutritional supplements and dressings should be stored in a locked area and each service user's supplements should be stored separately. This is to ensure that they are only given the supplements/dressings that they have been prescribed. Bulky items must be stored off the floor at all times to prevent dust contamination. Items should also not be stored in under sink cupboards as they may be contaminated by water droplets.

6.3 Refrigerator

Some medicines need to be stored in a refrigerator between 2 and 8°C. Information on whether a medication needs to be refrigerated will be on the dispensing label and /or in the medication's patient information leaflet. A lockable refrigerator should be available in the home/ service to be used exclusively for the storage of these medicines. Small homes/ services, which do not have regular refrigerated medicines, may use a lockable cash box within the domestic refrigerator in the home/ service location.

The refrigerator temperature should be monitored and recorded daily using a minimum/maximum thermometer following the manufacturer's instructions, this is so that temperature fluctuations can be seen (see Form 6b for an example). Records should be kept of the minimum temperature that the refrigerator reached since last checked, the maximum temperature as well as the actual running temperature. Staff must ensure the thermometer is re-set after the temperatures are recorded.

If the temperature goes out of range the manager should be informed in order to make a decision as to whether the medication should be moved temporarily to an alternative fridge. If in doubt the pharmacy should be contacted for advice as to whether the medicines should be moved and are still fit to use. If not fit to use, a further supply should be obtained by requesting a new prescription and the original stock destroyed.

It is important that the refrigerator is cleaned and defrosted (in-line with manufacturer's guidelines) on a monthly basis and the date recorded. The outside surroundings of the

refrigerator should also be kept clear e.g., the back vents of the fridge must not be obstructed by other items as this may cause the refrigerator to overheat.

It is best practice that the fridge is serviced annually and general maintenance includes portable appliance testing.

CQC recommends observing the four Rs in relation to refrigerator monitoring:

Read the thermometer at least daily
Record the temperatures
Reset the thermometer after each temperature reading
React to any temperatures outside +2°C to +8°C and document actions

Hints & Tips –

- Recommend keeping temperature recording forms for at least a year.
- Ensure the temperature reading is recorded on the correct form. A common error is to record the room temperature reading as the fridge temperature reading.
- Staff should be suspicious if the thermometer reads the same temperature on every shift; this normally means it has not been re-set.

Day Care Services

During the opening hours of the day care setting, the keys to all medicine cupboards must be securely held by a designated member of staff and spare keys are the responsibility of the manager. There must be procedures in place for the safe custody of keys at times when the unit is closed.

6.4 Oxygen

If the room is used to store oxygen cylinders these must be stored securely attached to the wall to prevent the cylinder from falling which can cause damage to the cylinder and injury to staff or people living in the home. A statutory hazard notice should be placed in areas where oxygen is being stored.

Advice from the supplier on the operation, maintenance, safe storage and handling of the equipment must be followed.

Further information on 'Managing Oxygen in Care Homes' can be found on CQC website.

Example Form 6a

DAILY ROOM TEMPERATURE MONITORING FORM

MONTH _____ YEAR _____

Date	Time	Room Temperature °C	Checked by (initials)	Thermometer Reset (Tick)	Actions Taken
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
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21					
22					
23					
24					
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27					
28					
29					
30					
31					

- **Room temperatures should not exceed 25°C**
- **If room temperature exceeds 25°C report to Manager or person in charge**
- **If the room temperature constantly exceeds 25°C extra ventilation or air-conditioning unit may be required**

Example Form 6b

DAILY MEDICINES REFRIGERATOR TEMPERATURE MONITORING FORM

MONTH _____ YEAR _____

Date	Time	Refrigerator Temperature °C			Checked by (initials)	Thermometer Reset (Tick)	Clean/ Defrost (initials)	Actions Taken
		Actual	Max	Min				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
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31								

- **Refrigerator temperature range should be between 2 and 8°C.**
- **If refrigerator temperature falls outside this range report to Manager or person in charge.**
- **In these circumstances medication should be transferred to an alternative fridge and quarantined. Advice should be obtained from the pharmacy on whether medicines are safe to use.**

Guidance 7

Administering Medicines

Making sure that the administration of medicines is done correctly will ensure service providers are complying with section 1.14 of NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

Who can administer medication?

Medication administration may only be undertaken by staff that are trained, competent and insured to do so. In homes providing nursing care, support with medicines may be from registered nurses or carers, normally senior carers. In residential homes (care homes without nursing) medication can be administered by carers, normally senior carers. Residential homes will also be supported by visits from registered nurses from community or primary care services, to provide nursing care when required.

What is the role of the registered nurse, if care assistants administer medicines in care homes (with nursing)?

The law does not prevent care assistants from administering medicines in care homes (with or without nursing). When a registered nurse delegates the administration of medicines to a care assistant then the registered nurse must be confident that the care assistant is competent to take on this task. Any care assistant accepting the delegated task will be responsible for administering the medicine as per the prescription and within their organisation's protocols and guidance.

Where care assistants are involved in medicine administration, the registered nurse needs to ensure the continuing assessment of care home residents and their medicines to manage their health care needs and to apply the principles of medicines management. Ultimately the accountability for the overall nursing care of the patient rests with the registered nurse.

Delegation, accountability, liability, and criminal responsibility need to be clearly understood by the registered nurse and care assistant.

The administration of medicines by invasive or specialised techniques, or the administration of controlled drugs will normally involve a registered nurse, however suitably trained and competent senior support staff may administer certain medicines when it has been deemed in the best interests of the resident.

Direction to administer forms – Nursing Homes

For a prescription only medicine (POM) to be administered, it must have been prescribed and a legal supply made. A prescription is an authorisation against which a supply of medication is made (usually by a pharmacist). Legal mechanisms to supply and administer medicines to individuals must be included in the employing organisation's overall clinical governance framework.
A direction to administer is a written instruction from a registered prescriber that indicates the intent (for a medicine that has already been legally supplied) that it can be administered to an individual by a suitably trained and competent person. A prescription can also be used as a direction to administer a medication to an individual.
However, a written instruction is particularly important where the prescription directions may not specify dose and frequency e.g. insulin, medication administered via a syringe driver or where the dose may have changed since the prescription was written.

In Nottingham and Nottinghamshire Integrated Care System (ICS), prescribers use agreed Direction to administer forms, see below, as written instructions for specific types of medicines, ensuring that all the information required for safe administration is provided. Requesting information from the prescriber in this form for this purpose is recommended as best practice.

Type of Direction to administer (DA) form	Purpose / used for
DA- AM	For sub cut palliative care medicines / anticipatory medicines
DA- SD	Syringe driver
DA- Vitamin B12	Vitamin B12
DA	Any medicine that requires administration, if not accounted for by use of the other DA forms listed above.

Further information regarding direction to administer can be found via Medicine administration by registered and non-registered staff – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice.

Direction to administer forms - Residential Homes

Direction to administer forms will be used by community staff e.g. District nurses to administer specific types of medication as per the table above.

Medication Rounds

Service Providers should consider ways of avoiding disruptions during the medication administration round. This will ensure that there are less medication errors and that service users receive their medication in a timely fashion. It is recommended that:

- staff who are administering medicines are not interrupted and allowed to request a fellow colleague to carry out a non-urgent request for help from a service user
- there are more trained and skilled staff on duty at medication round times
- the times for administering medication are reviewed with the prescriber
- planned staff breaks are avoided during medication administration round times

NICE recommends the 6 rights should be followed at all times to ensure that:

- the **right** service user receives the
- the **right** medicine
- via the **right** route
- and the **right** dose
- at the **right** time
- and that the service user has a **right** to refuse

It is recommended that in addition following the **right** procedures is also included and ensuring the **right** record is made.

7.1 Medication Administration Procedure

The following procedure is recommended for staff to undertake when administering medication within their service.

- Staff must first ensure their hands are washed and equipment is clean, they should also put on a “do not disturb “apron if available.

- A clean tumbler of water or squash must be made available for each service user to wash down the medicine. Hot drinks should be avoided as these could cause burns and it could affect some medicines.

Hints & Tips - Fruit juices, especially grapefruit and cranberry juice and milky drinks should be avoided due to the risk of drug interactions.

- Consider priority of administration to those service users who need their medication at a specific time or in relation to food e.g., those service users prescribed diabetic medication, Parkinson's medication, anti-epileptics or antibiotics.

- Locate the service user's MAR chart and take note of any allergy or compliance information detailed on the MAR chart cover sheet e.g., on covert medication or likely to refuse or spit out medication. The pMAR chart must also be checked to ensure that if it contains handwritten prescription entries that these have two signatures on them (staff member who transcribed the prescription and the staff member who checked it for accuracy). Staff should also check that once weekly medication is being given on the correct day and that patch medication is being changed on the correct day.

- Staff must check that there are no missing administration signatures on the MAR chart from the previous medication round. If there are, the cause of these must be identified straight away and an incident form completed if necessary. Advice may need to be sought from the service user`s GP/prescriber or community pharmacist if a medication has been missed by accident. Staff **must not** double dose a service user.

- The service user should be asked to confirm their name, if possible, before the medication is administered, the photograph of the service user must also be checked. If the staff member is still unsure (e.g., if they are an agency member of staff, they must check the service user`s identity with another regular staff member).

- The service user should be asked if they want to take their medicines or if there are any that they do not want to take at this time (e.g., when required medication for pain, constipation, or indigestion). If the service user has capacity, it is their right to decide not to take their medicines.

- Efforts should be made to preserve the dignity and privacy of the service user e.g., when asking about bowel movements. It may be that certain medicines may be requested to be administered in the privacy of the service user's room.

- Working down the MAR chart, the correct medicines for the time of day must be selected (checking any MDS containers and other boxed, bottled, inhaled or refrigerated medicines that may be required).

- If the service user is on when required medications, their when required medication protocols must be referred to and also it should be confirmed when their previous dose was administered.

- If the service user is prescribed a variable dose of medication e.g., 1or 2 tablets, the number of tablets that were administered must be recorded on the MAR chart. It is vital that it is clear on the MAR chart how many tablets can be given in a 24-hour period and that this is not exceeded.

  Staff must check the service user`s name is on the label, name of medication and strength, directions and that the medicines appearance hasn't changed and is in date (see Guidance 14 - Topical Preparations Table 14b for information on expiry dates).

- If the label is attached to the outer packaging it is essential that the packaging is retained for reference.

- If the label becomes detached or is unreadable, the prompt advice of the supplying pharmacist must be sought. Until then the original container must not be used.

- Staff must **never** alter labels on dispensed medicines. However, if the container is being started for the first time (excluding MDS containers) then the date of opening must be written on the container.

- **Medication must not be removed from the original container in which the pharmacist or dispensing doctor supplied it, until the time of administration.**

- **Medication must only be administered to the service user for whom they have been prescribed, labelled and supplied. Medication may not at any time be used for other service users as though they were 'stock' held by the service.**

- The medicines must be placed into a clean, dry medicine cup without touching them. This may require several different medicine cups if some medicines are tablets or capsules, if a tablet is to be dispersed in water, dissolved in the mouth or if some are liquids.

- A 5ml medicine spoon, oral syringe or a graduated medicine cup must be used to correctly measure out any liquid medicines. Do not mix liquid medicines together in one pot or syringe. Use a separate measure for each medicine.

Hints & Tips - Some medicines need to be given in very small quantities. If this is the case, they may come with a specific syringe to be used only with this medicine e.g., citalopram drops. Ensure the correct syringe is used if this is the case.

- The service user should be encouraged to sit upright or to stand. The medicines should be handed to the service user and asked to take the medicines. Once the service user has taken the medicines (and staff are certain that they have taken it), the MAR chart must be signed for each medicine given (including homely remedies).

- There may be some medications e.g., creams that have a separate medication administration record, these should therefore be cross referenced on the MAR chart.

- Where the service user does not want to take the medicines at that time, staff should wait a while and then ask them again. If the service user continues to refuse, staff must never force the medicine on them or hide the medicine in food or drink. The GP/prescriber should be contacted for guidance.

- Medication must never be left unattended. Medication should not be handed to another staff member to give, unless they have personally checked each medicine is correct and also signed the record, as this can lead to a service user receiving the wrong medication.

- If the service user is asleep the service user should be re-visited at the end of the medication round. It is important that service users do not miss their medicines.

Hints & Tips - If a service user is constantly asleep it may be wise to think about changing the time the medication is given. A discussion should be had with the service user`s GP/prescriber. All communications and decisions must be documented.

- If the medicines have not been given for any reason e.g., the service user was in hospital, on leave, or refused to take the medicine a code must be written in the signature box, for that date and time of day to show why the medicine was not given. The home/service must have a set of codes for this purpose. These must then be listed, with an explanation of what each code means, on the MAR chart. It is recommended on a pMAR that if staff use a code, then they place a circle around it. This distinguishes the code from a normal staff administration signature.

- The registered manager or responsible care home worker will contact the prescriber for advice and where the refusal falls within part of a defined course of treatment or is a time sensitive medication, the GP needs to be informed after the first refusal.

- Staff must record on the reverse of the pMAR/eMAR exactly what has happened including the signature of the person making the entry. For example why the "when required "was given, that the service user spat out the medicine, that a dose had been dropped on the floor so another had to be administered or that the medicine was found later on the floor. A record must also be made where the MAR chart has been signed by mistake.

- Staff should check with service users who are prone to refusing meds or are on PRN meds, whether or not they want/need the medication before they draw up liquids or decant out tablets and capsules. This will reduce medication waste.

- If there are any refused medicines that need disposing of these should be placed in an envelope, documenting what the medication is and whose medication it is and date and time of refusal along with the staff members name. If the medication is liquid this may be placed onto a tissue and disposed of in clinical waste.

- Administration of medicines to the next service user must not begin until the previous service user`s MAR chart has been completed with all necessary signatures.

- At the end of the medicine round, staff must check that all the medicines that should have been given have been given and check that the MAR charts have been completed correctly. They should check for any administration gaps and make a note of any medications that require ordering and chase any medications that are still out of stock.

- The medicines must be secured by locking the cupboards and the trolley at any time that staff have to leave them. Keys must not be left in the door of the trolley. At the end of the medicine round, the trolley must be secured to the wall in the treatment or storage room.

- Medication must not be left in medication cups in the trolley for administration at a later point.

- Any medicine cups (excluding single use), spoons or oral syringes must be washed and dried in a dishwasher or if not possible a sink not designated as a hand washing sink with detergent and water. They must then be rinsed and dried with paper towels (not fabric) and put away immediately. Staff must ensure that they dispose of any medicine pots that are marked for single use only - see section 7.11.

Alcohol

Alcohol can interfere with the action of many drugs. Where a known interaction exists between a medicine and alcohol, a warning will appear on the label of the medicine container.

If a service user appears to be intoxicated with alcohol or other substances, staff must not administer until they have spoken to the service user`s GP or a pharmacist.

Day Care services

Care needs to be taken as service users may bring their medicines in a variety of Monitored Dosage Systems (MDS) or original boxes. It is important therefore that it is recorded what medication has been given, dose and time of administration. This information must also be communicated to the service where the service user resides or their carers.

7.2 Administration of eye medication

Staff administering eye drops/ointment must check that they are in date. The container must have a date of opening marked on it as drops/ointment have a short expiry after opening. Drops/ointment must not be used if they do not have a date of opening on them, unless staff can be assured, they are within the expiry period stated on the packaging (usually 28 days).

When administering eye drops:

- Staff must ensure that the dropper does not touch the service users' eye, or staffs fingers
- The lower lid of the eye must be gently pulled down and 1 drop administered to the correct eye
- The eye lid must then be let go to allow the eye to close briefly
- If two drops or two different eye drops are to be used at the same time of day, then 5 minutes should be left between doses.
- The service user must be asked to blink and not to touch their eye/s

When administering eye ointment:

- The lower lid of the eye must be gently pulled down and 1cm of ointment squeezed along the inside of the lower lid
- Staff must ensure that the tube tip does not touch the eye
- The lid must be released, and the service user asked to close their eye to allow the ointment to spread over the surface
- The service user must be warned that their vision may be slightly blurred but that it will clear

7.3 Administration of ear medication

Staff administering ear drops must check that the ear drops they are using are in date. The container must have a date of opening marked on it as the drops have a short expiry after opening. Drops must not be used if they do not have a date of opening on them, unless staff can be assured, they are within the expiry period stated on the packaging.

When administering ear drops:

- Staff should first warm the container between their hands if it is cold
- The bottle should then be shaken
- The service user ideally should be asked to lie down, or could just tilt their head
- The correct number of drops must be put into the correct ear/s
- The service user should be asked to lie on their side or keep their head tilted for a few minutes
- Staff should wipe away any excess medication when the head is then upright

7.4 Administration of Inhaled medication

Inhaler medication
Inhaled medication can be simply split into two types, prevention medication and reliever medication.

- **Prevention medication** contains steroid medication and should be taken on a regular basis by the service user even when they are well. Inhalers containing this medication come in a variety of colours, but the commonest are brown, green, red, pink and purple. It is important that staff offer a service user a glass of water to rinse their mouth out after they have had a dose of their preventer inhaler.

- **Reliever medication** is usually only used when breathless if the service user has asthma but can be used all the time in some other conditions. The inhaler is normally blue in colour.

NOTE
If service users are prescribed a preventer and reliever medication to be given at the same time, then the reliever medication should be administered first.

Types of inhaler device

Common inhaler devices include:

- Metered Dose Inhalers (MDIs) e.g., salbutamol inhaler, Luforbec ®100/6 or autohalers.

- Dry powder inhalers (DPIs) e.g., salbutamol Easyhaler®, Beclometasone Easyhaler ®, accuhalers, turbohalers, Tiotropium/Spiriva capsules in a handihaler

Administration will differ depending on the type of device prescribed so staff must assist the service user by reading the instructions supplied with the device.

Inhaler technique videos can be accessed via the Right Breathe website

Spacer Devices

If the service user finds the administration technique difficult, they may be prescribed a spacer device for the inhaler to be attached to. These are made specifically to fit a certain type of inhaler and therefore should only be used for that specific inhaler and service user.

Staff should therefore make sure that devices for individual service users can be easily identified, through labelling, particularly if they have a number of service users using spacer devices.

