# Adult Social Care

**Making a Difference in the Right Way, Every Day**

# Management, Storage and Administration of Medicines Policy

Solihull Metropolitan Borough Council

| Version | Date | Author Name | Rationale |
|---|---|---|---|
| 1.0 | 26.03.2019 | | Initial document |
| 2.0 | 10.07.2019 | Roger Catley - ASC Governance Lead | Review of existing policy and update to reflect latest guidance. |
| 3.0 | 06.10.2021 | Amy Cole Service Manager | Review and update of policy |
| | 30.11.2024 | Mike Strauss | |
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## 1. INTRODUCTION

1.1. This policy applies to all the residential learning disability services provided by Solihull Metropolitan Borough Council (SMBC) where medicines are handled and administered by all staff. This policy has been produced to safeguard both individuals being supported and staff. Its purpose is to promote a quality service without contravening the philosophy of an 'ordinary life'.

## 2. STATEMENT

2.1. This document states the overarching framework in relation to the handling of medicines, including, obtaining medicines, administration, storage and disposal. It is based on current legislation, NHS, Care Quality Commission (CQC) and professional body guidance, Epilepsies: diagnosis and management (Clinical Guidance (CG137) Last updated April 2018.

2.2. Approved Standard Operating Procedures (SOPs) for the Small Homes Service must be produced and implemented within each unit following the guidance and core principles of this document.

## 3. SCOPE

3.1. To ensure that all staff working in residential learning disability homes in SMBC, including bank and agency staff, carry out safe handling of medicines.

## 4. RESPONSIBILITIES

4.1. All health and social care professionals are responsible for their own actions and must exercise their own professional judgment at all times. However, any decisions that vary from the agreed SMBC procedures or guidelines should be documented in the individuals care and support plan and include the reason for variance and the subsequent action taken.

4.2. An accountability structure is in place. It starts from the support staff, managers who oversee the local delivery of all relevant policies, to the Head of Provider Services through to the Service Director who has overall responsibility and accountability for SMBC Learning Disability Services (please note titles of posts/positions may change due to organisational restructure).

4.3. **Management Responsibilities**

4.3.1. To ensure that safe and secure systems are in place and maintained for the management of medicines throughout the service, from medicines reconciliation through to administration, disposal or transfer.

4.3.2. To ensure this document reflects current policy and thinking and is reviewed at regular intervals (every 2 years).

4.3.3. To ensure that all staff are aware of this policy, understands content, are compliant with the policy and to ensure that copies are available for reference.

4.3.4. To prepare, review and approve SOP's specific to the units they work in, in line with this policy.

4.3.5. To ensure all staff have awareness and understand the content of the SOP's and work to them at all times.

4.3.6. To ensure that only appropriately trained and competent members of staff (i.e 'authorised persons') are involved in the management of medicines.

4.3.7. To identify the training needs of staff in relation to their duties to this policy and to ensure that suitable training is provided for its implementation.

4.3.8. To ensure the competency of each 'authorised person' is maintained and assessed on at least six-monthly intervals.

4.3.9. To keep a record of all 'authorised persons' (staff trained and deemed competent to administer medicines).

4.3.10. To keep an up-to-date list of specimen signatures and initials of each 'authorised person' (to be up-dated 2 yearly and when new staff join the team) in order to facilitate identification of the person who administered each medication. This includes agency and bank staff whose duties include administration and handling of medicines.

4.3.11. To support audits as identified within the learning disability services and/or if requested to do so by the SMBC Care Quality Monitoring Officers (CQMO), SMBC Investigation and Audit Team, or CQC.

4.3.12. To ensure procedures are in place so that individuals have an adequate supply of medication.

4.3.13. To ensure procedures are in place to support safe sharing of accurate and up-to-date information about an individual's medicines, including when they

transfer between care settings.

4.3.14. To ensure that procedures are in place so that medicines remain fit for use and do not exceed their expiry date.

4.3.15. To ensure the recommendations in relation to any handling of medicines audit are actioned within identified timescales.

4.3.16. To ensure that any incidents relating to medicines are reported internally and, where required, externally (e.g. to the CQC and Police), and to ensure that they are investigated in a timely manner and any learning is shared. https://www.cqc.org.uk/guidance-providers/adult-social- care/reporting-medicine-related-incidents

**4.4. Staff Responsibilities**

4.4.1. To ensure that they maintain awareness and understanding of the content of this policy, including any amendments or revisions.

4.4.2. To ensure they attend training as identified by their line manager and ensure they maintain their medication competency.

4.4.3. To ensure that they have received training as detailed in this policy and verify any further training needs relating to this policy and the SOPs to their line manager.

4.4.4. To adhere to this policy and follow all SOPs specific to the area they are working in and within their own competency.

4.4.5. To report any medication errors or concerns to a manager and complete an SMBC Incident Report form if appropriate.

4.4.6. To ensure medication is administered as prescribed within the agreed timeframe, as detailed on prescription.

4.4.7. To inform the appropriate manager if medication supplies are running low. Ensure PRN checks are completed weekly and any medication to be carried forward is recorded in correct section on MARS

4.4.8. To ensure correct expiry dates are recorded on PRN balance sheets and medication is re-ordered to ensure a constant supply of medication .

4.4.9. Undertake checks of medicines, be part of ordering and auditing as and when required by a manager/the service. And be able to undertake the checking in and ordering of medication.

## 5. TRAINING AND COMPETENCIES

5.1. Throughout this document an 'authorised person' is defined as either a line manager who has attended SMBC approved medication training, or a member of support staff who has also attended SMBC approved medication training but in addition has successfully completed the in-house competency framework including Standard Operating Procedures. See the separate SMBC in-house training/competency documents (Appendices 1-5):

5.2. All staff have a responsibility to ensure that their training is current and up to date.

5.3. Training for specific delegated tasks (i.e. Midazolam or insulin) will need to be attended by all staff supporting individuals requiring these tasks.

**Appendix 1** - This form is used to record three separate sessions where the candidate observes an 'authorised person' administer medication.

**Appendix 2** - This form is used to record the candidate being supervised administering medication over 3 separate sessions.

**Appendix 3** - This form is used to record the final assessment which demonstrates that the candidate has been deemed competent to administer medication.

**Appendix 4** - This is the record sheet documenting dates of assessment and reassessment.

**Appendix 5** - This provides questions for the final assessment.

5.4. An 'authorised person' may be a permanent member of the team at the service or agency or bank staff who can demonstrate competency across all areas.

5.5. During their induction period, all staff that will administer and handle medicines as part of their duties must be registered on a medication training course from a SMBC approved provider. Refresher training must then be completed every two years as a minimum.

5.6. SMBC staff must be competent to be able to administer medication from all types of packaging, including, Multi meds system (MMS), cardboard boxes and liquid medicine bottles. The type of system assessed must be stated on assessment form - Appendix 4. They will have their training and competency reviewed and documented on a six-monthly basis.

5.7. If an assessment of competency is conducted using the MMS system, then a

further observation / assessment of competency should be conducted if the staff member, then works in a different area using an alternative system. They will not be required to complete the full process but must show awareness and understanding of the alternative when administering medication.

5.8. Once assessed as competent it will be the expectation that all 'authorised persons will support the administration of medication within other homes/services as required to meet operational needs.

## 6. EQUALITY STATEMENT

6.1. All public bodies have a statutory duty under the Equality Act 2010 to measure how their policies and functions impact on people with Protected Characteristics under the Act

6.2. SMBC endeavor's to challenge discrimination, promote equality and respect human rights, and aims to design and implement services policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

6.3. All staff are expected to deliver services and provide care in a manner which respects the individuality of each service user and their carer's, and to treat users of SMBC services and their carer's fairly and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.

6.4. When administering medication, staff should take into consideration any religious or cultural views of the individual. For example, medication containing gelatin, alcohol or pork products may not be suitable for certain religious/cultural groups. This should be recorded in the individual's support plan and hospital passport. Also, during religious festivals, special timings for medication may need to be considered.

6.5. Advice must be sought from the pharmacist or prescriber regarding these issues.

## 7. DOCUMENTATION

7.1. SOPs should be written for all stages of the medicines management process, including obtaining, handling, storage, administration and disposal processes that take place within the service. Template SOPs have been produced by a Learning Disabilities Procedures Working Group and are available from the Learning Disabilities (LD) managers (a selection of template SOPs are included as appendices to this policy).

7.2. SOPs should be reviewed at least every two years or sooner if there is any change in the processes that occur, change in SMBC or professional body guidelines (e.g. Nursing and Midwifery Council (NMC)), or changes to legislation.

7.3. Staff involved in handling medicines should sign to confirm that they have read and understand the content of this Policy and the service's SOPs and that they agree to comply with them.

7.4. A register must be maintained within the service of all staff trained and authorised to administer medicines.

7.5. There must be adequate documentation in place to facilitate an audit trail for all medicines received into the service, administered to individuals and returned to the pharmacy for disposal or transferred elsewhere.

7.6. Documentation for ordering prescriptions, including all record books (e.g. CD Register), must be locked away when not in use.

7.7. A Medicines Administration Record (MAR) chart must be used for all prescribed medications for each individual.

Records retention:

- MAR charts and photocopied prescriptions must be retained for 2 years.
- Controlled Drugs (CD) record books must be retained for 7 years from the date of the last entry.
- Health Care records should be retained for 8 years.
- Incident reports should be retained for 10 years.

## 8. CONSENT TO EXAMINATION, SUPPORT/CARE OR TREATMENT

8.1. Before beginning an examination, providing support/care or treatment, staff must ensure that they obtain the informed consent of the person they are examining, supporting, caring for or treating. For informed consent to be valid, the person must:

- **Be competent to take the particular decision** - it is presumed that adults have capacity to consent unless it is shown otherwise. The Mental Capacity Act 2005 provides a test for assessing whether a person lacks capacity to take a particular decision at a particular time and the steps to be taken if the person lacks capacity.

- **Have received sufficient information to make it** - this will include information about the benefits and risks, including side effects, of the proposed course of

action, the implications of not receiving the examination, care or treatment and alternatives.

- **Not be acting under duress** - there is a need to balance ensuring that all the person's concerns are fully identified and addressed with not persisting in discussions to such an extent that the person feels harassed. Staff must also be aware of the possibility of undue influence from family and friends.

- If there is anything that may hinder individuals ability to give informed consent to administration of medicines (e.g. health problems or impaired hearing or vision), this must be recorded and brought to the attention of the Line Manager as soon as possible. A healthcare professional may be required to undertake a formal assessment of the individual's mental capacity in line with the Mental Capacity Act 2005.

- If the individual is found to lack capacity to consent, decisions must be made in the best interests of that person. The Mental Capacity Act 2005 provides structured and specific tests for capacity and a list of issues to be taken into account when determining what is in the person's best interests. Any assessment of an individual's mental capacity will be documented in their support/care plan.

## 9. SUPPORTING PEOPLE TO TAKE THEIR MEDICINES ADMINISTRATION

### 9.1. Medicines reconciliation (on moving into/out of the service)

9.1.1. A full review of the current medication requirements of a new individual are to be established during the assessment process prior to moving into the service.

9.1.2. All medication to be checked against current MAR chart and prescriptions. (See SOP MM16) Further checks can be made with GP or Social Worker if required.

9.1.3. At least one month's supply of medication to be requested ready for admission/transfer, to include MAR chart.

9.1.4. When the individual moves into the home the Manager must ensure that:

9.1.5. Medicines reconciliation is carried out by coordinating a comprehensive list of all of the individual's prescribed medicines. This should be obtained via their current GP, or hospital discharge summary, and any other health care practitioners involved in managing medicines for the individual.

9.1.6. Sufficient, reliable and up-to-date information is obtained for the individual, including full demographic information (full name, date of birth, address and

weight), details of any allergies/sensitivities, their GP and pharmacy, details of any recent changes to the individual's medical/medication history, details of any preference

9.1.7. Contact is made with the GP on the first working day to register the new individual. Once they are registered with a local GP, prescriptions can be obtained as described in section (Ordering Prescriptions.)

9.1.8. When an individual is moving out, a prescription is requested from the GP for one month's supply (or a minimum of one week's supply) of medication for them to take to their new home.

**9.2. Obtaining medicines**

9.2.1. The supply of medicines to residential services comes under the remit of the Medicines Act 1968. Medicines prescribed and dispensed for individuals (including dressings and nutritional supplements) are the property of the named person and are never to be used by others.

9.3. **Ordering prescriptions**

9.3.1. All individuals must be registered with a local GP practice.

9.3.2. Repeat prescriptions will normally allow for 28 days' worth to be supplied at a time and should be ordered in a timescale adequate to ensure continuity of supply.

9.3.3. Medication may only be ordered by an 'authorised person' and they must take into account any supplies of medication left over from previous cycles - if non - MMS medicines are still prescribed, within their expiry date and fit for use, they should be carried forward to the next cycle and may only be re-ordered if the remaining quantity will not sufficiently cover the whole of the next month's cycle.

9.3.4. Prescriptions should be written with full and precise instructions avoiding the use of ambiguous phrases such as 'take as directed'. Any ambiguous directions must be queried and, where appropriate, amended by the GP.

9.3.5. Prescriptions produced by the GP Practice must be retrieved, checked for accuracy and completeness, and photocopied before they are sent to the pharmacy for dispensing. This should be carried out sufficiently in advance of the individual needing the medication to ensure that there is enough time to address any discrepancies or queries with the GP practice. Arrangements should not be made for the pharmacy to collect the prescriptions directly from the GP practice.

9.3.6. Photocopies of prescriptions should be filed in the MAR chart folder before sending the original prescription to the pharmacy to be dispensed. New medication should be added to the current medication record on the individual's file.