Hints & Tips - Spacer Care

Staff commonly forget to clean spacers, which can affect their efficiency and infection control. Spacers should be cleaned in accordance with manufacturers guidance (see leaflet, Right Breathe website or speak to your local pharmacy).

7.5 Specific Day Medication

Most services will have specific times when the medicine 'round' will be undertaken; this usually follows the pattern of mealtimes. However, the time of administration must respond to the service user's needs and that of the specific medicine. Some medicines, for example, must be given before or after food.

Some medicines need to be given once a week e.g., osteoporosis medication or every few days e.g., painkilling patch medication. Care needs to be taken when giving these medicines to ensure they are given as per the prescribers and manufacturer's instructions.

It is important that it is clear to staff on the MAR chart when these medicines are to be given. It is recommended that the day to be given is boxed and all other days are crossed through (see example below). Ensure the transcription is checked for accuracy by another staff member.

		M	T	W	T	F	S	S	M	T	W	T	F	S	S
Alendronic Acid tablet 70mg															
One to be taken		X	X	X	X		X	X	X	X	X	X		X	X
once a week (Friday).															
To be taken on an empty															
stomach at least 30 minutes															
before breakfast or another oral															
medicine															

It is important when administering these medicines that if the service user is asleep, they do not miss out on having these medicines.

For those service users receiving hydroxocobalamin or other depot injections it is important that the MAR chart is annotated with the date they are to be next administered.

Hints & Tips - Alendronic acid tablets should be swallowed whole and solution swallowed as a single 100ml dose with plenty of water whilst sitting or standing; to be taken on an empty stomach at least 30 minutes before breakfast (or another oral medicine); service user should stand or sit upright for at least 30 minutes after taking dose.

7.6 Crushing Tablets, Opening Capsules and Splitting Tablets

If a service user is having swallowing difficulties and cannot take their medicine the service /care home must contact the service user`s GP/prescriber.

Options may include reviewing the need for the medication, trying a different formulation if available, e.g., liquid, or dispersible tablet or changing it to an alternative medication. These considerations must therefore be discussed first with the service user`s GP/prescriber and pharmacist.

Medicines should only be given as per the information contained in the Patient Information Leaflet unless written instruction from the prescriber. Medicines used in a different way from what the manufacturers have stated are being used 'off-licence' which means the manufacturer does not accept responsibility for any harm caused as a result of this. A person giving crushed tablets or opened capsules to a service user without specific directions from the prescriber and without making the appropriate checks could be held liable for any harm caused.

Tablets must therefore **not** routinely be crushed, or capsules opened unless it has been agreed with the prescriber and pharmacist. If the prescriber agrees then this should be carried out with the service user's consent and documented in the care plan. The prescriber should clearly state in the prescription directions that the tablets should be crushed, or the capsules opened, so the pharmacist is aware, and can check it is appropriate. This will then be printed on the medication dispensing label and accompanying MAR chart so that staff are informed.

It is important that the service user`s pharmacist is involved in the process, and this is documented in the care plan and the MAR chart as certain medicines may be harmful if crushed or opened. Be aware that certain foods or drinks can affect the active ingredients or how it is absorbed.

For example:

modified release tablets/capsules - If these medicines are crushed the dose could be released much quicker than intended.
enteric coated tablets/capsules - These medicines have a special coating on them and if crushed or opened the medicine may be destroyed in the stomach or cause side effects such as indigestion or ulcers.
hormone, steroid, antibiotic or cytotoxic medicines - Crushing or opening any of these may cause some of the medicine to go into the air as dust. The dust may cause side effects to the person crushing the tablets or anybody else nearby.

On rare occasions a tablet may have to be split e.g., halved or quartered in order for the correct dose to be given. In these instances, staff should request that this is done by the community pharmacist. Community pharmacies will have a tablet cutter and therefore will be able to complete this accurately.

In circumstances where the pharmacy refuse to split tablets and staff are required to undertake the splitting of tablets a tablet cutter should be used (which can be purchased from a pharmacy). The dose required should be given to the service user and then the remaining part of the tablet must be disposed of as per the organisation's disposal procedures. It should not be placed back into the medicine bottle/packet (see section 7.8 for halving warfarin). It is best practice that service users have their own pill cutters/crushers).

7.7 Medicines given via a PEG (Percutaneous Endoscopic Gastrostomy) tube

Medication administration via a PEG must only be carried out by staff who have received appropriate training and been assessed as competent to carry out the task. In a residential care home, there will need to be involvement from a healthcare professional e.g., District Nurse. The tasks must be clearly defined in the care plan and kept with the MAR chart. Enough staff need to be trained to ensure cover during periods of holiday or sickness.

Administration of medication via the enteral route is usually unlicensed. The prescriber e.g., GP must specify clearly on the prescription that the medication is for enteral administration.

If the enteral route is not specified, the medication must not be administered until the prescriber has been contacted and route of administration has been confirmed. The

prescriber must accept liability for any adverse effects resulting from this route of administration.

The prescriber e.g., GP will be responsible for liaising with the pharmacist to review the patient's prescription and discuss if alternative licensed liquid medicine formulations are available within the same class of drug or whether the drug prescribed could be given by an alternative route.

Not all medicines can be given via PEG route. Altering the medicine (i.e., crushing) may cause blockages in the tubes or increase/decrease medication concentrations in the body. Additional monitoring of the service user may be required (see crushing tablets section for further information). When administering medication via feeding tubes other issues such as interactions with feeds need to be considered and advice obtained from a pharmacist/ dietician.

7.8 Anticoagulants

Warfarin

Service users who are on warfarin will need to be monitored more closely and will require regular blood tests to determine the dose required.

It is important that the following procedure is followed:

- All staff should have received training to enable them to administer warfarin safely, this must include drug and dietary interactions e.g., cranberry juice
- Ensure the information on when service user`s blood tests are due is recorded in the care plan and on the MAR chart and actioned accordingly (this is particularly important for new service users on admission and post discharge
- Ensure it is documented in the care plan who is responsible for performing the blood tests
- Ensure all communication received is read in a timely manner and on a regular basis. The most recent communication regarding doses should be stored in the MAR chart folder or scanned onto eMAR system.
- The service users' yellow book must be taken to all appointments and on days out. This is to ensure that in an emergency situation information is available that they are taking warfarin and at what dose.
- It is good practice that 2 members of trained staff check that the right service user`s INR results have been received. The doses on the INR report should be written on the MAR chart and then countersigned. The date of the next INR can also be documented on the MAR chart.
- Warfarin should always be dispensed as whole tablets by the pharmacy. As the dose of warfarin is often variable depending on the INR results there may be instances where warfarin tablets will need to be halved. In these cases, the care home can half the tablet using an appropriate tablet cutter. The remaining half should be disposed of as per the home's disposal process.

Direct Oral Anticoagulants (DOACs)

Like warfarin DOACs help to prevent blood clots from forming, however, DOACs do not require a regular INR blood test. Examples of DOACs include rivaroxaban, apixaban, edoxaban and dabigatran.

The following points are important when service users are on a DOAC:

- Service users taking a DOAC will receive a DOAC alert card to highlight to Health Care Professionals in an emergency situation that they are taking a DOAC. It is important that

this is taken with the service user when attending appointments and leaving the care home.
- Ensure all communication received regarding reviews etc. are read and actioned in a timely manner.
- Due to the risk of blood clots it is important that service users receive their medicine on time and doses are not missed or allowed to become out of stock.
- As with warfarin there is an increased risk of a bleed following an injury. It is important to obtain advice if an injury occurs i.e. a fall.

7.9 Administration of transdermal (patch) medication

To ensure the safe administration and management of transdermal patches it is important that all staff involved in the application of patches have received adequate training, have been proven to be competent to undertake the task and follow set procedures at all times.

The following procedure can be used for any patch medication, however additional considerations need to be made for controlled drug patches (see Form 7a for additional information on fentanyl patches).

Removal of old patch

It is important that the old patch is removed before applying a new one. If an old patch or patches cannot be found on the service user, a thorough body search **must** be undertaken and also a search of the service user`s immediate surroundings. The prescriber should be contacted for advice. It is good practice for an incident form to be completed and it should be clearly documented in the service user's notes. All staff should be notified including laundry, kitchen and cleaning staff and made aware of what to do if found.

A new patch **must** only be applied if the staff are satisfied that the service user does NOT have remaining patches on them.

The site should be checked for signs of allergic reaction, redness, itching or blistering; any concerns should be highlighted to the service user's GP/prescriber.

Wearing disposable gloves, the edge of the patch should be lifted gently and removed from the skin surface. The old patch should then be disposed of by folding the patch in half and placing in a denaturing kit, clinical waste bin or returned to the supplying pharmacy for destruction.

It is possible for a service user to wear more than one patch at a time; if this is the case then these should be applied to the same area but do not overlap and should be changed on the same day to avoid confusion.

Application of patch

It is important to first check the label on the box against the service user`s MAR chart. This is to verify identity, medication name, strength and dosing interval. The staff member must then check on the MAR chart and topical patch chart where the patch needs to be sited.

If a patch is inadvertently omitted or there is a delay in application advice must be sort from the prescriber before application.

Patches should be applied to clean, dry, non-inflamed, non-irradiated, hairless skin usually on the upper arm or trunk (check Patient Information Leaflet). Upper back may be preferable in a confused person to reduce the risk of unintended patch removal (first refer to local procedures on capacity and consent). It should not be applied to broken skin.

Patches must never be cut prior to administration, or damaged patches applied.

The staff member applying the patch must put on disposable gloves prior to opening the patch packet.

Patches should be pressed in place firmly with the palm of the hand for 30 seconds. Body hair may be clipped but do not shave. Some service users may need a semi-permeable dressing to ensure adherence.

If the patch is a CD, it should be administered by two medicine trained staff members, one to administer and one to witness the correct administration and countersign all documentation.

Once application has finished, the gloves may be removed, and hands washed thoroughly.

Recording

It is good practice to cross through the days on the MAR chart of when the patch is not to be changed.

A patch chart (see Form 7b for an example) must be used to indicate the date and position of the patch on the service user so that sites can be rotated as per manufacturer's instructions. It should also be clear on the MAR chart and the service user`s care plan when their patch should be changed. Ensure the manufacturer's instructions are followed as to where to position the patches and how long it needs to be before a patch can be applied to the same area of skin.

Hints & Tips - For some patches it isn't appropriate to just keep switching shoulder applications. For example Butec patches should not be applied to the same area of skin for 3-4 weeks. Rotigotine and Rivastigmine patches should not be placed in the same area within 14 days (see Form 7c for an example form for Rotigotine and Rivastigmine).

Important points to note

A new patch should not be applied immediately after a bath or a shower or immediately after using creams, talc, or soap on the skin.

Service users can bathe or shower (with care) whilst wearing a patch, but the water should not be too hot.

Heat (e.g., hot baths, electric blankets, hot water bottles) should NEVER be applied over the top of the patch as it may enhance the absorption.

An increased temperature / fever may also increase absorption and the service user should be monitored for side effects and toxicity. Advice from the service user's GP/prescriber should be sought.

The service user should avoid excessive sun exposure.

Site irritation, usually from the adhesive, may necessitate a change of brand and so should be discussed with the service user's GP/prescriber.

Only patches with metal backings would need to be removed during an MRI scan to prevent the risk of burns.

Patches must be worn at all times and must NOT be cut in an attempt to reduce the dose (unless advised in writing by the prescriber).

Staff members should regularly check (daily) that the patch remains adhered to the skin properly.

7.10 Administration of medication using specialist or invasive techniques

Diazepam rectal solution

Service providers must ensure that they have clear instructions from the prescriber or specialist service on how this is prescribed and administered to a service user. Staff must also have been specifically trained in its administration technique.

Nebulisers

Where medication is to be delivered via a nebuliser, staff must receive detailed information from the prescriber and must have been specifically trained in this administration technique as well as instructions relating to the specific nebuliser to be used.

Oxygen

Where this is prescribed staff must receive detailed information from the prescriber and must be specifically trained in the handling and administration of oxygen.

7.11 Single Use devices

Single use means do not re-use. A single use device is for use on an individual service user during a single procedure and must then be discarded. It is not intended to be reprocessed and used again, even on the same service user. Re-use can be unsafe because of the risk of cross contamination. The single use symbol, if it applies to a device e.g. a medicine pot, is a number 2 within a circle with a line crossed through it. This may be located on the device or the packaging it came in.

7.12 Administration of thickening agents

Prescribe on specialist SALT advice only

Thickeners are indicated for the treatment of dysphagia, difficulty in swallowing, eating and drinking. They act by slowing down the transit of food and fluids to allow the service user more time to co-ordinate the swallowing process safely. This helps to prevent the liquid or food from entering the lungs which can lead to serious complications such as chest infections and even potential risk of death due to choking or aspirational pneumonia.

Service users should be assessed for their swallow capabilities first by a Speech and Language Therapist (SALT). There are a number of commercially available thickeners on the market. Some are starch based and some are gum-based, some are used to thicken food only and others are indicated to thicken both foods and fluids. Gum based thickeners are usually preferable due to longer lasting texture benefits.

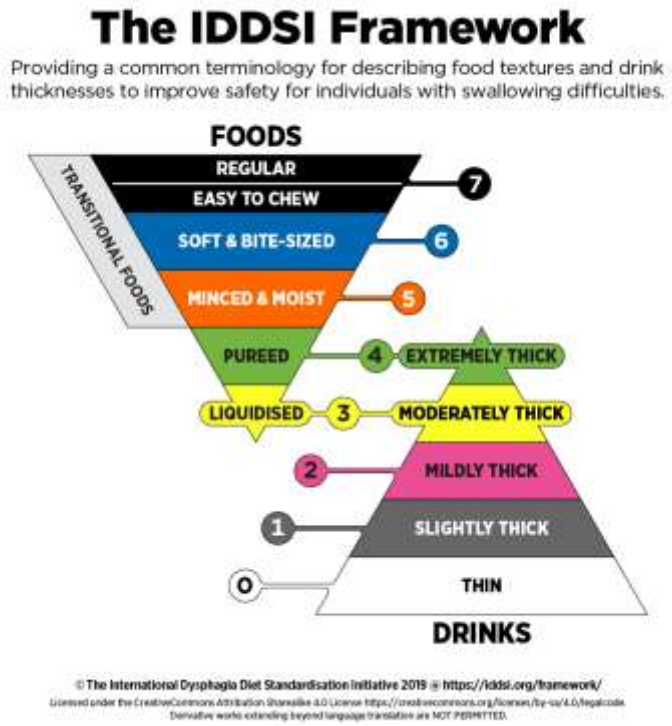
IDDSI Framework Descriptions of different consistencies/textures for thickening fluids

Slightly Thick - thicker than water. Requires a little more effort to drink than thin liquids. Flows through a straw

Mildly Thick – Flows off a spoon. Can be sipped, pours quickly from a spoon, but slower than thin drinks. Effort is required to drink this thickness through a standard straw.

Moderately Thick – Can be drunk from a cup. Some effort is required to suck through a standard or wide straw.

Extremely Thick – Cannot be drunk from a cup. Cannot be sucked through a straw. Falls off spoon in a single spoonful when tilted and continues to hold shape on a plate.



Care Homes should be encouraged to use one brand of thickener throughout for all their residents to avoid errors.

When administering thickening agents, the following points should be considered:

When thickening foods and fluids it is important that only the scoop provided with the thickener is used as these can vary between different products. Using the correct scoop will enable the correct amount of thickener to be mixed with the correct amount of foods and fluids.

Always follow the manufacturer's instructions to enable the correct texture/consistency to be achieved.

Always follow the manufacturer's storage instructions. Thickeners should be locked away if stored in a kitchen. Some brands require them to be stored between 5-25°C so if stored in the kitchen it is recommended that daily temperature checks are undertaken.

Thickening agents must be documented on the service user`s MAR and prescribed on the recommendation from an appropriately trained healthcare professional, e.g., a Speech and Language Therapist, GP, Dietician.

It is also recommended that the consistency/ texture the service user requires is also noted on the MAR.

Thickeners must only be administered to the service user they were prescribed for.

A service user`s care plan must clearly document the texture/consistencies the service user is able to manage and duration of treatment as dysphagia can be a temporary condition.

The service user`s other medications may need to be reviewed to ensure they are suitable for a patient with dysphagia, discontinuation, alternative formulations, or routes of administration should be considered. Liquid formulations may not be appropriate as they may also require thickening to enable the service user to take them.

Carers and staff working with service users with dysphagia should be aware that a change in the service user`s medication can cause side effects which could worsen their condition, any changes should therefore be checked with a GP or a pharmacist.

NHS England and eLearning for Healthcare (eLFH) have produced a dysphagia guide which is a learning resource designed to support knowledge and understanding of the management of dysphagia https://www.e-lfh.org.uk/programmes/dysphagiaguide/

7.13 Administration of Oral Nutritional Supplements (ONS)

Prescribe on Specialist Dietitian advice only

Services must ensure they have systems in place to screen service users for the risk of malnutrition using the MUST Tool. Oral nutritional supplements (ONS) should not be requested as a first line treatment. A 'food first' approach should be used, with encouragement and support. This means offering food fortification to increase calories and protein in everyday foods. Additional snacks may be needed to meet requirements for those service users with a small appetite. Services should be able to provide adequately fortified foods and snacks and prepare homemade milkshakes and smoothies, which should **negate the need to prescribe ONS in the majority of cases, on specialist Dietitian recommendation only**. No ONS is prescribable without recording of current weight, BMI, and Malnutrition Universal Screening Tool (MUST) scores.

Services must work in conjunction with the service user`s GP and /or local community dietetic services in agreeing a co-ordinated planned approach. Services are advised to produce a food fortifying plan, as part of a nutritional support package, which can then be inserted into the service user`s care plan to instruct staff regarding food fortification.

Generally, service users should be reviewed by the service in conjunction with the GP/Dietitian after one month, to assess the progress with a 'food first' approach. If there is a positive change towards meeting goals, the changes should be encouraged and maintained, and a further review arranged until goals are met.