**9.4. Obtaining Medicines from the Pharmacy**

9.4.1. The service should have an arrangement with a community pharmacy to dispense medicines against a valid prescription for each individual in appropriate containers and to provide professional advice.

9.4.2. The pharmacy may agree to supply medicines in a MMS. The MMS service is not part of a pharmacy's NHS contract; this will be a good will gesture.

9.4.3. Where medicines are dispensed in the MMS system, Patient Information Leaflets (PILs) should be obtained from the pharmacy and kept in a file for reference.

9.4.4. Prescriptions should be taken to the pharmacy in a timescale adequate to ensure continuity of supply and to allow time for any discrepancies to be resolved.

9.4.5. A prescription for immediate treatment may be sent electronically (e.g. via fax or email) to the pharmacy, with the pharmacist's permission, in circumstances where a staff member is unable to get the prescription to the pharmacy in a timescale adequate for the clinical needs of the individual. The service should then ensure the original prescription is given to the pharmacy when the medication is collected or delivered.

9.4.6. The community pharmacy should be asked to supply printed MAR charts whenever possible.

9.4.7. A regular day for collection of repeat medication should be agreed so the service can ensure an 'authorised person' is available to receive and check in the medication.

9.4.8. Where staff collect and carry medicines, the transport arrangements must be secure and prompt. They must be in the possession of the staff member at all times, locked in the car boot and brought directly back to the service.

**9.5. Following Hospital Discharge**

9.5.1. When an individual is discharged from hospital, staff should ask the hospital to write the discharge to take out (TTO) medicine on a Hospital HPFP10NC

prescription form so that it may be taken to the service user's community pharmacy for dispensing and so a printed MAR chart can be provided.

9.5.2. Where discharge is at short notice or outside of normal working hours, the medicines will need to be supplied by the hospital. The discharge medication list must be checked against the discharge medication instructions on the pharmacy label and kept with the MAR chart. The individual's MAR chart should be accurately completed/amended as necessary by an 'authorised person' at RCM or deputy level. It should also be checked and countersigned by a second person who is also an 'authorised person'.

9.6. **Emergency/out of hour's prescriptions**

9.6.1. If an individual requires new medication outside normal working hours and it is in the individual's best interest to start the new medication straight away, an out of hours service prescriber may issue an FP10 prescription form, to be dispensed at any community pharmacy. If the prescription from an out of hours service prescriber does not need supplying immediately it should be obtained at the earliest opportunity in normal working hours from the service's regular community pharmacy.

9.6.2. If the supplying pharmacy is unable to supply a MAR chart then an 'authorised person' must add this new item to the MAR chart and sign and date the entry. Another 'authorised person' must check, countersign and date the entry at the earliest opportunity.

9.6.3. In all cases where this occurs, all appropriate staff must be made aware of the additional items to ensure correct and timely administration.

9.7. **Receipt of medicines**

9.7.1. On receipt of medication from the pharmacy the person in charge at the time must be informed and the medicines must be locked away as soon as they are received. Medicines must never be left unattended while waiting to be locked away.

9.7.2. The medication remains the responsibility of the staff member who collected it until the person in charge has taken receipt.

9.7.3. An 'authorised person' must check and record the receipt of all medicines received as soon as possible and always on the same day. The check should involve checking the photocopied prescription against the physical medication that has been received as well as the MAR chart where present. Checks should include checking the medicine's full name, strength and form, directions for use, quantity, and fitness for use (e.g. expiry date). Wherever possible, a

second ‘authorised person’ should perform the same checks independently and this second check should be documented (two signatures).

9.7.4. Where medicines received for an individual differ from those requested on the repeat form, the service must contact the supplying pharmacy as soon as possible. Any incorrect medication must be kept secure and separated from the other medicines until it can be returned to the pharmacy.

9.7.5. The ‘authorised person’ will then ensure the medication and MAR charts are stored appropriately (checking if any storage requirements have changed) in a locked area or cupboard until required. Please note that medicines must never be stored on the floor.

**9.8. Security and storage of medicines**

9.8.1. Access to medicines must be restricted and controlled. Medicines must be stored in a dedicated locked cabinet/cupboard when not in use, and medicines in use during an administration round must never be left unattended. It is the responsibility of all staff to ensure that medicines are kept out of reach of unauthorised persons including individuals and visitors.

**9.9. Keys and Key Holders**

9.9.1. The medication cupboard key must be kept secure at all times within the provided locked and security coded key holder and only be assessable to the authorised person allocated to the task medication administering that shift. This will be identifiable on staffing rotas.

9.9.2. Keys to the medicines cupboard must be kept on a separate ring from any other keys to ensure that the medicines keys are not accessible by unauthorised persons.

9.9.3. Keys should never be left unattended (except when locked in the key cupboard/safe which is only accessed by ‘authorised’ staff).

9.9.4. A spare set of keys must be available and kept locked away in a secure place. The main set and the spare set of keys must not be kept in the same place within the home. Alternatively, they may be exchanged with another service. All staff who work in the home and the Service Manager must be aware of the storage arrangements for the spare keys.

9.9.5. Loss of keys must be reported immediately to the relevant manager. If the lost keys are not located within 24 hours, the locks must be changed. An incident form should be completed and consideration given as to whether the police should be informed.

## 9.10. Storage

9.10.1. There must be adequate space to allow the appropriate and secure storage of all medicines within the service.

9.10.2. The designated medicine cupboard(s) should only be used to store medicines.

9.10.3. Medicines must be stored in line with the manufacturer's storage/temperature recommendations.

9.10.4. The following storage systems to be used:

- Medicines Cupboard(s) - this is for the storage of room temperature medicines (medicines indicated to be stored up to 25-30°C). Internal medicines (e.g. oral medicines, injections, MMS must be clearly segregated from external medicines (e.g. topical preparations).
- Controlled Drugs Cupboard - this should be a designated cupboard, which meets the standards of the Misuse of Drugs (safe custody) Regulations 2001 (for more information see CQC guidance).
- Fridge medicines - either a dedicated, lockable, medicines fridge or a lockable container within the normal domestic fridge to be used to store medicines requiring storage at temperatures between 2°C and 8°C. Medicines are not to be allowed to freeze.

## 9.11. Temperature monitoring

9.11.1. A digital maximum/minimum thermometer to be used to maintain a record of all areas where medicines are stored. Temperatures read and recorded, and the thermometer reset, at least once per day. Temperatures recorded on a temperature log. Local SOPs should be in place in case the temperature goes outside the recommended range.

9.11.2. Medicines must be kept in the container in which they were supplied from pharmacy. Blisters of tablets/capsules must never be removed and stored outside of their original container. Items such as eye drops and creams should be kept in the outer carton.

## 9.12. Multi Meds System (MMS)

9.12.1. MMS blister packs may be provided by the pharmacy. Care must be taken to ensure that all MMS medicines are checked on receipt and are identifiable. Any medicines left over in MMS blister packs at the end of the cycle must be returned to the pharmacy for destruction.