To maximise their effectiveness and avoid spoiling appetite, if indicated by MUST and ONS is prescribed, service users should be advised to take ONS between or after meals and not before meals or as a meal replacement. The following parameters should be monitored:

- Weight/BMI/wound healing, depending on the goal set – if unable to weigh patient, record other measures to assess if weight has changed e.g., mid-upper arm circumference, clothes/rings/watch looser or tighter, visual assessment.
- Changes in food intake.
- Compliance with ONS
- MUST Score

The most commonly prescribed ONS are powdered supplements, AYMES Shake powder is 1st line, available in a variety of flavours.

Services must ensure that:

- If powdered supplements are prescribed these are made up correctly according to the manufacturer's instructions
- That supplements are documented as received and administration recorded on the service user`s MAR or dietary chart, cross referencing as appropriate
- That supplements are only given to the service user they have been prescribed for
- Once opened supplements should be dated and stored in the refrigerator between 2-8°C. Check the packaging for shelf life of product after opening
- On-going need should be reviewed regularly and the current weight, BMI and MUST score communicated to the prescriber, ideally on a monthly basis

The British Dietetics Association (BDA) guidance 'Care Home Digest – Menu planning and food service guidelines for older adults living in care homes'. Includes tools to support care homes to meet resident's nutritional needs.
https://www.bda.uk.com/practice-and-education/nutrition-and-dieteticpractice/care-home-digest.htm

PrescQIPP Creating a Fortified Diet in Care Homes Recipe booklet

This recipe book can be found here on our website www.nottinghamshiremedicinesmanagement.nhs.uk under 'social care policies and guidance'

Guidance for the Safe Management of Transdermal Fentanyl Patches

Fentanyl is a strong opioid which is often used in the management of cancer pain. It is available as a self-adhesive patch that is changed every 72 hours (3 days). This allows a standard amount of fentanyl to cross each hour from the patch into the skin and provides a continuous delivery of fentanyl into the body over the 72-hour administration period.

The following guidance has been produced to remind staff of the procedures that need to be followed to ensure the safe administration and management of transdermal fentanyl patches. This also relates to all transdermal patches.

The use of fentanyl patches can be compromised by incorrect administration; in particular medication errors have been reported when old patches are not removed at the time of the new application.

Training

It is important that all staff involved in the administering of fentanyl patches have received adequate training and proven to be competent to undertake the task.

Storage and Record Keeping

Fentanyl is a Controlled Drug (CD) and should be stored in a CD cabinet that complies with the Misuse of Drugs (Safe Custody) Regulations 1973. Its use must also be documented in a CD register as well as recorded on the MAR chart.

Application and Removal of patch

As fentanyl is a CD it should be administered by two medicine trained staff members, one to administer and one to witness the correct administration and countersign all documentation.

Staff must document the removal of the patch from the CD cupboard in the CD register. They should also check the label on the box against the service user`s MAR chart to verify identity, dosage, and date of application.

It is important that disposable gloves are worn by staff applying patches as fentanyl is an extremely potent painkiller, and it is important that staff do not absorb any of the drug through their skin.

Ensure the old patch is removed before applying a new one and this is documented. **If an old patch or patches cannot be found on the resident, the "Loss of fentanyl patches" procedure below should be followed.** A new patch MUST only be applied if the staff are satisfied that the service user does NOT have remaining patches on them.

Check the site for signs of allergic reaction, redness, itching or blistering; any concerns should be highlighted to the service user`s GP. The old patch should then be disposed of as per the "Disposal of fentanyl patches" procedure below.

The new patch should be dated (on the edge) and a patch chart used to indicate the date and position of the patch on the service user so that sites can be rotated. It should also be clear on the MAR chart and the service user`s care plan when their patch should be changed. It is possible for a service user to wear more than one patch at a time; if this is the case then these should be changed on the same day to avoid confusion.

Fentanyl patches should be applied to clean, dry, non-inflamed, non-irradiated, hairless skin on the upper arm or trunk. The upper back may be preferable in a confused person to reduce the risk of unintended patch removal (first refer to local procedures on capacity and consent). They must not be applied to broken skin.

Patches should be pressed in place firmly with the palm of the hand for 30 seconds. Body hair may be clipped but do not shave. Some service users may need a semi-permeable dressing to ensure adherence.

If patch application is inadvertently omitted or delayed advice should be sort from the prescriber prior to reapplying.

Gloves should be removed, and hands washed thoroughly.

Important points to note:

A new patch should not be applied immediately after a bath or a shower or immediately after using creams, talc or soap on the skin.

Service users can bathe and shower (with care) whilst wearing a patch, but the water should not be too hot.

Ideally the underlying skin should be allowed to rest for several days (check the manufacturer's instructions) before applying another patch to the same area.

Heat (e.g., hot baths, electric blankets, hot water bottles) should NEVER be applied over the top of the patch as it may enhance the absorption of fentanyl. Avoid excessive sun exposure.

An increased temperature / fever may also increase absorption and the resident should be monitored for side effects and toxicity. Advice from the service user`s GP should be sought.

Fentanyl patches can cause drowsiness, if affected the service user should be advised not to operate any tools or machinery. It is an offence to drive if their ability is impaired by the use of fentanyl patches.

Alcohol can increase the side effects of fentanyl, increasing the risks of drowsiness.

If a patch is accidentally swallowed, then dial 999 immediately.

If a fentanyl patch is inadvertently transferred to another person, it should be removed immediately, and medical advice sought.

If a service user has trouble breathing, shallow breathing, tiredness or extreme sleepiness, inability to think, walk or talk normally, feels faint, dizzy or confused, then these could be signs and symptoms of fentanyl overdose. Seek medical guidance immediately.

Site irritation, usually from the adhesive, may necessitate a change of brand and so should be discussed with the service user`s GP.

Only fentanyl patches with metal backings would need to be removed during an MRI scan to prevent the risk of burns. No such fentanyl patches exist at this time.

If a service user experiences hallucinations or confusion, then the fentanyl dose may need reducing. If the pain is not controlled, then alternative analgesia may need to be considered. In either of the above circumstances this should be discussed with the service user`s GP.

Patches must be worn at all times. Fentanyl patches must NOT be cut in an attempt to reduce the dose Do not apply damaged patches.

When more than one patch containing the same medication is prescribed apply to the same area of the body but do not overlap the patches.

Staff should regularly check (daily) that the patch remains adhered to the skin properly.

When ordering repeat fentanyl patches, it is important to ensure the service user has enough for continued therapy, but it is also important not to over order the patches as the dosage of the patch may need to be changed.

Loss of Fentanyl Patches

It is known that fentanyl patches still contain their active ingredient, which works for at least 48 hours and possibly up to 72 hours, after their removal. This can have serious and potentially fatal consequences, if they are found and touched by another service user, staff member or visitor.

If a service user`s patch or patches cannot be found, a thorough body search must be undertaken and also a search of the service user`s immediate surroundings. An incident form must be completed by the senior member of staff in charge, and it must be clearly documented in the service user`s notes.

All staff must be notified including laundry, kitchen and cleaning staff to ensure they are aware of the procedure if found i.e., pick up with care, preferably using gloves. Ensure prescriber is informed and advice given is followed.

Disposal of Fentanyl Patches

It is important to understand that used patches when removed still contain significant amounts of fentanyl which may be harmful to other people, as per above. Therefore, safe disposal is essential.

Disposable gloves should be worn when removing patches.

As soon as the patch is removed, it should be folded firmly in half so that the sticky side sticks to itself.
If staff touch the gel (sticky side) they must rinse their hands with water

The old patch should be placed in the empty foil pack the new patch came out of and discarded in a denaturing kit, or for care homes without nursing they can be returned to the supplying pharmacy for destruction or placed in the clinical waste bin.

Gloves should be removed, and hands washed thoroughly.

Any unused patches should also be disposed of and documented appropriately in line with the care homes Controlled Drugs policy.

These are general principles that apply to all transdermal patches – if unsure seek advice from a pharmacist

This guidance has been adapted and with contributions from:

Roger Knaggs- Advanced Practitioner - Anaesthesia & Pain Management, Nottingham University Hospitals NHS Trust
NHS Buckinghamshire & Oxfordshire Cluster - Good Practice Guidance 5: Use of fentanyl patches in Care Homes
NHS Lincolnshire Medication Procedure Guidance (Adult Care Homes)

Example Form 7b

Patch Application Record

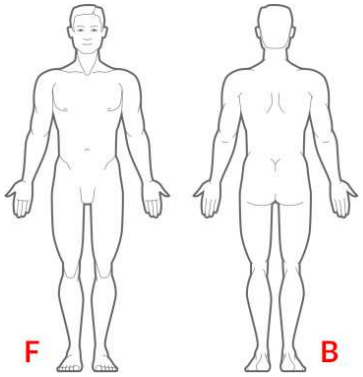
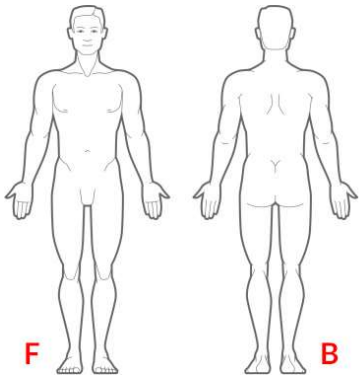
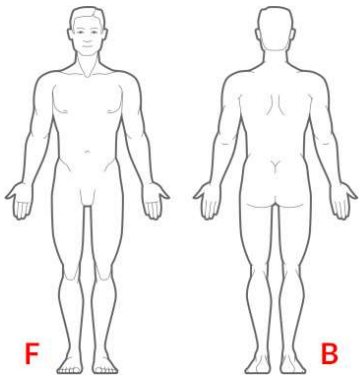
Name of Service User			
Name of patch		**Strength**	
Frequency of change			

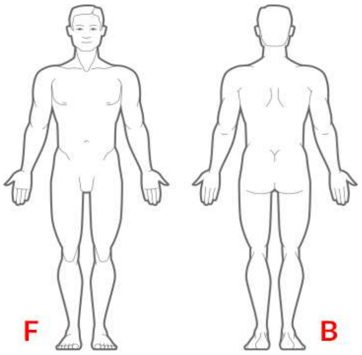
The patch should be checked on a daily basis to make sure it is still in place and initialed by the staff member undertaking the check.

The site of application should be rotated in accordance with the manufacturer guidance.

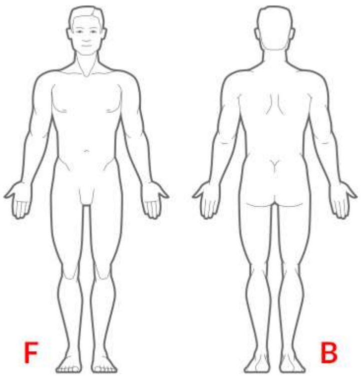
The old patch must be folded in half and stuck together before disposal, in accordance with the care home policy.

Please indicate where the patch has been applied using a cross (**x**). If more than one patch is in use please indicate with a separate symbol, e.g., **o.** Remember to complete the MAR chart

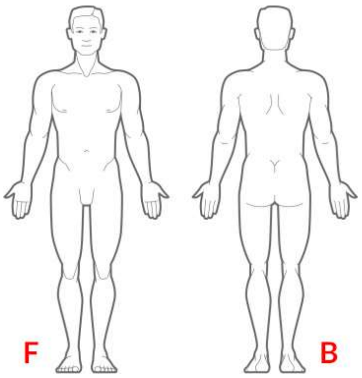
	**Date Patch Applied**				**Time**	
	Applied By			**Witnessed By (if CD)**		
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed				**Time**	
	Removed By			**Witnessed By (if CD)**		
	**Date Patch Applied**				**Time**	
	Applied by			**Witnessed By (if CD)**		
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed				**Time**	
	Removed By			**Witnessed By (if CD)**		
	**Date Patch Applied**				**Time**	
	Applied By			**Witnessed By (if CD)**		
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed				**Time**	
	Removed By			**Witnessed By (if CD)**		



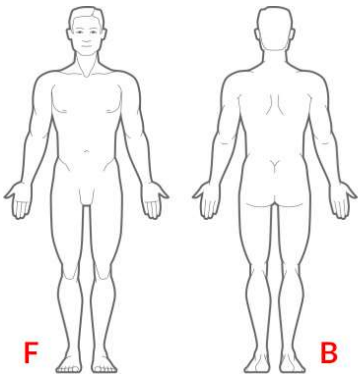
Date Patch Applied			Time		
Applied By			Witnessed By (if CD)		
Daily Patch Check	2	3	4	5	6
Date Patch Removed			Time		
Removed By			Witnessed By (if CD)		



Date Patch Applied			Time		
Applied By			Witnessed By (if CD)		
Daily Patch Check	2	3	4	5	6
Date Patch Removed			Time		
Removed By			Witnessed By (if CD)		



Date Patch Applied			Time		
Applied By			Witnessed By (if CD)		
Daily Patch Check	2	3	4	5	6
Date Patch Removed			Time		
Removed By			Witnessed By (if CD)		



Date Patch Applied			Time		
Applied By			Witnessed By (if CD)		
Daily Patch Check	2	3	4	5	6
Date Patch Removed			Time		
Removed By			Witnessed By (if CD)		

Example Form 7c

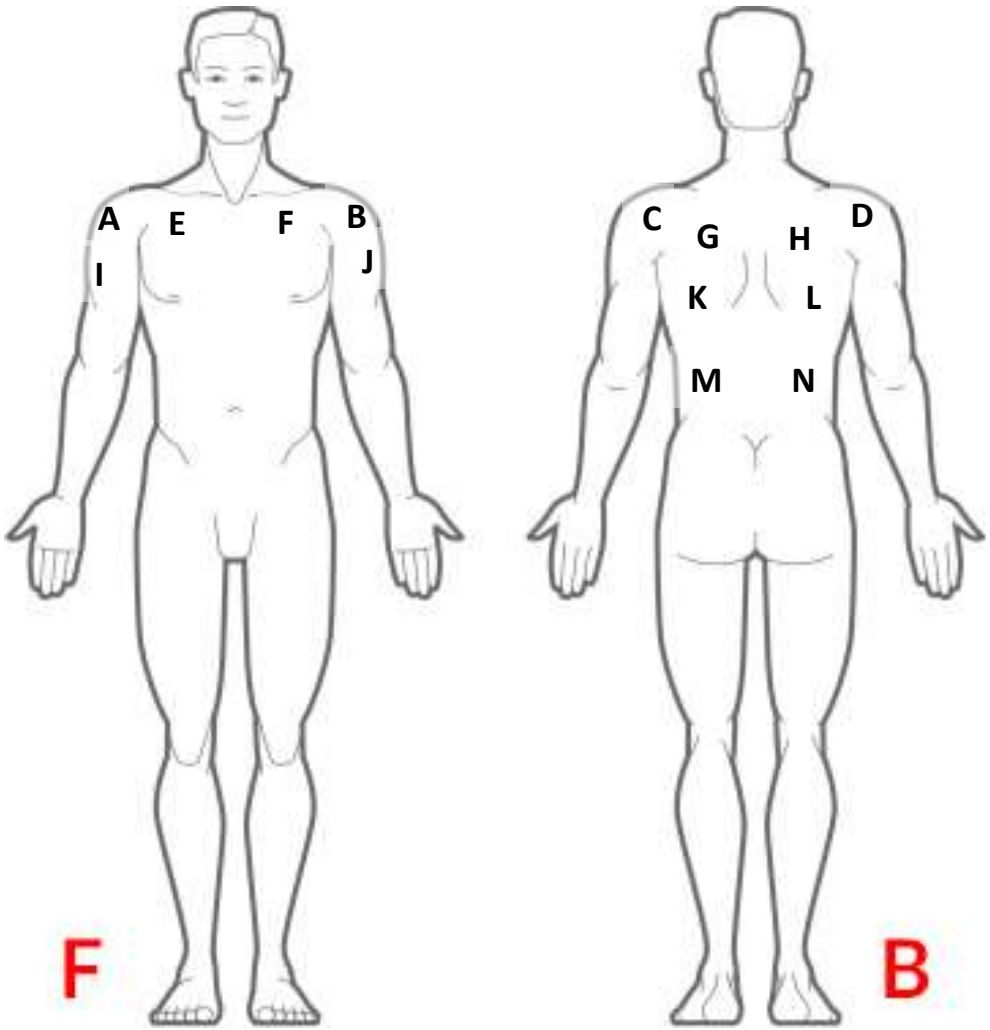
Patch Application Record (14 day patch rotation)

Name of Service User			
Name of patch		**Strength**	
Frequency of change			

The site of application should be rotated in accordance with the individual manufacturer guidance.

The old patch must be folded in half and stuck together before disposal, in accordance with the care home policy.

Please indicate where the patch has been applied using the coding system. Remember to complete the MAR chart.



Date Patch Applied	Applied By	Application Area (letter)	Date Patch Removed	Removed By

Guidance 8

Self-Administration

Making sure that the correct procedures are followed regarding self-administration will ensure service providers are complying with section 1.13 of NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

It is important for service users to be given the opportunity to take responsibility for their medicines wherever possible. This will preserve independence for as long as possible and prepare those in short term/respite care for their return home where they may look after their own medicines.

It should be assumed that a service user can take and look after their medicines themselves unless a risk assessment has indicated otherwise. Service users may decide to self-administer only part of their medicines like inhalers or creams and ask the staff in the home to be responsible for all other medicines.

8.1 Assessment

A robust risk assessment should be in place to determine which service users would be able to self-administer their medicines. This should include whether the service user:

- Wants to look after and take their medicines and list which medicines this would include.
- Has the mental capacity and manual dexterity to self-administer.
- Requires any support for them to be able to do this e.g., a MDS, inhaler aid etc. (Community Pharmacists can undertake assessments under the Disability Discrimination Act to adjust packaging and labelling in order to promote self-administration).

It is important that the service user knows the medicines they take, what they are for, how and when to take them and what is likely to happen if they do not take them. They need to understand that it is important not to leave their medicines lying around as someone else may unintentionally take them. Part of the assessment should also include how often a review will take place, where the medications are to be stored, and what responsibilities the service staff have.

See Form 8a for an example of a risk assessment.

8.2 Documentation

A record should be made of what the service user would like to do on either a form or in the care plan, listing each medicine that is to be self-administered and how to monitor whether the service user is still able to self-administer medicines without constantly invading their privacy.

The service user should sign this record and agree to let the staff know if they are having any problems, to allow regular reviews to form part of the service user's care and that if the carers are to be responsible for obtaining the medicines that they are informed in advance that a new supply is needed (see Form 8b for an example).

It is also advisable to obtain consent from the service user to conduct a periodic audit of the medicines in their possession.

A record must be kept of all the medicines that the service user is on, just in case they are admitted to hospital for any reason, and this should be updated if any medicines are added or discontinued.

If the staff in the home are responsible for obtaining the medicine a list of what, quantity and when the medicines are given to the service user should be kept. This can also be helpful to review and monitor the service user's progress.

There is no need for the carer to fill in the administration section of the MAR chart when a service user self-medicates just indicate on the MAR the medicines that are self-administered. It is important that care staff record when a resident has been reminded to take their medication.

8.3 Storage and security

A lockable drawer or cupboard secured to a wall should be provided by the home for a service users medicine to be stored (this includes any Controlled Drug's that are self-administered) or where special storage is required like refrigerated storage, that the service user has easy access to these medicines when they need them. It is important that any keys are stored safely to prevent other service users gaining access. If a room is shared, then separate storage is required for each service user's medicines. Service users should be encouraged not to keep medicines routinely in handbags.

It is important to recognise that the medicines are the property of the service user for whom they are prescribed, and staff should not assume that these can automatically be removed from them.

Hints & Tips - Medicines (including creams) should not be stored in a bathroom due to the heat and moisture affecting them. The home needs to ensure that they are being stored correctly (below 25°C), this may require the temperature of the storage area to be monitored periodically.

8.4 Review

A risk assessment should be carried out six monthly or more frequently if an incident occurs that suggests the service user is experiencing problems.

If a service user's capacity to self-administer diminishes, the relevant health or social care worker should undertake a formal two stage capacity assessment and the matter discussed sensitively with the service user and, bearing in mind the duty of confidentiality, with their family to determine the best interests of the service user.

If a service user is found to be so ill that they are unable to take their own medicines, they should be reviewed by their GP.

Hints & Tips - It is frequently seen that risk assessments are never re-visited. Don't forget to review.

Day Care Services

The most common medicines that will be brought into the service will be those medicines for asthma (inhalers), painkillers and diabetic medicines (insulin). It is important to ensure a copy of the risk assessments are held in the day care service.

Example Form 8a

Risk Assessment for Self-Administration of Medication

Resident Name:

DOB:

		Comments
Has self-administration been explained?	Yes/No	
Which medicines would the service user like to self-administer?		
Does the resident understand what their medication is for and how it should be taken?	Yes/No	
Can the resident demonstrate a good technique in administration e.g., inhalers, eye drops	Yes/No	
Can the resident demonstrate an understanding of The name of the medicine The purpose of the medicine Dose and frequency When and how often to take 'PRN' medicine and what the maximum dose is?	Yes/No	
Can the resident read and understand the label?	Yes/No	
Does the resident understand the requirement to store the medicines safely?	Yes/No	
Is there a suitable facility to lock the medication away?	Yes/No	
Can the resident access and manipulate the storage facility?	Yes/No	
Can the resident access the container and handle the medicine/measure the dose?	Yes/No	
Does the resident understand the passage of time and have access to a clock or watch?	Yes/No	
Is the health and medical condition of the resident appropriate for self-medication?	Yes/No	
Does the resident know what the likely side effects are and know to inform staff?	Yes/No	

Has the resident been advised to inform the staff if they take the medicine incorrectly?	Yes/No	
Is the resident likely to self-harm or abuse the medicines?	Yes/No	
Will the resident want to/be able to obtain own supplies?	Yes/No	
Is the resident happy to be monitored and reviewed?	Yes/No	
Special Dispensing Requirements	**✓if needed**	**Comments**
Large print labels		
Dispensing aid e.g., to pop out of foil		
Inhaler Aids		
Other aids e.g., to administer eye drops		
Reminder cards, pictures, or other aids		
Other help		

Self-administration approval Yes/No

Re-assessment Date: ……..

Staff Name……... Staff Signature…….

Date……

Resident Signature…… Date……

Example Form 8b

Self-Administration Record

I..... *(Name)*

Will be staying at - - - - - - - - - - - - - - - as a *****Permanent/Temporary resident.

I wish to exercise personal control and custody of my own medication and therefore will not hold ( ) responsible for maladministration of any drugs.

I understand that I will be provided with a lockable facility and arrangements will be made for the safe keeping of the keys.

I am fully aware that I am responsible for the safe custody of my medication and should not leave it unattended when in use.

I understand that I must not give my medication to any other person at the home.

*****I will be responsible for re-ordering my own medication
or
*****I will liaise with staff to ensure that arrangements are made for the re-ordering of my medication if necessary
*(*Delete which part does not apply)*

I will report any missing medication to the Manager immediately.

If I purchase homely remedies, I will check with the Pharmacist/GP that they are compatible with any medication I may be taking and/or liaise with a senior staff member.

I agree to staff performing periodic audits of my medicines upon asking.

I agree to the above and fully understand the implications.

Signed ..... **Date.....**
(Resident)

Signed ..... **Date.....**
(Staff member responsible)

Please delete as appropriate

This form should be reviewed if circumstances/residents' decision changes

Covert Administration

Making sure that covert administration is done correctly will ensure service providers are complying with section 1.15 of NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

All health and social care organisations are accountable for ensuring the safe and legal administration of medicines.

Covert administration is the term used when medicines are administered in a disguised form **without** the knowledge or consent of the person receiving them e.g., in food or drink. This should not be confused with adding medication to food with the knowledge of the service user to enable them to swallow medication or make the medication more palatable, this is **overt** administration.

Covert administration is sometimes justified and necessary but must never be used where the resident is capable of deciding about their medical treatment. Giving medication covertly without either the service users consent or that of a multidisciplinary team may be regarded as deception and is potentially an assault. Covert administration must only take place within the context of existing legal and best practice frameworks. This ensures that the service user receiving the medication is protected as well as the staff administering the medication.

All healthcare professionals should follow guidance set out by their professional body.

9.1 Consent

Medication must always be administered by consent with the full agreement and understanding of the service user. Every effort must be made to obtain consent. All service users must be presumed to have capacity to consent to treatment unless proved otherwise.

It should be explained to service users what the medication is for, what will happen if they refuse their medication and the risks of doing so. The service user should be asked why they are refusing their medication to see if there is any reason. If the reason is that they are struggling to swallow the medication, then alternative formulations of the medicine or alternative medications should be explored. The service user`s GP and pharmacist should be contacted to discuss the options available.

If the service user has capacity, they do have a right to refuse their medication, even if it presents risks to their well-being.

There are different policies in place in secure institutions for persons detained under the Mental Health Act, for those medicines related to their mental disorder.

9.2 Assessment Process

The service provider must have a process in place for covert administration of medicines. The information below complies with best practice guidance (NICE, 2017). See Table 9a for a flow chart to support staff with the covert administration process.

If a person is refusing medication, the care home worker must provide them with information about the medicine in a format that they find easy to understand, which may enable the resident to reconsider their decision. If they continue to refuse medication, then the care home worker must try to ascertain the reason for medication refusal and record this on the

Medicine Administration Record (MAR) chart, daily care records and inform the Registered Manager.

The Registered Manager or responsible care home worker will contact the prescriber for advice and where refusal falls within part of a defined course of treatment or time sensitive medication (e.g., Parkinson's medication), the GP needs to be informed after the first refusal.

Following refusal of medication that is essential to health and wellbeing for two consecutive days or more, a mental capacity assessment specific to the person's refusal of medication must be undertaken, in line with the Mental Capacity Act 2005.

If the situation is urgent, a discussion between the care home and prescriber should take place to support decision making. Ultimately the final decision should be made by the GP or medically trained professional on duty.

Covert administration should never be used if the service user has the mental capacity to decide to take or not take medication. It should only be considered as a last resort when all other options have been fully explored. Only medication which is regarded as essential for the service user's health and wellbeing, or for the safety of others, should be considered for administration in a covert way.

Any staff administering medications must not make a decision about covert medication on their own. The decision should be made by a multidisciplinary team for example the GP, home manager and staff, other healthcare and/or social care professionals involved in their care, relatives or independent advocate. It should only be considered where the service user has been assessed under the Mental Capacity Act. Lawful authority for the administration of covert medication applies to any persons over the age of 16 who lack capacity.

The Mental Capacity Act requires that any intervention is undertaken in a way that is least restrictive of the person's rights and freedom of action. Any staff administering covert medication must consider the consequences of this and ensure that the treatment is administered in the least restrictive and effective way whilst achieving a legitimate aim.

If the assessment indicates a lack of capacity, it is the responsibility of the staff under the services duty of care to use the best interest's checklist in accordance with section 4 of the Mental Capacity Act.

The two-stage capacity assessment and best interests' decision should be recorded in the persons care/support plan and reviewed regularly or whenever there are significant changes in the person's needs.

A decision to covertly medicate a service user who lacks the capacity to consent must involve consultation with others, including anyone named by the service user as appropriate to consult or anyone who is appointed as a welfare power of attorney. If there is no-one appropriate to consult other than professionals, an Independent Mental Capacity Advocate (IMCA) must be instructed. Covert medication must not be administered unless there has been a documented best interests meeting beforehand, unless in urgent circumstances.

It must be established if an advanced decision to refuse treatment has been made by the service user, if so, staff must secure a valid copy of this for the individuals care plan.

If it is agreed, it is in the service user`s best interests to receive their medication covertly this must be risk assessed and detailed in the care plan.

Covert administration can also occur in certain circumstances where the medicine is vital to the service user's wellbeing or that of others. This may need the permission of the courts.

9.3 Documentation

Covert administration of medication will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the persons care and clear documentation is essential. It is not appropriate to act on an “ad hoc” verbal direction or a written instruction to covertly administer as this could be liable to legal challenge.

The following information should be documented (see Form 9b for an example of a record form):

- Evidence that an assessment of mental capacity has been undertaken
- Evidence of a best interests meeting with a multidisciplinary team and names of those involved
- Evidence of why mental incapacity has been decided
- Proposed treatment plan agreed and recorded in the service users care plan
- Clear documentation on the MAR chart that service user is having medication covertly, which medications it applies to and what form it is being disguised in i.e., what food or drink or whether the tablet can be crushed (this should have been discussed and agreed with a pharmacist).
- Dates for reviewing the decision

The prescriber must have documentation of both mental capacity assessment for the understanding of medication issues and the best interest’s decision pathway to support covert administration. Copies of this documentation should be in the service user’s clinical records in their GP surgery and a copy needs to be shared with the service.

NB: a service user does not need to have a DoLS in place to be administered their medication covertly. Where a Deprivation of Liberty Safeguards (DoLS authorisation has been granted, the decision to covertly medicate following such authorisation, or a decision to change or introduce other medication covertly needs to trigger a review of that DoLS authorisation. It will be the service provider’s responsibility to notify the Supervisory Body immediately using a DoLS Form 10 (Review of a Standard Authorisation). The service user’s Relevant Person’s Representative must be included in the decision-making process.

Carers should produce a personalised instruction for each medicine to be given covertly in line with the advice of the pharmacist. This should be added to the care plan and a copy kept with the MAR charts to ensure that all carers are aware of the correct process. It is also useful for kitchen staff to be aware of a person who is being given medication covertly as dietary changes may be needed.

Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR.

Confirmation should be obtained from a pharmacist and included in the risk assessment that the medication can be administered in a particular way (i.e., medication is suitable to be mixed with food or liquid). They will also advise if medication can be crushed, or capsules opened (see Form 9c for example of a pharmacist guidance form).

9.4 Administration

In the context of care, it is important to remember that dignity and respect must be maintained in a potentially abusive situation. Staff must be supported by healthcare professionals to be able to deliver care appropriately with due regard to their accountability.

Consistency in practice is only possible if carers are given clear guidance that they can follow. Staff who are trained to administer medication should consider the following points when covert administration has been deemed necessary.

- A service user should be offered their medication **overtly** each time, especially where fluctuating capacity is evident.
- Staff should be aware of personal preferences for administration through the care plan. If the service user continues to refuse after appropriate steps have been taken, then medication can be administered covertly as per care plan.
- In general, the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible (rather than the whole portion). This increases the likelihood that the prescribed dose is actually taken. Not all drinks are suitable, e.g., tea or milk interacts with some medication, and this should be documented clearly (always consult a pharmacist).
- The medication must be administered immediately after mixing it with the food or drink. Do not leave it for the person to manage themselves. If the person is able to feed themselves, observe to ensure that it is consumed.
- Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet.
- Refusal of the food or drink containing medication must be recorded on the MAR sheet as refusal. It should also be noted if it is partially consumed as the dose is then uncertain.
- Refused food or drink that contains medication should be disposed of in a medicines waste or clinical waste bin.
- Robust record keeping is evidence to enable the prescriber to review the continued need for covert administration.

9.5 Review

The decision to administer covertly should be reviewed at regular intervals as service users' mental capacity can change. The dates for review should be documented in the care plan.

9.6 Summary of covert administration principles

Human rights law is the first principle that determines the decision to proceed. The right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal might lead to a detrimental outcome. **Covert medication cannot be given to someone who is capable of deciding about medical treatment.**

So, the first step in the process is ascertaining the capacity of a person to make a decision about their medical treatment.

Where covert administration is being considered as the most appropriate option, the following principles should be seen as good practice:

Last resort - covert administration is the least restrictive when all other options have been tried.
Medication specific - the need must be identified for each medication prescribed.

Time limited - it should be used for as short a time as possible.
Regularly reviewed - the continued need for covert administration must be regularly reviewed within specified time scales as should the person's capacity to consent.
Transparent - the decision making process must be easy to follow and clearly documented.
Inclusive - the decision making process must involve discussion and consultation with appropriate advocates for the service user. It must not be a decision taken alone.
Best interests - all decisions must be in the person's best interests with due consideration to the holistic impact on the person's health and well-being.

Hints & Tips - Adding medicines to food and drinks, with the service user's knowledge, to make it easier for them to take is not classed as covert administration. Hiding it in food and drink without them knowing is.

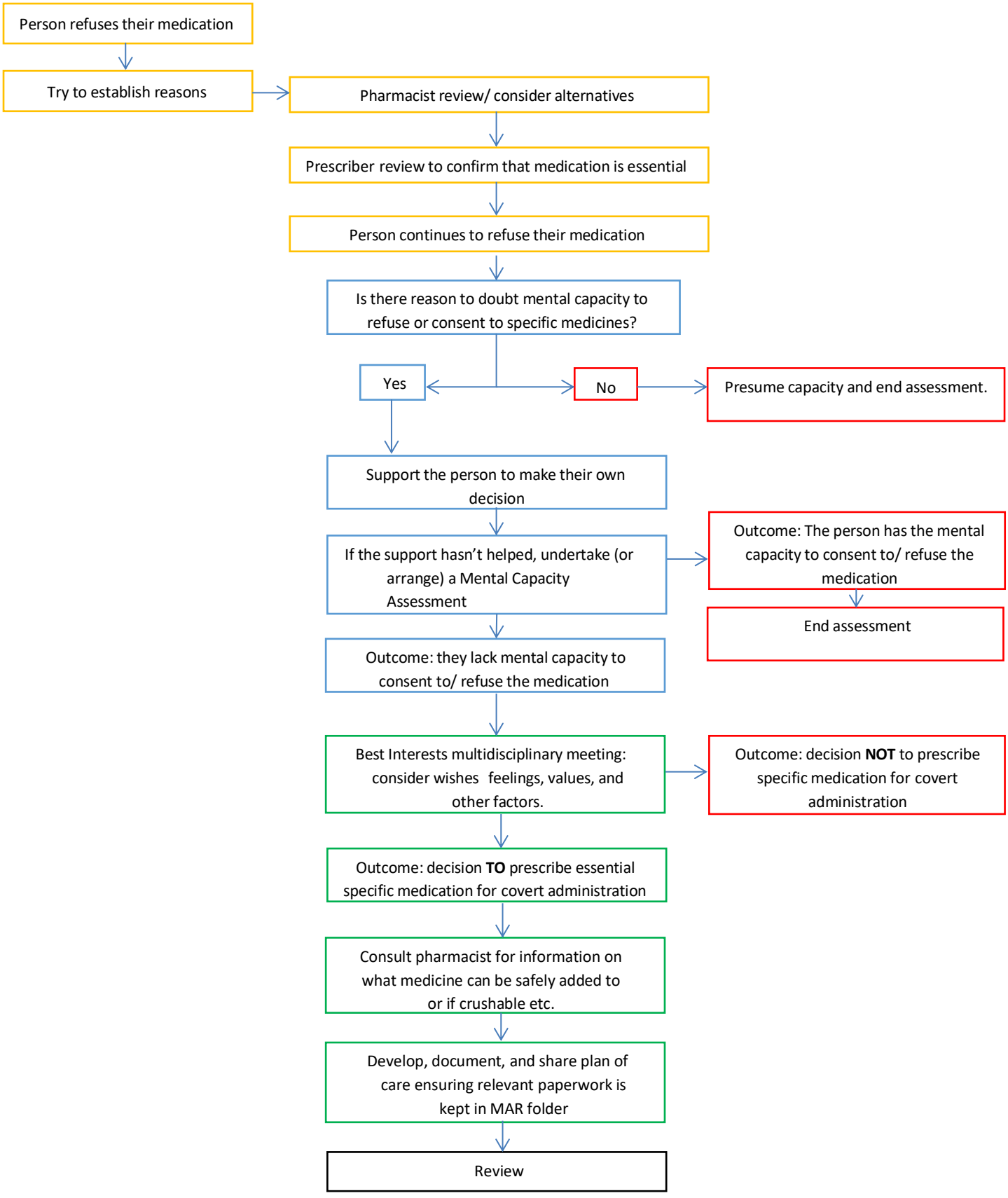
Ensure that the pharmacist has been contacted for guidance on whether the medicine can be added to a particular food or drink.

Day Care Services

Ensure that copies of the documents from the multidisciplinary meetings are obtained which should include information obtained from the pharmacist as to what the medication should be added to i.e., drink, yogurt etc.