9.12.2. PRN ('when required') medication must not be put into an MMS as this can lead to wastage of medicines.

9.12.3. Certain medicines cannot be put into MMS this may be for a number of reasons including sensitivity to moisture in the air, because they won't physically fit, or because they have other specific storage requirements. These medicines must not be removed from the original container in which the pharmacy supplied them and care must be taken to ensure that the MMS blister packs and non-MMS medicines are administered.

9.13. Medicines administration record (mar) charts

9.13.1. Each individual must have a current MAR chart. The supplying pharmacy should be asked to print the MAR charts wherever possible.

9.13.2. Each MAR chart should be dated, unambiguous, complete, legible, written or printed in indelible ink and updated following any change to the individual's prescribed medication. The supplying pharmacy will print MAR charts wherever possible. Checks must be in place to ensure MAR charts contain:

- the individual's demographics i.e. full name, address or location, date of birth, GP and/or consultant and weight, where appropriate e.g. frail older individuals
- details of any medicines the individual is taking, including the name of the medicine and its strength, form, dose
- directions for use, including the dose (quantity of medicine to be administered), time of administration, how often it is given (the frequency), how it is to be given (route) and duration if the medicine is only prescribed as a course
- any known allergies or reactions to medicines or their ingredients, and the type of reaction experienced (the allergy field must never be left blank)
- any special instructions about how the medicine should be taken (such as before, with or after food, dissolved in water etc.)
- the quantity that has been received and/or carried forward; it is good practice to also include regular stock balance checks
- clear records of any medicines being self-administered, being administered by healthcare professionals (not staff) or being administered outside of the home.

9.13.3. If possible, no more than one MAR chart should be in use at any one time for any individual. On occasions where individuals are taking a large number of medicines it may be unavoidable to have more than one current MAR chart at

any one time, in which case each chart must be clearly marked e.g. '1 of 2', '2 of 2' etc.

9.13.4. A new chart must not be started because the first is not immediately available. If a further MAR chart is supplied mid-cycle then the page numbers are to be changed accordingly with two staff signatures next to the number change.

**9.14. Amendments to MAR charts**

9.14.1. If there are any changes mid-cycle to the individual's medication regimen, a new MAR chart should be obtained from the pharmacy or the entry rewritten by the prescriber. In exceptional circumstances where this is not possible in a timescale to meet the clinical needs of the individual, an 'authorised person' can cross out the old entry using a diagonal line (records must not be obliterated, Tippex or sticky labels must never be used) .and clearly write in block capitals the new information on a new section of the MAR chart.

9.14.2. All amendments must be signed and dated by the 'authorised person' carrying out the amendments, and a brief reason for the amendment stated nearby; a witness must also check, sign and date the amendments. Instructions for mid-cycle amendments to prescriptions that have been received from the prescriber by telephone must be supported in writing (or by fax/email) before the next dose is given. Superseded MAR charts must be cancelled by a diagonal line, signed and dated, and retained in the individual's records.

**9.15. Six Rights**

When administering medication, staff must consider the six rights of administration:

**Right Individual**

- Check the individuals name against the care plan, medication and MAR chart.
- In care homes and day services a photograph of the individual must present to assist with confirming the individual's identity. A photo should be taken upon admission to the care setting, dated and reviewed or updated annually.
- Providers must ensure that medicines prescribed for an individual are not used by any other person.

**Right Medicine**

- Check that the medicine is labelled with the individual's name.
- Check the medicine name (e.g. Paracetamol), strength (e.g. 500mg) and form (e.g. tablets); the MAR chart, medication label, packaging and contents all must match.
- Check there have not been any recent changes to the medication.
- Check the dosage instructions before giving medication.
- Check that the medicine is fit for use i.e. in its original packaging as supplied by the pharmacy and in date (check the expiry date, taking into account whether or not the medicine has a reduced shelf life after it has been opened).

**Right Route**

- Check the way in which the medication is to be administered (e.g. orally, topically, nasally etc.) - this should be recorded on the MAR chart.
- Medication must only normally be administered by non-invasive routes.
- Any invasive medicines (e.g. those administered rectally, by injection, by feeding tube etc.) carry a higher level of risk and should only be administered by a healthcare professional or, in exceptional circumstances, by 'authorised persons' who have been specifically trained and deemed competent by a healthcare professional to administer via a specific invasive route e.g. by PEG feeding tube. This must be risk assessed by the Registered Care Manager (RCM).
- When the staff member needs to insert drops to ears, nose or eyes; or administers inhaled medication - the patient information leaflet that comes with the medicine 'How to use' must be followed.

**Right Dose**

- Check that the dose on both the MAR chart and medication label match (dose is the amount of medication to be given to the individual).
- Check that the dose has not already been administered by checking the MAR chart – if the dose has already been signed for on the MAR chart, the service manager, On Call Manager or the pharmacist should be consulted before the medicine is given.
- Check for changes to the dose (any amendments must be clearly signed and dated).

- Record on the MAR chart the actual amount given at each administration where a variable dose is prescribed.
- Check that you have the right measuring device for liquid doses; the smallest marked measuring device available to suit the intended dose should be used in order to ensure accuracy, and oral syringes should be used for small doses of liquid medicines that cannot be accurately measured in a 5ml spoon.
- Doses should be equally spaced throughout the waking hours as per prescription.

**Right Time**

- Check that the dose time is clearly specified on the MAR chart and/or the medication label. For example, 'Take one tablet in the morning' clearly identifies when this medication is to be given, however, 'take one tablet daily' leaves this open to interpretation, unless the dose column on the MAR chart is marked as to identify the time.

- Ensure the dose is offered within an hour of the time indicated on the MAR chart. For a medicine that needs to be given or taken at a specific time, where a delay in receiving the dose or omission of the dose may lead to serious patient harm (e.g. insulin injections for diabetes. HIV meds or specific medicines for Parkinson's disease), this needs to be clearly documented on the MAR chart.

  This should also be documented in the individual's medical notes and information passed on as required to the appropriate others.

  Information about time sensitive medicines needs to be shared with other agencies involved.

  See appendix 3 when to refer to Safeguarding (criteria for considering a medication incident/error as a safeguarding concern)

- Ensure a record (administration signature or omittance code) is made on the MAR chart immediately after administration.
- Check for any additional labels, precautions or special instructions such as 'take with or after food' or 'avoid grapefruit juice' and ensure these are adhered to.
- Record on the MAR chart the actual time given where a PRN medicine is administered.
- Before administering a PRN medicine, check the last time of administration against the PRN protocol to ensure the necessary time

interval between doses has passed.

**Right of the Individual to Refuse**

- The individual has the right to refuse to take any medicine, unless they have been assessed and found to lack capacity (see Covert Medication Administration).

- Do not give the medication if one or more of the above rights is incorrect. Seek further guidance, initially from a manager.