Table 9a

Covert Medication Flowchart



Example Form 9b

Covert Administration Medication Record Form

Name of service user:

Date of birth:

Has a Mental Capacity Assessment been undertaken to confirm service user lacks capacity to consent?	Assessment completed and appropriate documents stored in service users care plan and with MAR chart Signature ……..... Name …… Designation …… Date ……
Has the person expressed views in the past when they had capacity that is relevant to the present treatment? Yes/No If yes, what were those views?	
Name all involved in the Best Interests Meeting and decision to administer medication covertly (e.g., Multi-Disciplinary Team including GP, health care professionals, carers, family, advocate etc.) Name Designation Date …..... …… …… ……. …….. …… ……. …….. …… ……. …… …… ……. …….. …….. Ensure all paperwork from Best Interests meeting is stored in the service users care plan	
List medications for covert administration as agreed by Multi-Disciplinary Team (MDT)	

Are these medicines considered essential? What alternatives have been tried/considered?	
Name the pharmacist consulted and record advice on Form 9c Pharmacist name: …….. Date: ……. Organisation: ……...	
When will the need for covert administration be reviewed?	Date for first planned review:

Care Home Manager Signature:

Name:

Date:

To be stored in service user's notes

Example Form 9c

Covert Administration Medication Guidance from Pharmacist

Service Users Name: **Date:**

Pharmacist Name: **Pharmacy:**

Medication	Formulation	Advice From Pharmacist	Date	Pharmacist Signature
Example *xxxxxxxxxxxxxxxxx*	*liquid*	*Add to small amount of blackcurrant juice just prior to administration. Witness all juice has been consumed by service user*		

To be stored in service users notes. A copy should be kept with the current MAR chart

Guidance 10

Non-prescription Medication

Making sure that non-prescription medication is managed appropriately will ensure service providers are complying with section 1.16 of NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

Staff have a recognised duty of care to be able to respond to minor ailments experienced by service users.

This guidance should be used to support development of a non-prescription medication policy. It aims to highlight those areas which should be considered during the development process and to encourage safe working procedures and best practice. In addition, it also describes what services should do if a service user or their family obtain other products such as supplements or items for use as part of their own personal care regime. It is not intended to be used without further input from each individual provider, GP and community pharmacist.

A good practice guide has been produced to help care homes navigate self-care and highlight the differences when managing self-care and homely remedies in the care home (see Table 10b).

10.1 Homely Remedies

These are a limited range of over the counter (OTC) medicines purchased by the care home and kept as stock and given to treat minor ailments as a person would do if they lived in their own home. Examples could include:

Paracetamol - for aches and pains, headaches, colds, sore throats and fever.
Peptac Suspension - for indigestion
Simple Linctus (sugar free) - for coughs
Oral Rehydration - for diarrhoea
Senna - for constipation

External preparations are best excluded from being on the homely remedy stock list as they should be used by an individual service user to avoid cross contamination.

Key points:

- Homely remedies do not require a prescription.
- Homely remedies are kept as stock in the care home to allow access to products that would commonly be available in any household.
- The home should discuss with each GP practice that has patients in the home as to which medicines they wish their patients to use as non-prescription (homely remedy) medicines. This will be person specific. The pharmacist should also be consulted. A procedure for the administration and recording of non-prescription homely medicines must be written and included in the medicines policy and reviewed regularly.
- Homely remedies can be administered to any appropriate resident.
- Homely remedies should be purchased by the care home. It is not appropriate to use discontinued medicines as stock. A record should be made of all stock purchased for audit purposes in a homely remedy book or recording sheet (see example form 10a).

- Homely remedies should be administered at the discretion of a carer (following initial written agreement with the GP) to a resident for up to 48 hours. If symptoms persist longer then their GP should be contacted.
- Homely remedies should be stored in a locked cupboard away from other medicines, clearly annotated with 'homely remedy'.
- Homely remedies can be administered to residents by Care home staff who are trained and competent to administer homely remedies.
- Administration should be recorded on MAR/eMAR and annotated that a 'homely remedy' was given. An entry should also be made in the homely remedy book or recording sheet.
- Homely remedies are the property of the care home.
- The balance and expiry dates should be checked regularly (monthly). Any expired stock should be disposed of in line with the services disposal procedure.

10.2 Self-care

Self-care treatments can be purchased by or on behalf of a service user either following a request from the service user or by a Health Care Professional. Where the request is from the service user their GP or health care professional should be contacted to check it is safe and appropriate for them to use.

OTC products for self-care are usually not prescribed through the NHS because they are for self-limiting conditions e.g. olive oil ear drops or are classed as having 'limited evidence of clinical effectiveness'.

The homes medicine policy should cover self-care and the purchasing of OTC products.

Key points:

- Self-care is the actions an individual can take for themselves to develop, protect, maintain, and improve their health and wellbeing. Individuals may do this independently or with support from others. Certain OTC products can be purchased to support an individual to self-care.
- A self-care product is purchased for or by an individual in response to a specific medical condition.
- Self-care medicines can only be given to the individual service user for whom it was purchased.
- There is an extensive list of medicines covering a large number of conditions listed in NHSE guidance on self-care.
- Medicines should be purchased by the service user or their representative.
- Length of use should be determined by the condition being treated following GP/HCP advice.
- Medicines should be stored in a locked cupboard or drawer usually in the service user's room, clearly annotated as a 'self-care product' and the service user's full name.
- The service user, or care home staff who are trained and competent to administer medicines, should take or be given/applied in accordance with any appropriate GP or HCP advice (including a check on possible interactions).
- Administration should be recorded on MAR/eMAR and annotated that a 'self-care product' was given or self-administered.
- A self-care medicine is the property of the individual service user.

Day Care Services

It is important that if any non-prescription medications are given this information is fed back to staff where the service user resides.

10.3 Supplementary medicines

Supplementary medicines may include products such as herbal and vitamin supplements, many of which are not available to be prescribed on the NHS but can be purchased from health food shops or via the internet.

If relatives wish a service to administer supplementary medicines to their relative, it is important to undertake the following process:

- Any supplementary medicines purchased by the family need to be checked to ensure they are in date and that they are in a sealed container. This is so that staff can be assured that what it says on the label is what is inside the bottle.
- Ask relatives where they purchased the supplements from. If they were purchased from the internet check the MHRA website (see below).
- Inform the service user`s GP that they wish to take the supplements so that they are aware. Supplementary medication must **not** be given until the GP has confirmed they are happy for it to be given.
- Staff must check with the service user's community pharmacist that the supplements do not react with any of the service user's current medication.
- Generally supplementary medication e.g., vitamins are not prescribable. They will therefore need to be transcribed onto the MAR (Medicines Administration Record)/ eMAR (electronic Medication Administration Record) chart each month by staff and countersigned.
- If staff are unsure of the quality of the medication that has been bought to the service, they must not administer it to the service user.

Hints & Tips - Service users who purchase their own supply of 'Over the Counter' medicines.

Service users and their relatives should be encouraged to inform staff of all non-prescription medicines entering the home to ensure that these do not interact with any prescribed medicines.

The safety, storage and recording issues need to be discussed and explained, but without invading the patient's privacy.

10.4 Medication purchased from the internet

Purchasing medicines via the internet is not recommended unless it is from an online pharmacy registered with the General Pharmaceutical Council (GPhC). This is because medicines purchased from some websites could be potentially dangerous as they may be out of date, diluted with other ingredients or fake.

Online pharmacy websites that are registered with the GPhC will have this logo on their main page. Clicking on this logo will redirect you to the registration information on the GPhC website.

10.5 Personal care

It is acceptable for body lotions and washes used to moisturise the skin to be purchased or brought in by the residents or relatives. However, service providers must still be aware of the risk to service users of severe and fatal burns when using emollients. It is advisable to record use of such products in the residents' care plan.
(See section 14.5 Side effects and Sensitivities for more information)

Staff must ensure that personal care products are only applied to the service user for whom they have been purchased; they **must not** be used on other service users or by staff for their personal use.

Example Form 10a

Record of non-prescription medications and audit sheet

Name formulation and strength of medication Please use one sheet per product	

Purchased From/Date	Batch No./ Expiry date	Amount received	Balance	Date Given	Time	Name of resident	Dose given to resident	Given for	Administered by	Balance	MAR completed

NB

Note some products may have a shorter shelf–life once opened, check the manufacturer's literature. Please record clearly the date of opening on the bottle.

For residents who purchase their own medications, record separately to those purchased and stocked by the care home

Table 10b

Good Practice Guide – Supporting Self-care in Care Homes

	Homely Remedy	Self-care
What is it?	OTC products purchased by the care home without the need for a prescription to help manage self-care conditions and minor ailments.	Self-care is the actions an individual can take for themselves to develop, protect, maintain, and improve their health and wellbeing. Individuals may do this independently or with support from others. Certain OTC products can be purchased to support an individual to self-care.
When would it be purchased?	Homely remedies are kept as stock in the care home to allow access to products that would commonly be available in any household.	A self-care product is purchased for or by an individual in response to a specific medical condition.
Who can it be given to?	Can be administered to any appropriate resident.	Can only be given to the individual resident for whom it was purchased.
What products are included?	Limited list of medicines for a small number of conditions e.g. pain, indigestion etc. listed in the care homes homely remedies policy that have been agreed by the residents GP.	More extensive list of medicines covering a larger number of conditions listed in NHSE guidance.
Who pays for it?	Purchased by care home.	Purchased by resident or their representative.
How long can it be used for?	Administered at the discretion of a carer (following initial agreement with the GP) to a resident for up to 48 hours.	Determined by the condition being treated following GP/HCP advice.
Storage	In a locked cupboard away from other medicines, clearly annotated with 'homely remedy'.	In a locked cupboard or drawer usually in the resident's room, clearly annotated as a 'self-care product' and the resident's full name.
Who can administer it?	Care home staff who are trained and competent to administer medicines/use homely remedies.	The resident or care home staff who are trained and competent to administer medicines and in accordance with any appropriate GP or HCP advice (including a check on possible interactions).
Record Keeping	Administration recorded on MAR/eMAR and annotated that a 'homely remedy' was given. Completion in homely remedy book or recording sheet.	Administration recorded on MAR/eMAR and annotated that a 'self-care product' was given or self-administered.
Whose property is it?	It is property of the care home.	It is the property of the individual resident.

Record Keeping & MAR Charts

Making sure that record keeping is done correctly will ensure service providers are complying with section 1.4 & 1.14 of NICE guidelines – Managing Medicines in Care Homes.

The registered manager will have overall responsibility for the service. There is a statutory requirement for recording all medicines brought into the service. The registered manager must be responsible for ensuring the appropriate maintenance of records and the manner in which records will be kept. The standard of record keeping should ensure that records are properly completed, legible, current, written in ink, dated, and signed to show who made the record providing a complete audit trail of medication.

All medication records should be referenced back to the service user's original prescription and not the previous Medication Administration Record (MAR) chart. Each service must retain an up to date reference of current medication prescribed for each service user.

11.1 Ordering and Receipt of Medicines

All medicines, including homely remedies and self-care brought into a service from whatever source, must be recorded. At any given time, the service must be able to identify the medicines prescribed for each service user. On admission to a service written confirmation of the medication a service user is taking should be obtained from an authoritative source such as the service user`s own GP or from hospital.

The service should record requests for prescriptions on behalf of a service user. This ensures that all items ordered have been received and that no inadvertent changes to medication have been made.

When the pharmacy or dispensing doctor delivers medication to the service the following information should be recorded - date delivered, medication delivered, prescriptions collected, deliverers signature and signature of the staff receiving it.

For additional information see guidance 5 – Ordering & Receipt of Medicines.

11.2 Self-administration

If a service user is self-administering their own medicines, then record on the MAR chart the date and the amount of the medicine that they have been given (it is good practice to ask them to sign the MAR to confirm that they have received them).

A service user self-administering does not need to record on a MAR chart however the MAR chart should indicate that the service user self-medicates.

11.3 Administration of Medication (MAR charts)

The responsibility for providing MAR charts is that of the service provider and not the supplying pharmacy, however most pharmacies will provide these as part of their contract with the home.

Poor records are a potential cause of preventable medication errors. It is important to remember that MAR charts are a formal record of administration and may be required as

evidence in determining whether someone has been given their medicines as the prescriber instructed.

Paper based (pMAR) or electronic (eMAR) medicines administration records should:

- Be legible
- Be signed by the service staff
- Be clear and accurate
- Be factual
- Have the correct date and time
- Be completed as soon as possible after administration
- Avoid jargon and abbreviations
- Be easily understood by the service user, their family member or carer.

For monitoring and audit purposes of pMARs the service must keep a record of the name, role, initials and signature of all those staff who are trained and competent to administer medication, this should include agency staff and be updated regularly (see Form 11a for an example). It is advisable to store this with the MAR charts.

If a service user requires support with the administration of their medication, then the service should get service users to sign a consent form authorising staff to administer their medication. This is generally done when the service user is first admitted to the service.

Front Sheet

A front sheet should be available that contains:

- A current photograph of the service user, which should be dated. It is important this is regularly updated to ensure an accurate identification of the service user, particularly by agency staff.
- Name (including the name that they like to be called)
- Date of birth
- GP's name
- Any allergies (reactions to medicines or other ingredients and the type of reaction experienced)
- Service user's personal preferences and helpful information e.g., must be given their medicines by a member of the same sex, cannot take any capsules made of gelatine, has a tendency to chew or conceal medicine, prefers to take medicine with squash instead of water.

See Form 11b for an example.

Information that should be on a MAR chart

The MAR chart (paper based or electronic) should contain:

- The name of the service user
- Their date of birth
- The GP's name
- Known allergies
- The dates (including the year) that the MAR chart covers
- Spaces for the MAR chart to be signed for each dose of each medicine given
- A list of ALL the service user's current medication (including any self-administered and anticipatory medicine) stating
- The name of the medicine (either its generic or brand name as appropriate)
- Strength

- Formulation (e.g., tablet or capsule etc.)
- The dosage as printed on the label
- The times of day that the medicine should be given (be careful to spread the medicine out evenly especially if the medicine is an antibiotic unless the GP says otherwise). It is also important to record the time and quantity given if an 'as required' (PRN') or variable dose (e.g., one or two) medication (see Guidance 13 for an example of a PRN protocol).
- Any special information such as giving the medicine before or after food or where the cream should be applied or any support the service user may require
- When the medicine was first prescribed
- When a medicine was received and how much
- How the medicine is taken or used (e.g. via a PEG)

Hints & Tips

It is important that allergies noted on the MAR chart front cover are also printed on the pharmacy MAR chart. If not, it means that the pharmacist is not aware; hence they may not identify any drug allergies the service user may have.

Handwritten entries

Handwritten entries on a MAR chart increase the risk of medicine errors due to incorrectly transcribing the details from one document to another and handwriting that is difficult to read and potentially misunderstood.

Service providers must ensure that a new handwritten entry is produced only in exceptional circumstances and is created by a member of staff with the skills and training for managing medicines. The entry must be checked for accuracy and countersigned by a second trained and skilled member of staff before it is first used.

Staff must be reminded of the high level of risk they are placing their service users and themselves in if they administer a medication against a handwritten entry that has not been signed or countersigned to ensure accuracy.

Handwritten entries may be required if a service user has been prescribed an acute medication mid cycle and the dispensed item has not been provided with a printed MAR chart. In this case staff must transcribe the name, strength, and formulation of the medication along with directions that are printed on the dispensing label including any special instructions. The entry must be written clearly in ink and include no abbreviations. The staff member who has done the transcribing must then sign the entry; the entry must then be checked against the dispensing label by a second member of staff who must also sign the entry.

The above information is also relevant when inputting new medicines mid cycle on an eMAR system. Entries should be made by a trained staff member, assigned to their individual ID and checked by a second trained member of staff

See guidance 12 - Dose changes & verbal orders for additional information.

Topical Preparations

If a cream or external medicine is being stored securely in the service users' room then write the date on the MAR that the medicine has been put into their room so that a date is known when to replace or retrieve it.

The MAR chart must show when an external preparation has been applied or if this application is recorded on a separate chart in the service users' room or care plan.

For additional information see guidance 14 – Topical Preparations.

Transdermal Medication (patches)

It is important that a record is completed showing when the patch was applied, where it was applied and also when it was removed. This record must be kept with the MAR chart and completed at the time of application.

See guidance 7 for information on patch application and an example of a patch application record

Oxygen

Oxygen is a medical gas and should be treated as a medicine. It should therefore be entered on the MAR chart/eMAR system and reference made to any oxygen chart used and care plan that is in place.

Codes

A list of codes that can be used to show why a medicine has not been given should be available on the MAR chart with an explanation of what each code means. If staff write a code on the pMAR chart, then it is recommended that a circle is drawn around the code so that it can be distinguished from a staff signature. Reasons for non-administration of medicines should be documented on the reverse of the pMAR chart or eMAR system.

Variable Doses

If a service user is prescribed a variable dose of medication e.g., "one or two" or "5 or 10ml" then the actual dose administered to the service user must be recorded on the MAR chart.

This is important as otherwise the maximum prescribed dose of the medication may be exceeded.

Refusals

Ensure that the appropriate code is used to document a refusal and further information regarding the reason for refusal is entered on the reverse of the MAR or eMAR system.

Whilst administering (e.g., tablet dropped or spat out)

If a MAR chart has been signed in error or the service user may for example spit out the medicine or be sick straight after administration, then write on the reverse of the MAR or eMAR system what has happened (there may be a code on the MAR chart that says "see note on reverse of MAR, if so, you can neatly record this code alongside the original signature)

If a medicine is dropped on the floor, then this must be picked up and disposed of following the service providers disposal policy. In this case, in order for the service user not to miss a dose, another dose must be administered. If the service user has a MDS blister pack then it is recommended to select the last dose from the pack. This should then be recorded for audit purposes what has happened (to show why you are missing a dose) and an additional dose ordered on the next prescription.

For what to do if a dose is changed see guidance 12 on 'Dose changes and Verbal orders'.

Where medicines are to be disposed of, these should be recorded on the MAR (and documented in the separate record for returns/disposal)

The MAR chart must be signed after each medicine has been given by the person who has given the medicine, not at the end of the medicine round or by another member of staff.

Some medicines need to be given once a week or every few days. It is important that it is clear to staff on the MAR chart when these medicines are to be given. It is recommended that the day to be given is boxed and all other days are crossed through (see example in guidance 7). It is important that the correct days are annotated, and it is recommended that the transcribing of this is checked by a second member of staff.

Audit

MAR chart completion should be reviewed as part of the medicines audit but should also be checked at the end of every medication round. See Form 11c for an example audit checklist. All MAR charts should be kept according to company policy and destroyed securely after this time.

Day Services

It is important that for all service users who are coming into the service from their own home that information with regards to medicine administration is fed back to any carers who go into their home. This is particularly important for PRN medicines (pain relief) to ensure that the service user does not receive more medication in 24 hours than they are supposed to have.

11.4 Disposal of medication

To provide a full audit trail of medicines, a record is required to identify the disposal from the service of all medicines (see guidance 16). This information should be recorded on the MAR chart and in a drugs disposal book (which may be supplied by the pharmacy).

This record must include the following: - date of disposal/return to pharmacy, reason for disposal, quantity removed, name and strength and formulation of medicine, person for whom the medication was prescribed or purchased and their signature to agree the disposal (if applicable), signature of staff member arranging disposal, signature of witness, signature of disposal agency. CDs must be clearly marked.

11.5 Medication Review

Record clearly in the resident's care plan when a medication review was undertaken and when the next one is due. Ensure the GP surgery is contacted if overdue.

See guidance 18 – Medication Review & Medicine Related Problems for more information.

11.6 Electronic MAR Charts (eMAR)

Electronic MAR charts must contain the same information as the paper MAR chart (see above). It is important that providers ensure that the eMAR system used supports all service

user's' needs e.g., monitoring of medicines, recording allergy and drug intolerances, data protection, safeguarding and near miss reporting, audit, medicines review and medicines reconciliation. Care homes should ensure that:

- Staff receive robust training
- The member of staff making each entry can be identified
- Entries cannot be altered at a later date
- Access controls are in place to prevent unauthorised access to records
- Staff are aware not to share login details and the person logged into the eMAR is the person actually administering the medication to the service user
- A process is in place to get medicines information off the system if service user is to go into hospital
- Adequate back-ups are in place to prevent data loss
- Staff know what to do if internet/power failures or issues out of 9-5pm working hours
- Reporting and audit systems are used to look for anomalies/recording issues
- Staff are aware of what procedure to follow if an item is prescribed mid cycle and may not have been dispensed by their normal pharmacy

Example Form 11a

Medicines Administration Staff Signatures

Care Home/Unit Name	

To be signed by a senior healthcare professional or care home manager only: I confirm the below signatories have undertaken medicines administration training and are competent to provide service users with their medication.

Name (print)…….

Signature …….
Date……...

All care home staff qualified to administer medicines please sign below

This record should be reviewed and updated on a regular basis especially when there are relevant staff changes

Name (print)	Signature	Initials as used on MAR chart	Senior healthcare professional signature	Date

Example Form 11b

Service User Name

Room Number

Date of Birth

Photo

Date Taken……...

GP Name ……

GP Surgery ……

Tel Number ……

Allergies

……

……

Self-administered Medication ……...

Covert Medication ……

Medication Taking Preferences e.g., with water, squash, in own room etc.

……

……

Example Form 11c

Medicines Administration Record (MAR) Chart Checklist

MAR charts form an essential element in determining whether people have been given their medicines as the prescriber instructed.

Care Home/Unit		**Date Completed**	
Number of MAR charts checked		**Checked by**	
	Yes	**No**	**Comments**
Does each service user have a front sheet and contain photo, name, DOB, allergies, GP details and preferences for taking medicines?			
Are handwritten entries legible and contain the correct information?			
Has the handwritten entry been signed and countersigned?			
Does the chart show the date including the year?			
Does the chart look 'used', an indication that it was completed at each medication administration?			
Are there any gaps seen on the MAR chart? If so, do these need to be investigated further?			
Any out of stock medicines? Have these been actioned?			
Has the actual dose given been documented for variable dose medicines e.g., when the dose is one or two tablets?			
Is there sufficient information to enable care workers to give 'as required' (PRN) medicine safely?			
Is the actual time a PRN is administered recorded on the MAR or on the back of the MAR?			
Are PRN protocols in place?			
Are topical/transdermal patch charts in place and have they been completed correctly?			
Do medication dose changes/medicines stopped have authorising doctor name, date and staff signatures?			
When using MAR chart codes, has further information been added to the reverse of the MAR chart?			
Do records for controlled drugs match both MAR chart and CD register?			

Have there been any crossings out in the CD register?			

Any Issues should be documented below

Action Point	By Whom	By When	Date Completed

Guidance 12

Dose Changes & Verbal Orders

Making sure that making medication dosage changes and verbal orders is done correctly will ensure service providers are complying with section 1.9 of NICE guidelines – Managing Medicines in Care Homes and ensure that service users receive the medicines as the prescriber intended.

Problems can occur when doses are changed by means of a verbal order, but no written document is sent. Usually this happens when a prescriber telephones a dose change, but a new prescription is not necessary e.g., Furosemide 80mg daily may be reduced to 40mg daily.

Staff members who receive verbal orders for dosage changes/new medications must

- Write the dosage change or new medication instruction down
- Read back the information that has been written down to reduce the chance of misunderstandings checking service user`s name, medicine name, dose, frequency
- Spell out the name(s) of medicine(s)
- Ask the GP/ prescriber to repeat the message to another member of staff, if possible or put the GP/ prescriber on speaker phone
- Request written confirmation, if a new prescription is not appropriate, within 24 hours (this should be kept with the MAR chart.

NICE recommends that service providers should ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing via a secure encrypted email i.e. an nhs.net email account before the next or first dose is given.

The service should also keep a record in their communications book of:

- Who took the call and who witnessed the call
- The time of the call and the name of the person who called
- The changes made

When there is a dosage change it is recommended that:

- A line is put through the old prescription entry on the MAR chart (rather than scribbling and altering the original prescription)
- Alongside the old entry must be the name of the staff member who is altering the chart, who has authorised the change and what the change is, date and time and reference made to refer to the new prescription entry.
- The same staff member must then write a new handwritten entry on the MAR chart which has the new dose on it (this should be countersigned by a second staff member who has heard the message/seen the written confirmation).
- Any changes should be written in capital letters and full directions should be used e.g., write ‘when required’ **not** ‘PRN’.
- Under no circumstances should the medication label be altered. Staff must be advised to follow the new direction written on the MAR chart

It is important that staff ensure that any changes made by visiting GPs or other health care professionals to doses or medicines are seen on the prescription when requesting the subsequent months medicines.

PRN Medication

Making sure that PRN medication is managed appropriately will ensure service providers are complying with section 1.9 & 1.14 of NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

Definition: - When required (Pro Re Nata- PRN) medication is administered when the service user presents with a defined intermittent or short-term condition i.e. not given as a regular daily dose or at specific times e.g. medication rounds.

13.1 Initiation of when required medication

Where a service user is prescribed PRN medication, it must be documented in the service user's clinical records. This should state the date when the PRN medication was started by the prescriber and also include, name, route and dose of drug. The frequency including minimum time interval between doses, maximum number of doses in 24 hours, what condition the drug is being prescribed for, expected outcome and date for review must also be recorded. A PRN protocol should then be developed for the service user.

13.2 PRN Protocols

To administer PRN medicines safely and as prescribed it is advisable to develop PRN protocols for each service users PRN medicines (see Form 13a for an example).

A PRN protocol should include the following as a minimum:

- The reasons for giving the 'when required' medicine e.g., for back pain etc.
- How much to give (dose, how often and maximum dose in 24 hours)
- What the medicine is expected to do
- The minimum time interval between doses
- When to use another prn medication if the first does not work (e.g., this may be used in anxiety or epileptic service users)
- When to check with the prescriber or alert them
- Signs and symptoms the service user may display if unable to communicate their need for the medicine
- A review date

If staff are unaware of any of these, they should contact the prescriber for advice.

A copy of the PRN protocol should be kept in the MAR chart folder or on the eMAR system, so staff can easily access the information.

13.3 Administration and recording

It is good practice to ask the service user whether they would like their PRN medication when doing the medicine round, in accordance with the dose times that the prescriber has indicated. Any administration should be documented on the MAR chart. If the medication is refused and the MAR charts used have an 'offered but not required' code, then use this to show that the medicine was offered. Failure to use this code could imply the service user was never offered the medicine.

Where a medicine is used for seizures or angina attacks then these should only be recorded when they are used i.e. no code needs to be written routinely.

PRN medication should not be offered or given **only** at the times listed on the MAR chart or at specific medication rounds. The medicine should be available and be offered at times when the symptoms are experienced either by the service user asking for the medicine or by the staff identifying the person's need. **It is essential that the administration time is documented on the MAR chart to allow the correct interval between doses to be calculated.**

Particular attention should also be given to preparations containing paracetamol e.g. co-codamol to ensure that staff do not administer more than the maximum daily dose if they are already prescribed paracetamol regularly. In these circumstances the prescriber should be consulted for advice

All PRN medicines should be recorded on the MAR chart including the time given or applied, the quantity given and where the prescribed dose is variable i.e., one or two.

It is good practice to record either on the reverse of the MAR chart or on a separate PRN chart why the medicine has been given, especially if the medicine is given infrequently for pain e.g. for headache or toothache. The response to the medicine should also be recorded e.g. no longer in pain or still in pain.

NICE also recommends that service providers record any when required medications that are administered in the service users care plan.

13.4 Ordering

Medicines that are only used when required (PRN) should only be ordered if needed and in suitably small quantities so that they will be used before they go out of date. Large quantities should **not** be stored in the home "just in case" as this is a waste of valuable NHS resources. PRN medicines that are still in use and in date should be carried forward from one month to the next and the amount carried over recorded on each new month's MAR chart.

PRN medicines should not be routinely packaged in MDS packs as this may lead to medicines being wasted if not required.

External medicines like medicated creams should also not routinely be kept 'just in case' as the condition that they are to be used for may be different when they are eventually needed. Also, once opened some creams have a limited life span (see Guidance 14 - Topical Preparations).

13.5 Review

If PRN medication is given regularly then a referral to the prescriber should be considered for a review, as their treatment may need altering. This should also be done if the PRN medicine is not working as expected or if they haven't used any in the last six months.

If PRN medication is discontinued, then this must be crossed off the MAR chart with an explanation and countersigned by another member of staff. The service user's clinical notes must then be updated to reflect this change. In addition, the service must contact their community pharmacy stating that the PRN medication has been stopped and will be discontinued from the next monthly order.

Any remaining medication must be disposed of following the services disposal procedure and the service user monitored in case symptoms re-occur.

13.6 Audit

As PRN medicines are usually dispensed in their original boxes it is good practice to record the amount left at the end of each month to ensure that there is enough stock for the next month and to reduce waste. It will also ensure a complete audit trail.

Day Services

If a service user attends for a part day, it is important that it is determined what PRN medicines have already been given to the service user on that day to help decide future dose timings. Also, it is important to communicate what PRN medicines they have received whilst at the day services to avoid maximum doses being exceeded.

Example Form 13a

PRN Protocol

Name of Service User		**DOB**	
GP Details		**Room**	

Medication to be administered "as required"

Name of medication		**Form** e.g., tablet, liquid etc.	
Strength		**Route of Administration**	
Reason for administration (signs & symptoms)			
How does the service user express or indicate a need for this medicine? (verbal or non-verbal)			
Dosage (if variable, define circumstances of what to give when, consider lowest dose first)			
How and when the dose can be repeated (minimum time intervals)			
Maximum dose in 24 hours			
Special instructions i.e. with or after food etc.			
Expected/desired outcome			
Other medicines to be aware of (possible interactions)			
When should the prescriber be contacted or called?			

Written by:		**Checked by:**	
Date:		**Review Date:**	

Ensure the medication is always administered for the reasons it was prescribed
Always read the label on the medicine and MAR chart
Always check when the last dose was given
The MAR chart must be completed and clearly document when it was offered/given

Topical Preparations

Making sure that all topical medicines are managed appropriately will ensure service providers are complying with the NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

14.1 Storage

All external preparations like creams, shampoos, bath preparations or ointments should be stored securely in a locked cupboard separated from all internal medicines and as per manufacturer's instructions.

Where the dispensing label is attached to the outer packaging it is essential that the packaging is retained for reference.

External preparations for personal care can be kept in the service user's room with their permission within their locked facility. They should not be stored on window ledges or anywhere where the temperature exceeds 25°C (e.g. a bathroom).

If an external preparation is to be stored in the service user`s room, then the date that the preparation was put into the room should be recorded on the MAR chart (i.e. the date that it was opened) and that date should be transferred onto each new month's MAR chart to show that it is available and in date.

Certain external preparations need to be stored in the fridge; this should either be in a locked drugs fridge or in the case of small homes, a locked box like a cash tin which can be kept in the domestic fridge.

14.2 Application

Registered nurses can delegate the application of moisturising creams (emollients), barrier creams, shampoos or bath preparations to a suitably trained and competent member of the care staff who may be responsible for the service user's personal care. The nurse is responsible for ensuring that these preparations are used correctly.

When applying or using any external preparation, wash your hands, wear protective gloves and ensure they are applied to clean skin.

Check that the cream/ointment is in date prior to use and that it has the correct name of the service user for whom it has been prescribed; they **must not** be used on other service users or by staff for their personal use.

For nursing homes use the procedure pack in order to follow the Aseptic Non-Touch Technique (ANTT). For residential homes use a spatula to get the cream/ointment out of the pot prior to applying to the skin. **Do not** return gloved hand to the pot after cream has been applied to the skin or any unused cream/ointment to the pot following use, as this potentially transfers skin scales back into the pot. This way the cream can then be left the length of time that is recommended by the manufacturer in accordance with their storage guidance. If there is a concern about appearance of the cream/ointment or the lid has been left off for a long period of time dispose of and re-order the item.

Medicated creams, like steroid creams or ointments (e.g. hydrocortisone or betametasone), should be applied sparingly (thin layer) by a trained member of staff. One fingertip unit (that's the length from the top joint of the index finger to its tip) from a tube will cover an area approximately the size of one hand (both sides). These preparations should be applied thinly and only to the affected area. Overuse of steroid creams can cause problems like thinning of the skin so are only for short term use.

Moisturising creams or ointments can be applied liberally (a more generous layer should be applied).

When applying two creams/ointments to the same area i.e. an emollient and steroid the emollient should usually be applied first. It is best practice to wait 20-30 minutes before applying the steroid.

When applying creams or ointments, staff must smooth them gently into the skin along the line of hair growth, they must not rub them in.

If a Health Care Professional visits the home and leaves an unlabelled barrier cream for a service user, it is important that staff obtain information regarding the directions for use and this is documented in the care notes and on the MAR chart.

14.3 Expiry Dates

The date of opening **must** be written on the label to check that it is still fit to be applied. Once opened some topical preparations have a limited shelf life. Always read the manufacturer's instructions on the product or leaflet for individual product storage and expiry information. Unopened preparations can be used up until the manufacturer's expiry date. A symbol may also be on the container to advise of the expiry once opened.

Any discontinued or out-of-date preparations should be disposed of as per disposal procedure, recording what has been sent for destruction.

See Table 14b for further information on expiry dates once opened.

14.4 Recording

All external preparations when used must be recorded. This can either be done by signing the service user`s MAR chart or a topical chart kept in the service user`s room which can then be put with their MAR chart at the end of the month as a complete record of what has been used.

The MAR chart should show when the preparation should be used and where (e.g. apply to sore skin on left ankle). A specific topical MAR chart which includes a body map is recommended (see Form 14a for an example). If a separate record or MAR chart is kept in the service user`s room, then write on the main MAR chart 'See topical chart in room' or similar wording to show why the original MAR chart is not signed.

14.5 Side effects and Sensitivities

Creams and ointments may contain preservatives, fragrances, additives, arachis oil (peanut oil) and lanolin. Some service users may therefore be sensitive to any one or more of these ingredients. Staff must therefore check service users' skin for signs of redness, swelling or itching. If these do occur, then the prescriber should be contacted.

NOTE

Service providers must be aware of the risk to service users of severe and fatal burns when using emollients. This risk concerns paraffin-based emollients (regardless of paraffin concentration) and paraffin-free emollients. Extreme care must therefore be taken with service users who are treated with large quantities (100g or more), who smoke, or who may be near naked flames. Risk assessments must be completed. Particular consideration should be given to bedding and chairs, as emollients can be soaked into these items, and notifying relatives and carers.
Care should be taken when service users are prescribed oxygen alongside emollients. It is recommended that oil free preparations should be used where there will be direct contact with oxygen e.g. on the face including nasal passages and lips, due to the risk associated with high pressure gases and oil-based products. Paraffin based products can also block nasal prongs as well as being a fire risk. The prescriber should be contacted in these circumstances for advice and a risk assessment undertaken

14.6 Dressings & Wound Care

Making sure that residents always have a supply of the required dressings and that there are good auditable procedures in place to monitor systems so that only the dressings prescribed for the resident are used. Ensuring that service providers are complying with the NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

- All prescribed dressings and wound care products must only be used for the resident for whom they have been prescribed
- These products should be stored in a locked cupboard or a locked treatment room
- All the dressings for a particular resident should be stored together to prevent the wrong dressing being used for the wrong resident
- Any dressings that are prescribed for a resident should go with them if they leave to go home or elsewhere as they belong to the resident and not the home
- Any dressings for residents who have died should be removed and destroyed 7 days after they have died to prevent possible errors
- The expiry of these dressings should be checked monthly
- Order any required dressings in sufficient time for the dressings to be obtained and dispensed. Do not over order as this may mean that they have to be destroyed if the treatment is stopped

Dressings Request Form for Nursing

A request form is available for Nottingham City and Nottinghamshire County nursing homes to order dressings that are on the wound care formulary on the Medicines Optimisation Website. The form should be used to request prescriptions from the GP for your residents, for up to 2 weeks supply at a time.

Please note: These forms are only for use by nursing homes where trained staff are changing the dressings. District Nurses will provide dressings for residents under their care.