- If the person refuses, try offering again in a short while and. Do not persist if the person is becoming distressed and is continuing to refuse. Ensure that the care plan in the medication folder of how the person prefers to take their medication is followed. Those who can at times refuse medication should have a detailed approach recorded of what to do in this circumstance. If medication is refused completely, exceeds an hour from administration time or is a specific medication such as insulin or Parkinson's medication, immediate medical advice must be sought,

- Medicines that are prescribed and dispensed for one individual remain the property of that individual and must not, under any circumstance, be given to another individual or used for a purpose that is different from that for which they were prescribed. Medicines must never be used for social control or punishment.

- Medicines administration should only be undertaken by an 'authorised person' as described in (Training & Competencies Section). The service must have and maintain a register of 'authorised persons' as described in (Management Accountabilities Section) In line with the Health & Social Care Act 2008 (regulated activities) regulations 2010, there must be a sufficient number of trained and competent 'authorised persons' to ensure medicines can be administered safely at all times, including during periods of staff annual leave and sickness.

- It is the responsibility of the 'authorised person' administering the medication to ensure that medicines are administered as prescribed. If at any stage in the process the 'authorised person' cannot resolve any queries or discrepancies, then the Registered Care Manager, Deputy Manager, or if out of hours On Call Manager should be contacted as soon as possible.

- Medication must be administered directly from the container provided by the pharmacist and never be secondary dispensed ('put up' for someone else to administer to the individual at a later time or date).

- Where medicines are transported around the service for administration to be

undertaken, it must be done in a secure manner. Medicines must never be left unattended. It is the responsibility of all staff to ensure that medicines are kept out of reach of unauthorised persons including those individuals being supported and visitors.

- When an 'authorised person' is administering medicines, it should be their only task for that period of time. The same 'authorised person' should complete the whole administration process from start to finish for each person, dealing with just one person at a time, and they must have enough protected time allocated to be able to do it safely without distraction.

- Each medicine administered must be checked against the MAR chart as well as the container/MDS/BDS label using the Six Rights. For procedures specific to each service, the service's medicines administration SOP must be followed.

- The MAR chart must be signed/initialled by the 'authorised person' administering the medicines to the individual after each medicine is administered and before moving on to the next person.

**9.16. When assisting with medication administration please bear in mind the following:**

- If in doubt, DON'T administer, seek advice: IF IN DOUBT, CHECK IT OUT.
- If things go wrong, contact a manager for advice. Alternatively contact the GP, a community pharmacist or another healthcare professional. Call NHS 111 for urgent, non-emergency medical help.
- Hands should be washed before administering any medication.
- Medication must not be touched unless disposable gloves are worn.
- Any spoons / medicine pots used during the process must be washed after use.
- A glass of water should always be offered with medication that is taken orally.
- Spilled or dropped medication must be recorded on the MAR chart.
- Disposable gloves should be worn when applying topical preparations such as creams.
- Topical preparations such as creams must not be applied to broken skin unless specified by the prescriber.
- Do not advise on or suggest medication other than what is written on the MAR chart.
- Do not administer medication that has been tampered with.
- The date of opening must be recorded on medicines that have a shortened shelf life after they have been opened e.g. eye drops that state 'discard one month

after opening'.

- Staff must not assist with any medication that is not written on the MAR chart.

**9.17. Non-administration/refusal:**

9.17.1. Details of non-administration (e.g. refusal) must also be recorded on the MAR chart. Instead of an administration signature/initial, an omittance code must be put into the signature box and a record made on the back of the MAR chart and in the service user's care record; this information should also be passed on to the Registered Care Manager, Deputy Manager who will decide what further action is necessary, including notifying a healthcare professional if appropriate. In the absence of a manager contact should be made to a healthcare professional for advice and action unless there is already an agreed plan in place for this person regarding refusal.

Any omittance code used must be clearly referenced in the Key on the MAR chart; if there is not a code that adequately describes the reason that the dose has not been given, it is acceptable to create a new code as long as this is clearly referenced (added to the Key). Regular or on-going refusal or non-administration of medication must be communicated to the prescriber as a medication review may be required.

9.17.2. Planned non-administration e.g. due to service user being out of service on a visit or holiday must also be noted on the MAR chart using the appropriate code. See 'Medicines Given Outside the Service' section below.

9.17.3. The date of opening must be written onto the medicine container for any medicines with a reduced shelf life once opened (e.g. eye drops, creams etc.).

9.17.4. Crushing of tablets and opening of capsules to facilitate swallowing is not allowed unless it is authorised by the doctor and/or pharmacist.

**9.18. PRN and Variable Dose Medicines**

9.18.1. PRN medicines (medicines to be administered 'as required') must be available outside of the normal medicines administration times and must be kept in their original packaging as supplied by pharmacy – they should not be dispensed in MMS packs as this will lead to wastage.

9.18.2. A PRN protocol should be produced for each PRN medicine and put in the individual's Medicines Administration File – it must be easily accessible when administering medicines. PRN protocols should, as a minimum, state the reason/conditions that must be present in order to warrant administration, specify the maximum single dose, the minimum dosage interval (time between doses) and the maximum number of doses that may be given within 24 hours.

9.18.3. PRN protocols for behavioral medication should be drawn up in consultation with a psychiatrist and/or psychologist. All other PRN protocols can be drawn up by the RCM, Deputy and confirmed by the service user's GP.

9.18.4. All PRN medication administered must be recorded on the front and back of the MAR chart and in the individual's notes.

9.18.5. A protocol similar to a PRN protocol should also be used for variable dose medicines to ensure consistent administration in line with the prescriber's intentions. When administering a variable dose, the protocol should be adhered to and the exact dose given at each administration must be clearly recorded on the MAR chart.

9.18.6. If the MAR chart or prescribed directions are in any way unclear, the corresponding medication must not be administered. The RCM, Deputy or On Call duty manager should be contacted in the first instance as soon as possible. If appropriate the pharmacist or prescriber should be contacted.

**9.19. Self- Administration**

9.19.1. Individuals able to self-administer medication should be encouraged to do so in order to maintain and promote their independence. An individual risk assessment should be completed, and clear evidence of the level and type of support required must be documented within care / support plans.

9.19.2. A lockable storage facility must be provided for all individuals who choose and are assessed as safe to self-administer.

9.19.3. A MAR chart must be in place for all individuals, including those that self-administer, in order to ensure there is an audit trail for all medicines within the residential home. Staff should not sign for administration on the MAR chart on behalf of any individual who self-administers – instead, there should be a clear record on the MAR chart to indicate that the individual is 'self-administering'.

9.19.4. Monthly medication audits must be undertaken to ensure that medication is being taken and not being stockpiled.

**9.20. Medicines given outside the service ('TTOs')**

9.20.1. Individuals should not be prevented from going on holiday or visits simply because of their need for medication. Arrangements should be made for the medicines to be available and administered in a safe manner.

9.20.2. For planned holidays, a separate supply to cover the period outside of the

service should be obtained on prescription from the GP and dispensed by pharmacy.

9.20.3. When medication needs to be administered outside of the service unexpectedly or at short notice, an 'authorised person' may prepare the medicine(s) but must avoid secondary dispensing (removing the medicines from their pharmacy-issued container).