Example Form 14a

Topical Medicines Application Record

Name of Resident	Date of Birth	Room No.	GP Name	Allergies

Name of Topical Preparation	Completed by	Checked by

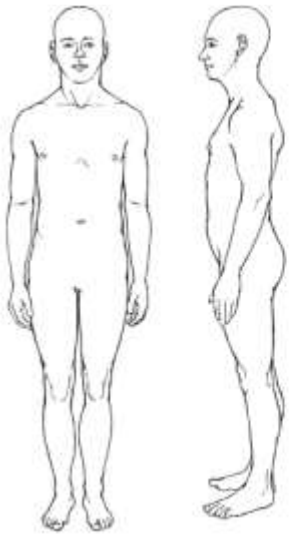
Site of Application mark on body map

Frequency of Application e.g., daily or after washing

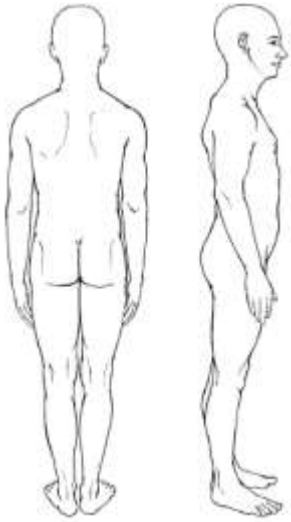
Month	Start Date	End Date

Body Map

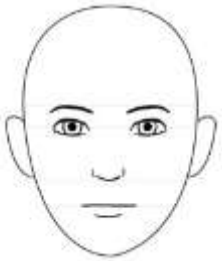
Front & Left Side



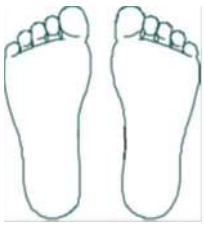
Back & Right Side



Face



Feet



Date																			
Time/Sig																			

Date																			
Time/Sig																			

Date																			
Time/Sig																			

Storage e.g., fridge	**Date opened**	**Expiry date after opening**

Table 14b

Expiry Dates of Medication

Stock levels of medication, in particular 'PRNs' (when required) and topical products, must be checked before they are re-ordered, so that items are not ordered unnecessarily.

Check quantities remaining and whether there is enough left for the next 28 days before reordering. Do not reorder 'PRN' or topical products if there is already an adequate supply. Ask the prescriber to adjust the quantity supplied if there is an overstock.

The expiry date is the point in time when a pharmaceutical product is no longer within an acceptable condition to be considered effective. The medication has reached the end of its 'shelf life'. Depending on the product, the expiry date may be set as a fixed time

- After manufacture
- After dispensing
- After opening of the original container

The shelf life of products is usually determined by either the break-down of the active drug or by risk of contamination.

Basic Storage Guidelines

Medicines can be affected by the conditions they are kept in. As a guide the following points should be adhered to:

- All medication should be kept in the original container which they were dispensed in and where possible in the original packaging (e.g., box) to protect from sunlight. Batches should not be mixed
- All medicines should be stored in a cool (below 25°c) dry place unless it needs to be kept in a fridge (between 2 and 8°c)
- Medicines should always be stored as recommended by the manufacturer
- The date opened should be recorded and always checked prior to administering
- Rotate stock so the earliest expiry is at the front and therefore will be used first
- Check expiry dates monthly
- Be aware the expiry date of products can change once opened

Examples of different wording of expiry dates

Wording on packaging	Definition
Use before end of January 2020	Discard 31/01/2020
Discard after January 2020	Discard 31/01/2020
Expires January 2020	Discard 31/01/2020
Use by/before January 2020	Discard 31/12/2019

Reasons why medication may go 'out of date'

- Inefficient prescribing or re-ordering systems
- Stockpiling
- Receiving excessive quantities/reduced need
- Poor stock rotation and not checking expiry dates

Expiry Dates of Medication

ALWAYS FOLLOW THE MANUFACTURERS GUIDANCE
ALWAYS WRITE ON THE PRODUCT THE DATE WHEN IT IS FIRST OPENED

Preparation	Expiry date once opened and stored in accordance with manufacturers guidance	Rationale/Information
Tablets/capsules in manufacturer's original blister	Manufacturer's expiry	Contents not open to environment.
Loose tablets/capsules in medicine bottles	Follow guidance in patient information leaflet (PIL) or maximum 12 months from date of dispensing	Stability of product once removed from original packaging
Tablets/capsules in MDS	8 weeks or expiry on MDS	Stability of product once removed from original packaging
Oral liquids in original manufacturer's bottle	12 months after opening or as per patient information leaflet (PIL) Some specials may be different Check to make sure storage in the fridge isn't required after opening/reconstitution e.g., some antibiotic liquids	Exposure of liquid to environment when dose is measured can introduce contamination Specially prepared medicines often take longer to be manufactured and have short expiry dates (4 weeks) so it is important that the quantity ordered is not more than will be used before the expiry date. Citalopram drops expiry – 16 weeks Oramorph expiry – 90 days
Oral liquids in brown glass bottle	Follow guidance in patient information leaflet (PIL) or maximum 12 months from date of dispensing	Stability of product once removed from original packaging
Open top container (Tub/Jar) of cream/ointment	3 months after opening	Always follow manufacturer's expiry instructions on packaging or in patient information leaflet (PIL) Always check for signs of contamination. If there is a concern about appearance or the lid has been left off for a long period of time dispose of and re-order the item.
Tubes of cream/ointment	3 months after opening	
Pump dispenser packs of cream/ointment	Manufacturer's expiry date	
External liquids (e.g., Lotions, shampoo)	Follow manufacturer's instructions on packaging or in patient information leaflet (PIL)	Limited exposure to the environment
Aerosols	Manufacturer's expiry date	Contents not open to the environment
Eye/ear/nose drops/ointment	Usually, 4 weeks after opening Follow information in patient information leaflet	Some newer drops/ointment may have a longer expiry once opened – always check Single use containers should be discarded after use.
Liquid dietary supplements	Follow manufacturer's instructions on packaging or in patient information leaflet (PIL)	Contamination/deterioration when made up. Usually have a short shelf life once opened and may require fridge storage
Inhalers & Spacer devices	Inhalers – Follow manufacturer's instructions Spacer Devices - need replacing after 6 – 12 months.	Spacer devices should be washed as per manufacturers cleaning instructions
Insulin	**Unopened in fridge** – manufacturers expiry **Once opened –** 4 weeks unless otherwise stated. When in use can be kept at normal room temperature (below 25°C).	One pen / cartridge will often be sufficient for a month. (A box of 5 will rarely be needed every month). Order the nearest number of pens / cartridges needed per month to reduce stock piling.

These guidelines are subject to correct storage at ambient temperatures recommended by manufacturers and are based on their guidance and general consensus due to a lack of evidence-based information available

Form 14c

Oxygen Safety information for residents and care workers

Always read the information that comes with the equipment. The oxygen supplier can also provide further advice on general oxygen safety.

General Advice

- Do not smoke or allow others to smoke near you.
- Do not use or store oxygen near naked flames such as candles, gas hobs, gas or open fires or similar. Check the information that came with the equipment for recommended distances from heat sources.
- Do switch off the oxygen when not in use
- Do make sure that the room is well ventilated.

Additional Safety advice when using cream/ointments with oxygen

- Do not use cream/ointments underneath an oxygen mask or around the nasal cannula or on areas of the skin in contact with oxygen including your hands. Use a water-based lubricant.
- If you do need to use a cream or ointment on other areas use the minimum possible and rub in well.
- Do not use oil based make up.
- Do not handle oxygen equipment with greasy hands. Wash hands thoroughly before handling oxygen.
- Do not allow any oxygen equipment or oxygen including mask or nasal cannula to come into contact with the cream/ointment.
- Do not use cream/ointments to lubricate oxygen equipment. Only ever use products specifically provided or advised by the oxygen company on oxygen equipment.
- Do wash bedding and clothes regularly to reduce the build-up of cream/ointment. Wash at the highest temperature that the material will allow. For example, wash bedding at 60°C.
- Do protect soft furnishings from contact with creams and ointments.

If you have been prescribed a paraffin free product you must still follow the safety advice

Information courtesy of North Yorkshire & Vale of York CCGs Using emollients with oxygen guidance

Guidance 15

Controlled Drugs

Making sure that Controlled Drugs (CD's) are managed appropriately will ensure service providers are complying with the NICE guidelines – Managing Medicines in Care Homes and help to keep service users safe.

Controlled drugs are subject to stricter regulations than other medicines because of the potential for them to be misused and/or abused. There are legal requirements for the storage, administration, records and disposal of CD's. These are set out in the 'Misuse of Drugs Act 1973 (Safe Custody) Regulations'

Service providers should only keep controlled drugs prescribed for an individual person. Care homes (nursing) are permitted to hold stocks of CDs but are required to have a home office licence for schedule 2 CDs. It is recommended that care homes (nursing) only keep stocks of CDs in exceptional circumstances.

15.1 Storage

All controlled drugs that require safe custody (i.e., need to be stored in a CD cabinet) should be stored in a designated metal CD cupboard which complies with the Misuse of Drugs (Safe Custody) Regulations see http://www.legislation.gov.uk/uksi/1973/798/made

The cupboard must be attached to a solid brick wall or if such a wall is not available in the room it should be fitted to a wall that has a steel plate mounted behind it. It should be attached using either Rawl or Rag bolts and has a specified double locking mechanism.

The keys for the CD cupboard should be stored with the keys for the medicine cupboards, on the person who is in charge of the medicines for that shift. Any spare keys must be stored securely (preferably in a designated key cupboard with limited access).

Only controlled drugs should be stored in the CD cupboard, not money or service users' valuables.

If the CD requires safe custody and it has been provided in a monitored dosage system (MDS) the whole MDS should be stored in the CD cabinet.

See Table 15a for the requirements for some commonly used CD's. If unsure of storage requirements contact a pharmacist for advice.

15.2 Administration

CD's must be administered in a care home providing nursing care by a registered nurse and witnessed by another person who has been assessed as competent in relation to CDs. This can be a trained carer who is aware of / understands what they are checking.

CD's in other types of care homes and social care settings must be administered by an appropriately trained and competent staff member. This must be witnessed by another appropriately trained staff member. The use of a witness is intended to reduce the possibility or an error occurring. Therefore, to be effective the witness must have the same level of training as the person administering the controlled drug.

The second signatory should witness the whole administration process.

Liquid CD's should be measured out using an oral syringe, not a medicine cup or spoon.

CD's may be administered by the community nurse, for example setting up a syringe driver for palliative care. In this scenario the nurse must make a record in the CD register of what quantities of medication have been used so that the appropriate amount of CD medication can be accounted for in the CD register and witnessed by a care home staff member. If a community nurse refuses to complete the CD register the home should record (including that the nurse refused) in the register and MAR chart to ensure a complete audit trail.

For liquid CD's there may be a small amount of liquid leftover (overage) at the end of the bottle even if an oral syringe has been used. This should be recorded by 2 people in the CD register and the balance corrected when a new bottle is started.

15.3 Record Keeping

Controlled Drugs Register (Paper and Electronic)

The paper CD register must be a bound book with numbered pages.

Electronic CD registers are permitted as an alternative. Legislation requires that computerised entries must be:

- Attributable to the person who made the record
- Secure
- Cannot be altered at a later time
- Capable of being audited
- Compliant with best practice
- Accessible from the service and capable of being printed

The CD register must be used to record the receipt, administration, disposal and transfer of CDs held by the service. Entries must be made as soon as possible on the same day and be in chronological order. They must be made in black ink and there must be no crossing out, overwriting or use of correction fluid.

The CD register is a legal document; it should not be used for any other purpose and must be kept in a secure place when not in use. Completed registers must be kept for a minimum of two years after the date of the last entry, archived in a safe place. After this time, they can be shredded.

Controlled Drugs Register - Errors

Do not cross out entries, overwrite or use correction fluid

To correct an error

- Next to the incorrect entry and at the bottom of the page put an asterisk (*)
- Next to the * write what has happened, what the correct entry should be, sign and date and get a countersignature
- Continue the entry on the next line

If the balance is not correct

- Check the CD register and cupboard with a witness
- Check the CD register against the MAR chart, look if an entry has been missed

- Check the returns records for CDs returned or destroyed

If it is a missed entry, then under the last entry write

- Date error discovered
- What happened e.g., dose administered but not recorded at the time
- Amend the balance to account for the error
- Amended entry to be checked and countersigned by a witness

If it is a calculation error

Do not change the balance column or use correction fluid. Under the last entry, details of the following must be recorded

- The date
- The error in subtraction/addition indicated with an asterisk
- The correct balance
- The signatures of the trained staff and countersignature

Receipt of Controlled Drugs

CD's must be recorded in the register as soon as they arrive at the service and locked in the CD cupboard. Records must include the date received, supplier (which may be a community pharmacy or hospital if the service user has been transferred from there) quantity, name, strength and formulation.

A separate page must be assigned for each service user`s controlled drug. The service user`s name and drug name, strength and form must be written at the top of each page. The running balance should also be recorded. All receipts must be documented by a trained member of staff and a second witness signature, who must understand what they are witnessing.

It is useful for an index page to be maintained in the CD register, indicating for individual service users, on which page of the CD register each CD can be found.

If the CD is collected by a member of the services staff from the pharmacy or dispensing doctor, there should be a procedure in place that provides an audit trail. It is good practice for the staff member collecting a schedule 2 or 3 CD from a community pharmacy/ dispensing doctor to be asked to sign for the CD (there is a space on the back of the prescription) and they may be asked for proof of identity.

NB Anticipatory medicines (used in end-of-life care) will include Controlled Drugs (CDs) that may be administered by nurses or visiting health care professionals e.g., Community Nurses. These should be treated like any CD entering the service and must be entered into the CD register and stored in the CD cupboard.

Administration of Controlled Drugs

Administration of any controlled drug must be recorded on both the service user`s MAR chart and in the CD register. The staff member responsible for administering the controlled drug and a trained witness should sign the CD register. The balance, before and after administration, should be checked to highlight any discrepancies. This can be a visual estimate for liquid medication ('approximate' should be recorded in the register if the volume is estimated and not measured). However, it is recommended that an accurate measure of liquids is undertaken on a monthly basis. The staff member administering the controlled

drug must also sign the MAR chart (It is good practice for the witness to also sign the MAR chart (although not a legal requirement).

Any controlled drug prepared and not used, or only partly used must be appropriately discarded in the presence of a second member of staff. In a nursing home (or if provided by the pharmacy in a residential home) the CD should be disposed of in a CD destruction kit specially designed for this. The used destruction kit should be allowed to set and can then be placed with other medicines waste to be returned to the pharmacy/dispensing doctor or waste company. In a residential home the CD should be quarantined in the CD cupboard until returned to pharmacy. In both cases an entry must be made in the CD register and returns/destruction book and signed by both the staff member and staff witness.

Transfer of Controlled Drugs

If the CD is transferred out of the service, e.g. when the service user is away from the home for a short period of time or is transferring to another care home, a record must be made in the CD register and witnessed by a second trained member of staff.

The record must include the date of transfer and the details of the CDs the service user has been transferred with. The balance of the CDs being transferred out must be recorded in the CD register. The service user or their representative must sign to say they have taken the CDs from the service. Upon return the CDs should be checked and booked back in to the CD register by two trained staff.

15.4 Stock Checks

Regular checks must be made by two trained staff members to ensure that what is in the CD cupboard matches what is in the CD register and that there are no discrepancies (see Form 15b for an example). This should be done at each administration. In addition, it is best practices that the care home manager/deputy should audit the register (including a balance check) on a weekly basis, to ensure all entries have been completed correctly, this should be documented in the CD register to indicate an audit has been undertaken.

If any CD's cannot be accounted for then a full investigation must be undertaken and the service manager informed. Checks that administration records have been completed correctly must be undertaken first, along with calculation errors. The services pharmacist could also be contacted to establish if they have any unrecorded returns of CDs. If the discrepancy cannot be resolved the Police and CD Accountable officer (NHS England) must be informed via the reporting tool - www.cdreporting.co.uk (see Guidance 17) and a report sent to CQC (Care Quality Commission). The home must also complete an internal incident form and follow their services incident procedure.

15.5 Disposal

When controlled drugs have passed their expiry date, the need for the prescription has ceased, the service user has died, or a dose prepared was not used or only partly used then the controlled drug must be disposed of safely and a record made in the CD register.

Even if in date, the controlled drug must not be used for another service user.

Services with nursing care

In a care home providing nursing care medication requiring disposal is via a licenced waste disposal company or supplying pharmacy if they have a disposal licence and contract in

place with the care home. CDs must be disposed of in a suitable CD destruction kit (denaturing kit) by a nurse and responsible witness. The CD destruction kit should be placed in the container with the other medicines waste to be collected by the waste disposal company. A signature should be obtained of the representative of the waste management company who removes the medicines. A nursing home will need to apply for a T28 waste exemption (to allow denaturing to take place on the premises) from the Environment Agency; this is free of charge and available at:

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

CD destruction kits should be locked away. CD destruction kits are available from:

Phs Group
Tel: 029 2080 9098

emt Healthcare
Tel: 0115 849 7700

It is important that homes obtain an adequate number of CD destruction kits for use during disposal – including varying sizes. CD destruction kits are designed for single use only.

The CDs should be destroyed using one of the following methods. Protective gloves should always be worn:

Tablets/solid dose forms – tablets should be removed from blister packaging and then added to the CD destruction kit.
Liquids – liquids should be decanted from their container directly into the denaturing granules.
Ampoules – ampoules should be opened, and the contents put into the denaturing granules. If in solid form, water should be added to dissolve the contents and the contents then poured into the kit. The empty ampoule should be placed in the sharps bin.
Patches – patches should be opened, the backing removed, and the patch folded over on itself and then placed into the granules.
Aerosol – aerosols should be expelled under water and the water treated as liquid (see above)

The container instructions should then be followed to render the CD irretrievable

A record must be made in the CD register of the
- Date
- Controlled drug name, form and strength
- Quantity of medication destroyed and balance remaining
- Stated that CD destroyed
- Signature of trained staff member
- Signature of trained witness

See 'Guidance 16 – Disposal of medicines' for general information on how to dispose of medicines.

Services with residential care

Services providing personal care should return CDs to the supplying pharmacy or dispensing GP practice for destruction.

A record must be made in the CD register of the

- Date
- Controlled drug name, form, and strength
- Quantity of medication returned and balance remaining
- State which pharmacy / GP dispensing practice the medication was returned to
- Signature of trained staff member
- Signature of trained witness

This return must also be recorded in the "returns book" showing the date the CD's were sent to the pharmacy, the amount and the signatures of the two people responsible for this. The signature and name of the person from the pharmacy/ GP dispensing practice to whom the CD was handed must also be recorded in the "Returns book".
Unwanted or out-of-date CDs should be stored in the CD cabinet, segregated from current stock and returned promptly.
Following a visit from a District Nurse any remaining liquid in the vial should be returned to the pharmacy for disposal as per the providers medicine policy.

Hints & Tips – Service providers need to ensure that they have procedures in place to deal with any illicit drugs which service users may bring in. They should also take advice from their local police force.

15.6 Self Administration of Controlled Drugs

Service providers should ensure that their process for the self-administration of CDs includes an individual risk assessment.

The risk assessment should note the ability of a service user to self-administer their medication and must be reviewed periodically, including if a service users circumstances change.

The risk assessment should include whether the service user understands:

- Why the medicine is prescribed
- How much and how often to take it
- What may happen if they do not take their medicine or take too much

See guidance 8 – Self-administration for additional information on risk assessments

If a service user is self-administering their own CDs then these can be stored in a locked cupboard or drawer in their room.

If the service is ordering and receiving the CDs on behalf of the service user a record should be made of the receipt, supply, and disposal of the CD in the CD register. If the service user is wholly independent, i.e. they are responsible for requesting and collecting their own CDs from the pharmacy, then there is no requirement to document this in the CD register.

Table 15a

Storage & Record Keeping requirements for Common Controlled Drugs

Schedule	Drug name (*Common Brand Names*)	Do we need legally to store in the CD cupboard?	Do we need legally to record in the CD register?
Schedule **2**	**Morphine** (*MST Continus, Sevredol, Morphgesic SR, Zomorph, MXL*)	✓	✓
	Oramorph 20mg/ml CONCENTRATED oral solution	✓	✓
	Oxycodone (*Oxycontin, OxyNorm*, Shortec and Longtec)	✓	✓
	Diamorphine	✓	✓
	Fentanyl (*Durogesic, Matrifen*)	✓	✓
	Methylphenidate (*Equasym, Ritalin, Concerta XL*)	✓	✓
	Pethidine	✓	✓
	Methadone (*Physeptone*)	✓	✓
	Dexamphetamine (*Dexedrine*, Amfexa) **or Lisdexamfetamine**	✓	✓
Schedule **3**	**Buprenorphine** (*Temgesic* – tablets, *Butrans* - Patches)	✓	✘ ..but recording in CD register is good practice
	Temazepam	✓	✘ ..but recording in CD register is good practice
	Midazolam (*Epistatus**(not a licensed medicine), Hypnovel*)	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice
	Phenobarbitone	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice
	Tramadol (*Zydol, Zamadol, Mabron, Tramquel, Maxitram, Tramacet*)	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice
	Pregabalin	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice
	Gabapentin	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice
Schedule **5**	**Oramorph** oral solution **10mg/5ml**	✘ ..but storage in CD cupboard is good practice	✘ ..but recording in CD register is good practice

Please note this list is not exhaustive and so advice should always be sought if care home staff are unsure of the schedule of a controlled drug

Hints & Tips

It is good practice to store midazolam in a CD cupboard. Records should be kept when midazolam leaves the home with the resident and when it is returned to the home so that an audit trail is available showing how much and to whom it was handed and how much and to whom it was returned to at the home. Records of any administration of midazolam when the resident is outside the home must be made on both the MAR chart and the CD register.

Example Form 15b

Controlled Drugs (CD) Audit

CD medication and register must be checked by manager weekly. Actual stock and register balance should tally. All Controlled Drugs must be audited.

Date of Audit:				**Time of Audit:**				
Service Users Name	**Medicine, strength, and form**	**Are two signatures present, any crossing out, overwriting detail**	**Balance in stock as recorded in CD register**	**Actual amount of medicine in storage**	**Correct**		**Signed**	**Comments**
					Yes	**No**		

Guidance 16

Disposal of Medicines

Making sure that medicines are disposed of correctly will ensure service providers are complying with section 1.12 of the NICE guidelines – Managing Medicines in Care Homes.

If service user's medicines are ordered appropriately there should be a minimum amount of waste. Any medicines left at the end of the month and where treatment will be continuing in the next month should be carried forward e.g. PRN medicines, inhalers etc. They should not be destroyed or returned as this is a waste of NHS resources. There will however always be a certain amount of unavoidable waste which may be due to the following:

- Course of treatment is completed
- Medicines have expired
- Death of service user
- Treatment or medication changed by prescriber
- Service users refuse, or have spit out medication
- Medication is dropped on floor by staff

It is important that the medicines held by the service relate to current therapy and any medicines not required are disposed of in a timely manner to reduce the risk of errors occurring. It is important that all medication entering the service can be tracked and there is a complete audit trail available.

All medicines that are unwanted or expired should be stored separately from the medicines in use and securely locked away with a sign stating, 'quarantined medication for disposal – do not use' (this includes medication disposal bins provided by the waste management company for nursing homes). The amount of waste requiring disposal must not be allowed to build up.

If a service user's medication is prepared for administration and then not taken the medication should be placed in a bottle or sealed envelope and labelled with the service users name, medicine name and date and recorded in the returns book. If a medicine is refused and is 'un-popped' in a blister pack it should remain there and be returned intact with other returned medicines and recorded in the returns book.

Where a service user has died all the medicines must be quarantined and held in the home for 7 days before disposal in case the Coroner's Office should ask for them.

16.1 Record Keeping

A written record should be completed to show what and how much of each service users medicine has been sent for disposal and reason why. This should be signed by the person documenting the disposal and **also witnessed and signed by a second member of staff**. All medication packaging that is discarded in the general waste should have any patient identifiable information i.e. name, DOB scored through with a permanent black marker pen.

Residential Homes

Medicines should be returned to the community pharmacy who supplied the medicines, in line with the pharmacy contractors medicines guidance.

A signature should be obtained of the pharmacist or the representative of the pharmacy who removes the medicines.

Nursing Homes

Homes that are registered for nursing care must have in place a contract with a licensed waste management company or their pharmacy who meets the same requirements (licence and contract in place) to remove unwanted medicines. These cannot legally be returned to the community pharmacy that supplied the medicines.

Environmental Considerations (see Green Plans)

Used pressurised Metered Dose Inhalers (pMDIs) should be returned to pharmacies for appropriate environmentally friendly destruction or recycling.

Auditing

It is recommended that as part of the home's medication audit that the returns/disposal book is checked to ensure staff are returning or disposing of medicines appropriately. Undertaking an audit check will highlight instances of over ordering (when medicines could have been carried forward) or where service users medication needs to be reviewed.

Further guidance for disposal of medicines in care homes can be found on the CQC website.

Please see Guidance 15 - Controlled Drugs for disposal of CD's

Guidance 17

Medication Errors, Near Misses & Drug Alerts

Making sure that all medication incidents are managed appropriately, including safeguarding arrangements, will ensure service providers are complying with section 1.5 and 1.6 of NICE guidelines – Managing Medicines in Care Homes, and hopefully prevent the incident occurring again.

Service providers must ensure they have a robust process in place for identifying, reporting, reviewing, and learning from medicines incidents involving service users.

It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the administration of medicines. The taking of automatic disciplinary action and inappropriate exclusion of staff from work following an incident will create a barrier to open reporting. A 'no blame' ethos should be implemented for genuine mistakes that are reported promptly by a staff member. All service providers should provide a learning and supportive environment for staff.

Medication errors/near misses will need to be fully investigated. Errors may include (this list is not exhaustive):

- Administering medication to the wrong service user
- Administering an incorrect medication
- Giving a service user the wrong dosage
- Failure to administer medication
- Not ensuring availability of adequate supply of medicines
- Not signing MAR charts
- Not following correct procedure
- Administering medication via the incorrect route
- Due to poor communication through inadequate handovers

17.1 Response Procedure

Service providers must have their own procedures and forms in place for staff to use when responding to a medication incident. As a guide, when a medication error or near miss occurs the following process should be followed:

- If the service user is at all unwell, call the Emergency Services
- If the service user is not unwell, call the GP, out of hour's service or NHS 111. Inform them of the incident and follow their advice (document who was contacted and what advice was given)
- Observe the service user if required and record any monitoring details
- Collect together all current documentation relating to the service user's medication, so it is available for paramedics to refer to if necessary.
- Collect all of the service user's current medication if the service user is to be transferred to hospital, not forgetting fridge items etc. and copy of the MAR chart(s)
- Contact the duty manager or the carer/nurse in charge immediately or as soon as possible to inform them what has happened and what has been done
- The service user and their relatives must also be informed of what has happened
- A written incident report must be completed describing what happened, what has been done, who has been contacted and any observations of the service user that have been

made since the incident took place. The report should be accurate and detailed and include times and names of all those who have been involved.

17.2 Incident Reporting

Depending on the severity of the incident the service provider has a responsibility to report it to a number of organisations:

- If the incident caused or could have caused harm a safeguarding referral should be made to the following:

  For Nottinghamshire County - MASH (Multi-Agency Safeguarding Hub) Tel. 0300 5008090.
  For Nottingham City - Safeguarding Team Tel. 0300 1310300 option 2 or email adult.contactteam@nottinghamcity.gcsx.gov.uk

  A serious incident must also be reported to **CQC** (Care Quality Commission) and the ICB quality team (nnicb-nn.chhcqualityteam@nhs.net) e.g. where service user is admitted to hospital

- Incidents relating to Controlled Drugs will need to be reported via the web-based controlled drug reporting tool – www.cdreporting.co.uk (all reporters will need to register on the website – as part of registration process the region that should be selected is 'Midlands'). The local Police will also need to be informed if any controlled drugs cannot be accounted for.
- The service provider must report the incident through their own internal company reporting procedure e.g., to head or regional office.
- The service provider needs to be aware of the incident reporting procedures through to their local commissioners.
- The service provider will need to consider whether a referral needs to be made, if applicable, to a staff members professional body e.g., NMC

It is important that all staff involved are supported at all times throughout this process.

17.3 Incident Investigation

For serious incidents an investigation should be carried out to find the root cause of the incident (Root Cause Analysis). It is particularly important not to focus exclusively on the last individual to provide care to a service user as it may be a system failure that primarily caused the incident.

The common contributing factors to medication errors/incidents and near misses are:

- Staff not being given protected time to order and receive medication
- Only one member of staff understanding the ordering and receipt process
- Medicines not being ordered or received on time
- Medicines not being stored correctly when they are received
- Not enough staff available on medication rounds
- Staff being rushed or disturbed on the medication round
- Staff not being able to identify service users
- Service users with similar names
- Poor legibility of handwritten prescriptions
- Transcription errors on MAR charts
- Poor communication of medication changes

- Poor or no documentation of patch medication
- Referring to old test results e.g., INR
- Poor temperature recording
- Not checking for expired medication

Service providers must therefore have in place a procedure that identifies the causative factors of incidents and what can be used to support staff. A review meeting should also be held to discuss what can be learnt from the incident and what needs to be implemented to prevent similar situations from occurring.

If causative factors are system failures, then this may require the purchase of new equipment, mending of current equipment, training on equipment etc.

Service providers also need to consider whether their policies and procedures are fit for purpose or do they need reviewing. Are they accessible to staff? Do staff understand them?

Considerations need to be given to the current skill mix of staff, staffing levels at medication rounds, additional training for staff, mentoring and competency assessments.

Service providers must also have a clear and transparent process about what support staff will be given and what process will be followed if they are identified as making a number of errors. This will include the criteria for when the service provider makes a referral to the staff member's professional body, if applicable.

17.4 Safeguarding Concerns

Service providers must all be aware of local arrangements for notifying suspected or confirmed medicines related safeguarding incidents.

Service providers must have a clear process for reporting medicines related safeguarding incidents under local safeguarding processes and to the CQC. The process must be recorded in the service provider's medicines policy and should clearly state:

- When the CQC should be notified
- Which medicines –related safeguarding incidents should be reported under local safeguarding processes and when
- That accurate details of any medicines-related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting

Service providers should give service users and/or their family members or carers information on how to report a medicine – related safety incident or their concerns about medicines, using the service providers complaints process, local authority (or local safeguarding) processes and/or a regulators process.

Service providers should ensure that all service users can use advocacy and independent complaints services when they have concerns about medicines.

17.5 Drug Alerts

Receiving Safety Alerts
Patient safety alerts are produced by the Patient Safety division (formally the National Patient Safety Agency) of NHS Improvement. This division alerts organisations to emerging patient safety risks. It ensures relevant safety information is received rapidly by providers.

Patient safety alerts are issued via the Central Alerting System (CAS). This system is a web-based cascading system and issues alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care.

Independent health and social care providers registered with CQC can sign up to receive safety alerts by email by contacting the CAS helpdesk (safetyalerts@mhra.gov.uk) and providing the following information (see Form 17a):

- Full name of organisation
- Business of organisation (e.g., school/charity/care home etc.)
- First name
- Last name
- Job title
- Full postal address
- Email address
- Telephone number

You can also view alerts at any time by accessing the Central Alerting System website at: https://www.cas.mhra.gov.uk

It is important that all safety alerts are acted on in a timely manner

Medicine Recall Process

Occasionally manufacturers may recall medicines where there is a quality issue that has been identified which may present a risk to people. This is mostly in connection with a particular batch and alerts will clearly identify the batch number involved.

In the instance of a medicine being recalled responsibility should be assigned to a designated person (ideally the manager). The alert should state what needs to be done.

Ideally the following process should be followed:

- Any stock identified should be segregated to ensure it is not used
- Ensure a new prescription is requested, if needed, to ensure residents are not left without their medicines
- Stock should be returned to the pharmacy as soon as possible
- Any action taken should be recorded and attached to the alert.

Form 17a

CENTRAL ALERTING SYSTEM

INDEPENDENT SECTOR REGISTRATION FORM

Full name of organisation	
Business of organisation (School/charity/care home/Private Healthcare etc.)	
Title (Ms/Mrs/Mr/Dr etc.)	
First Name	
Last Name	
Job title	
Full postal address	
Generic Email address *	
Personal email address (To manage delivery failures etc.)	
Telephone number	
Fax number	

When completed this form should be sent to the Central Alerting System team, safetyalerts@mhra.gov.uk.

*Email address for CAS alerts

Healthcare organisations should set up a generic email address for their CAS alerts. This should include the organisation name. For example, for an NHS mail account, the format of this generic email address will be organisation-name.cas@nhs.uk

Generic accounts can be used by more than one person, to maintain continuity of service. Access to the generic account can also be transferred when post holders change to minimise the risk of delays in communication.

Guidance 18

Medication Review & Medicine Related Problems

18.1 Medication Review

Making sure that all service users have a medication review ensures service providers are complying with section 1.8 of the NICE guidelines – Managing Medicines in Care Homes.

A definition of a medication review is "*a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste*".

The NICE Managing Medicines in Care Homes guideline (March 2014) recommends that health and social care practitioners should agree how often each service user should have a medication review based on safety, health and care needs. The frequency should be recorded in the service users care plan and who is responsible for that service user's medication review. The interval between medication reviews should be no more than one year.

In March 2020 NHS England & NHS Improvement published the updated version of 'The Framework for Enhanced Health in Care Homes (EHCH)'. The framework promotes collaborative working and describes best practice initiatives to improve safety, quality and health outcomes of people living in care homes. Structured Medication Reviews (SMR) form part of the EHCH model and should be part of the assessment when a person is admitted to a care home and as per NICE recommendations be no longer that one year apart thereafter.

Medication reviews should, ideally be conducted with the service user and/or their family members or carers and with their current medication to hand – but as a minimum with the full medical notes. Medication reviews may be carried out by the service user's GP or their nominated Health Care Professional e.g. pharmacist.

The following may be discussed during a review:

- The purpose
- What the service user or their representative understands about their medicines
- Any concerns the service user may have regarding their medication
- All prescribed, over the counter and complementary medicines the service user is taking and what these are for
- Any monitoring tests that are needed
- Any problems the service user has with them e.g. side effects
- Whether the service user needs any assistance to take them

It may be appropriate for a service user to have a more frequent medication review: this may be due to entering end-of-life phase, recent diagnosis of a long-term condition, those needing frequent or complex monitoring, and post discharge. It is also important to inform the prescriber of any fluctuations in a resident's weight which may affect medication doses.

Continual refusals of medicines should also prompt a medication review. The review may help to highlight why the medicines are being refused. Some reasons may be:

- On too many medicines
- May prefer a liquid/tablet
- Doesn't like taking medicines at a particular time
- Prescribed at the wrong time e.g. early morning or late at night when resident always asleep
- Not aware why they are having the medicines and what the consequences are of not taking them
- May be against the route it is being given

Similarly, if PRN medicines are continuously not required these medicines should be reviewed with the view of removing them from the current list of medicines if appropriate.

If a service user attends frequent day services, it may be more appropriate to alter the times the medicines are given so there is no need for any medicines to leave the care home.

18.2 Medicines-related problems

Service users and their families/carers should be encouraged to report any concerns they have regarding their relative/service users' medication to care staff.

If a service user has a suspected adverse effect from their medicines, the care staff must communicate this to the health professional who prescribed the medicines. Details should be recorded in the service user's care plan of who was contacted and what advice was given. If the surgery is closed, advice can be sourced from the out-of-hours service or a community pharmacist. Care staff should feedback to the service user and/or their family or carers and the supplying pharmacy. If a resident becomes unwell call the emergency services.

Additional information relating to side effects for medications can be found in the BNF and also patient information leaflets that are supplied with medications.

Staff can report side effects and adverse reactions using the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme. The Yellow Card Scheme is the MHRA's system of monitoring the safety of medicines in the UK and it acts as an early warning system to identify new concerns and strengthen existing safety information about medicines.

Yellow Cards can be found at the back of the BNF and completed cards sent to FREEPOST YELLOW CARD (no other address details required). Alternatively, staff can report online at https://yellowcard.mhra.gov.uk or use the new yellow card smartphone app.