9.20.4. For each medicine required during the period of leave, the pharmacy-labelled container must be provided. If a MMS is in place (where each individual pot is printed with the individual's name and medicine details), then the required number of individual pots may be provided. For all other medicines, the whole pharmacy-labelled container must be provided; this includes MMS r packs and PRN medicines in their original pack. A second 'authorised person' must check the preparation of the medicines as a witness.

9.20.5. Each service must keep a To Take Out ('TTO') Medication Record Book/Form. Each time medicines need to leave the premises for administration during a period of leave, a record must be made to include the following:

- Name of Individual
- Reason for taking medication out
- Date medication is going out
- Medication name, strength and form
- Dose and times to be administered
- Quantity of medicine being taken out
- Person responsible for taking medication out
- 'Authorised person' signature
- 'Authorised person' witness signature

**And on return:**

- Quantity of medicine received back onto the premises

9.20.6. The named person taking responsibility for giving the medication outside the service could include a staff member trained in the needs of the individual, a, family member, friend or advocate.

9.20.7. The 'authorised person' must explain to the named person when and how the medicine(s) should be administered (allowing opportunity for the named person to ask any questions). Clear directions should be given (preferably a

photocopy of the MAR chart) as well as contact details for who to contact if there are any queries or issues.

9.20.8. The named person must sign the TTO Medication Record Book/Form for receipt of the medicine(s) and to confirm that they understand when and how to administer each medicine, are responsible for their safekeeping, agree to keep them secure until needed, and will ensure the medicine(s) are looked after and stored in a responsible way to prevent theft, exposure to extremes of temperature or damp and kept out of reach of children.

9.20.9. Upon return, the containers (including any that are empty) should be returned to an 'authorised person' who will check them and make a record in the TTO Medication Record Book/Form. The named person should be asked if any doses have not been given, and to provide the reason for any non-administration – this must be recorded on the MAR chart as well as in the TTO Medication Record Book/Form and the individual's medical file.

9.20.10. During an Individual's leave, the MAR chart should be marked accordingly.

9.20.11. If there are any concerns about sending whole supplies of medicines outside of the home during periods of leave, a separate smaller supply should be obtained via the GP and pharmacist and held for such occasions.

**9.21. Covert medication administration**

9.21.1. Covertly giving medication means hiding it (e.g. in food or drink) so that the individual is not aware in any way that they are taking it. This practice will only be used in exceptional circumstances, never routinely.

9.21.2. Staff should never administer medicines to an individual without their knowledge (covert administration) if the individual has the capacity to make decisions about treatment and care.

9.21.3. Covert administration must be agreed by a Best Interest decision (a decision that the need for the medication is greater than the need for the individual to consent to taking it). A Best Interest decision should involve the GP (or other healthcare professionals trained to assess mental capacity), someone representing the service, someone acting in the best interests of the individual (e.g. a family member or advocate) and a pharmacist to ensure the medication will remain stable and effective when administered in food or drink.

9.21.4. The decision to covertly administer medication to an individual must be clearly documented in the care and support plan, detailing why the decision has been made, with copy notes from the Best Interest Meeting, which must detail all rights and benefits. This must also be recorded on the individual hospital

passport. The decision to covertly administer must then be reviewed regularly (minimum annually).

9.21.5. There must be individual guidelines in place to detail how to best administer each medicine to the individual.

9.21.6. Nutritional effects must never be compromised; generally, medication should be administered at the end of the meal in a small portion of food or liquid - not the whole meal.

9.21.7. For further information, see the policies, procedures and guidelines on consent and the Mental Capacity Act 2005.

**9.22. Homely or 'Household remedies**

9.22.1. We do not currently have any people on homely remedies but should an existing person or a new person come into our service, and the person or family member makes the decision to obtain an homely remedy or the services of an homeopathic practitioner, then this is something that can be discussed. A best interests meeting can take place to assist in making a decision involving the person and other relevant healthcare professionals.

9.23. **Anti-clotting/ Anticoagulation Medications**

9.23.1. Warfarin is an oral anticoagulant. Individuals on warfarin must have regular blood tests to ensure their dose of warfarin is safe and effective; these may result in the dosage being adjusted on a regular basis.

9.23.2. Individuals on warfarin will have either a 'yellow oral anticoagulant booklet' or a printed sheet from the GP where test results and the prescribed daily dose of warfarin are detailed. Doses of warfarin may vary on a day-to-day basis and are subject to change regularly, therefore 'authorised persons' administering warfarin must always refer to the most recent instructions from the GP in the yellow book or printed sheet before each administration. Warfarin must also never be supplied in MMS.

9.23.3. Side effects, including any form of bleeding (nose, vomit, urine, faeces), severe bruising and headaches must be reported to the GP.

9.23.4. A clear and detailed SOP must be in place to support local warfarin administration and must include:

- Take tablets at the same time each day (this will usually be in the evening)
- Instructions for if the individual misses a dose

- Administer from original packaging (not MMS
- Staff training and assessment must include the colour codes of the tablets
- Always check the International normalized ratio (INR). The INR is a standardized number that's figured out in the lab. If you take blood thinners, also called anti-clotting medicines or anticoagulants, it may be important to check your INR. The INR is found using the results of the prothrombin time (PT) test. This measures the time it takes for your blood to clot. The INR is an international standard for the PT.) report when giving medication (GPs and pharmacists should check INR is at a safe level before issuing the prescription)
- Process to ensure blood tests are taken at the correct time, that INR results are received and that the correct dosage is written on the MAR chart.
- Process to follow up results if not arrived within 3 days by contacting the GP or anticoagulant service
- Attach written dosage instructions from the lab to the MAR chart
- Details of all changes to be written in the care and support plan

**9.24. Adverse drug reactions**

9.24.1. Any adverse drug reaction or suspected adverse drug reaction must be reported to the prescriber and/or supplying pharmacist for that individual before further administration.

9.24.2. For serious reactions, medical advice should be sought immediately, and a manager informed. The reaction must be recorded in the individual's medical notes and hospital passport.

**9.25. Disposal of unwanted/expired medicines**

9.25.1. There must be an audit trail for all medicines leaving the service premises. If medicines are no longer wanted (e.g. if they have been discontinued by the prescriber, if they are no longer fit for use or if they have expired) an entry should be made in the 'Medicines Returns Book'. This should include:

- The entry date
- Individual's name
- Name, strength and form of medicine
- Quantity
- Date dispensed
- Signature of person making the entry

- If applicable, an entry should also be made on the MAR chart
- Reason for return
- Witness signature
- Where returned to (Pharmacy name & address)

9.25.2. The unwanted medicines should be stored securely and safely, separate from the medicines still being used, until they can be returned to the pharmacy for safe destruction. The pharmacist, dispensing technician, or delivery driver should sign and date the 'Medicines Returns Book' to acknowledge receipt and complete the audit trail.

9.25.3. Unwanted medicines must not be put in waste bins or down drains/toilets.

9.25.4. Medication which is spat out or dropped should be put in a clearly labelled container, stored safely and appropriately and returned to the community pharmacy.

9.25.5. Medication returned to the pharmacy must be recorded on the MAR chart following SOP MM11.

## 9.26. Controlled drugs (CDS)

9.26.1. CDs must be stored in a lockable metal cabinet meeting the requirements of the Misuse of Drugs (Safe Custody) Regulations.

9.26.2. Only 'authorised staff' should have access to the CD cabinet.

9.26.3. All services must have a CD cabinet and CD register (also known as 'CD record book') for the receipt, administration and return of CDs. All entries must be legible, made in indelible ink, signed by the 'authorised person' making the entry and countersigned by a witness.

9.26.4. The administration of CDs should be witnessed by another 'authorised person' and countersigned on the MAR chart as well as in the CD register.

9.26.5. The CD register must include a running balance for each individual CD with a separate record page being maintained for each individual. The balance must be checked at each administration and also on a weekly basis.

9.26.6. When receiving CDs from the pharmacy, the CD section on the back of the prescription must be signed by the staff member collecting the CDs. The name of the pharmacy should be written into the CD register to ensure there is a clear audit trail.

9.26.7. There must be a clear audit trial following the return/disposal of expired or unwanted CD's (see SOP MM 18). The collecting driver should sign the Controlled Drugs book to confirm collection.

9.26.8. **Controlled drugs include**

Schedule 2 Drugs - Common examples include morphine, diamorphine, methadone, fentanyl, alfentanil, oxycodone, methylphenidate, dexamphetamine, ketamine and tapentadol. Schedule 3 drugs - You do not need to record schedule 3 drugs in the controlled drugs register. You must store certain schedule 3 drugs in the controlled drugs cupboard.

This includes, for example, buprenorphine and temazepam. Schedule 3 drugs - You do not need to record schedule 3 drugs in the controlled drugs register. You must store certain schedule 3 drugs in the controlled drugs cupboard. This includes, for example, buprenorphine and temazepam.

9.27. **Medication errors and incidents**

9.27.1. All medication omissions, administration (such as missing signatures on MAR chart), dispensing or prescribing errors, including near misses, are considered incidents.

9.27.2. All incidents should be reported to the manager or deputy manager immediately after they are discovered. If no senior staff are available then the on-call duty manager is informed ***after*** first consulting with a medical practitioner for advice, the manager or deputy manager should be informed when they are next on duty.

9.27.3. Medication errors can be an indication of safeguarding issues (see section below).

9.27.4. An SMBC incident form should be completed for each incident. This helps ensure actions are taken to minimise the recurrence and to share learning.

9.27.5. It is the responsibility of the RCM / Deputy to inform Safeguarding Teams of the error and actions taken for safeguarding consideration.

9.27.6. On finding an **omission** the following actions must be taken as soon as possible:

- Find out if the medication has actually been omitted or just not signed on the MAR chart i.e. check MMS or packaging as appropriate and check with the person who was responsible for administering omitted medication
- If medication has been omitted, seek advice from the GP or pharmacist and ascertain if the medication can be given at a later time, or if any further action is needed
- Monitor/observe the individual if directed to do so
- Record omission in the individual's medical notes and on the MAR chart
- The manager should inform the individual's family/carer if appropriate (see 'duty of candour' section below)
- Follow the SMBC incident procedure ensuring complete and accurate details with actions taken are documented clearly.

9.27.7. On finding **any other error** the following action must be taken as soon as possible:

- Advice should be sought immediately from a prescriber/duty doctor/out of hours healthcare professional and, if appropriate, a pharmacist

- Any necessary corrective measures, observation or monitoring requirements requested must be carried out
- The error and any immediate action taken must be clearly recorded in the individual's medical notes and reported back to the manager and doctor in an agreed timescale
- The manager should inform the individual's family/carer if appropriate (see 'duty of candour' section below)
- The error must be reported following the SMBC incident procedure.
- The Registered Care Manager must re-affirm that any 'authorised person' who made the error is competent to continue administering medication. This person will need to be suspended from administering medication until they have been fully reassessed and deemed competent. This may involve further training and re-assessment. We have a local process for medication errors too that managers should follow needs referencing.

9.27.8. **Duty of candour:** This is the duty to be open and honest with the individual and/or their family/carer when something that goes wrong with their treatment or care or causes, or has the potential to cause, harm or distress to them. For any incident that results or has the potential to result in harm or distress to the individual, the service has a duty of candour to them.

The individual or their family/carer (as appropriate) must be contacted and informed of the incident, offered an apology, informed that the incident will be fully investigated and offered support.

9.27.9. **Pharmacy errors:** If any dispensing error or defect regarding a medicine, label or container is identified (e.g. a labelling error, wrong medicine found inside a differently labelled box etc.) the item(s) should be segregated from current stock and clearly marked 'Do not use'. The error should be reported to the supplying pharmacy and arrangements made to rectify the error in an appropriate timescale to ensure continuity of medication. An SMBC incident form should be completed.

9.27.10. **Prescriber errors:** Where the error has been a prescribing error, the prescriber should be notified and arrangements made to rectify the error in an appropriate timescale to ensure continuity of medication. An SMBC incident form should be completed.

9.27.11. If medication is discovered to be missing from the service, the RCM or Deputy manager or 'on call' duty manager should immediately be informed. An investigation should be carried out and appropriate action taken which may involve contacting the police if necessary and arranging for a replacement supply of medication. An SMBC incident form must be completed and senior.

management advised.

## 9.28. Safeguarding consideration and external reporting

9.28.1. Criteria for considering a medication incident/error as a safeguarding concern:

- The victim is caused significant and/or permanent harm or death.
- Errors in the administration of prescribed medication that leads to a medical intervention and/or A&E attendance.
- The incident/error was a deliberate act.
- The incident is part of a pattern or culture e.g. the same drug, carer or agency is involved, or the duration / frequency is particularly concerning.
- There is a risk of repeated or increasingly serious acts involving this or other vulnerable adults.
- The incident results in significant and/or permanent harm or death.
- Controlled drugs are involved, resulting in significant and/or permanent harm or death.
- Incidents where someone is given medication that has not been prescribed or bought specifically for them that results in significant and/or permanent harm or death.
- Incidents which involve a large number of people.
- Incidents that involve drugs liable for misuse/abuse; if unsure, consult a community pharmacist. Some common examples include:
- The 'Z' drugs – zaleplon, zolpidem and zopiclone (hypnotics indicated for insomnia)
- Sedating antipsychotics e.g. haloperidol, chlorpromazine
- Stronger opiate based painkillers like dihydrocodeine
- Benzodiazepines e.g. diazepam, temazepam etc.

The Care Quality Commission must be notified of all incidents that:

- Result in physical or mental impairment that is not likely to be temporary.
- Require treatment by a healthcare professional in order to prevent death or injury/impairment.
- Cause prolonged pain or prolonged psychological harm.
- Shorten the life expectancy of the person.
- Involve abuse or allegations of abuse in relation to the service user.

- Have been reported to, or are being investigated by, the Police.

**9.29. Drug withdrawals and hazard warnings**

9.29.1. The RCM must take action on any information received concerning a hazard warning and/or drug withdrawal immediately. The supplying pharmacy should be contacted for advice and to discuss.

9.29.2. A signed and dated record must be made noting the action taken (even if no action is necessary). Where necessary a new supply of the affected medication must be obtained in an appropriate timescale for the needs of the person.

9.29.3. The doctor must be contacted as soon as possible if the service user has been given faulty medicines or where it is necessary to change to an alternative medicine

9.30. **Medication reviews**

9.30.1. Arrangements must be in place for all individuals on regular medication to have regular medication reviews.

9.30.2. Arrangements (including frequency) for medication reviews should be agreed in advance and documented in the individual's care plan. The interval between medication reviews should be no more than 1 year. Medication reviews should involve the prescriber, the individual and/or their family/carer as well as, where possible, any other healthcare professional involved in the individual's medication (e.g. pharmacist) and a member of residential home staff.

9.30.3. Whilst regular reviews may be planned in advance, staff and 'authorised persons' who support the individual on a regular basis are well placed to identify if they may require a medication review sooner. Any recommendations for a medication review should be escalated via the RCM.

9.31. **Service self-assessment**

9.31.1. All Managers' must carry out at least six-monthly assessments of all staff to check that staff are complying with the SOPs in place.

9.31.2. All areas where medicines are stored should be regularly checked by the Registered Care Manager, Deputy Manager (at least weekly) for tidiness, cleanliness and appropriate stock management.

9.31.3. Expiry dates should be checked routinely and medicines rotated appropriately. This should be undertaken on at least a monthly basis by an 'authorised

person' and documented.

9.31.4. All records relating to medicines including MAR charts, receipts and returned medicines books, and daily records of temperatures should be checked by medicine competent staff within the monthly audit to ensure appropriate recording and use.

9.31.5. RCM's / Deputy Managers must undertake at least a six-monthly audit of each service.

9.32. **Sharing information about an individuals medicines**

9.32.1. All information relating to individual's medicines, especially anything that may identify them or anything of a sensitive nature such as information relating to their health should be treated confidentially and respectfully.

9.32.2. It is sometimes important to share confidential information outside of the residential setting, particularly when it is needed for the safe and effective care of an individual e.g. if the individual has been admitted into hospital or if they are being transferred to another care provider.

9.32.3. When sharing information about an individual's medicines, the most up-to-date source of information should be used; this will usually be the MAR chart and the physical medicines, but it may also be a hospital discharge summary or recent prescription.

9.32.4. When an individual's complete list of medicines needs to be shared outside of the residential setting, a photocopy of the most the MAR chart, latest prescription and/or hospital discharge summary (whichever is most recent) should be sent. Staff must avoid handwriting or transcribing lists of medicines wherever possible due to the potential for errors.

9.32.5. If it is not possible to photocopy the MAR chart or if details of only certain medicines need to be shared, the medicine name, strength, form and directions that have been printed by pharmacy on the MAR chart or medicine label should be used.

9.32.6. Before sharing information:

- The information must be checked for accuracy, completeness and validity, wherever possible this should be checked by two members of staff.
- The identity of the requestor/recipient and confirmation that they have a legitimate need to access the information must be obtained.
- A secure method of transfer must be agreed to ensure the information is protected as far as possible from accidental disclosure or theft. Sharing information over the telephone must be avoided due to the potential for mishearing.

9.32.7. Care must be taken to ensure that only information that is legitimately required for the benefit and care of the individual is shared.

9.32.8. Whenever information about an individual's medicines is transferred to an external organisation, details of the transfer must be documented locally and communicated to colleagues e.g. at handover.

9.32.9. An individual's right to object to the sharing of confidential information about them must be respected.

9.32.10. Information that does not need to be shared for the direct safe and effective

care of the individual may only be shared after it has been fully anonymised i.e. after any information that could potentially identify the individual has been fully removed.

9.33. **Ensuring records are accurate and up-to-date**

9.33.1. It is essential to ensure that all current information in use for an individual is accurate and kept up-to-date.

9.33.2. Any changes to an individual's situation (including but not limited to medication changes, drug reactions, new or changed medical conditions, allergies, transfers of care or medication errors) must be documented in a timely manner in the individual's medical record/care plan, communicated in writing to colleagues (e.g. handover document or communication book) and, where applicable, updated on the MAR chart.

9.33.3. Any information that is no longer relevant, accurate or required must either be updated or, if no longer required, removed for archiving or secure confidential disposal. The Registered Care manager must be consulted prior to disposing of any confidential information in order to ensure any statutory/mandatory retention periods are adhered to.

9.34. **Death of an individual**

9.34.1. In the event of death, all medication (including prescribed, homely and topical preparations) must be retained for at least one month after the date of death, or until otherwise told it can be returned for disposal. The medication may be required for evidence by the Coroner as part of any on-going investigation.

## 10. RELATED DOCUMENTS

- This document must be followed in conjunction with the following Policies:
- SMBC Reporting of Incidents
- Hand Hygiene Policy
- Safe Handling and Disposal of Sharps Policy

## 11. REFERENCE AND FURTHER READING

- NICE Managing Medicines in Care Homes 2014 *(last updated Dec 2017)*
- CQC Regulations *(www.cqc.org.uk)*
- HSCIC Guide to Confidentiality 2013 *(NHS Digital's online resources)*
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2010
- Records Management Code of Practice for Health and Social Care 2016
- Epilepsies: diagnosis and management (Clinical Guidance (CG137) Last updated April 2018.

**Prior to 2019 review:**

- BNF online
- NMC - Standards for Medicines Management 2008
- Medicines.org.uk
- MAR in care homes and domiciliary care
- Safe management of CDs in Care Homes
- The handling of medicines in Social Care
- Training care workers to safely Admin Medication in Care Homes
- CQC Essential Standards of Quality & Safety, Outcome 9.
- Management of Medicines, regulation 13 of the Health and Social Care Act 2008
- Hand Hygiene Policy
- Safe Handling and Disposal of Sharps Policy

## 12. COMMONLY USED ABBREVIATIONS

- MMS Multi-Meds System
- CD - Controlled Drug
- CQC - Care Quality Commission
- GP - General Practitioner
- LD - Learning Disabilities
- MAR - Medication Administration Record
- NMC - Nursing and Midwifery Council
- PIL - Patient Information Leaflet
- PRN - When required
- RPSGB - Royal Pharmaceutical Society of Great Britain
- SOP - Standard Operating Procedure
- RCM - Registered Care Manager
- INR – International normalized ratio. The international normalized ratio (INR) is a standardized number that's figured out in the lab. If you take blood thinners, also called anti-clotting medicines or anticoagulants, it may be important to check your INR. The INR is found using the results of the prothrombin time (PT) test. This measures the time it takes for your blood to clot. The INR is an international standard for the PT.)