Medication Policy

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Summary

This policy provides guidance and procedures for all colleagues across the areas of Christadelphian Care Homes (CCH) with regards to the management of medication.

This good practice guidance can also be used by colleagues who provide care and support services across the area who are not directly employed by Christadelphian Care Homes. However, CCH will not accept liability and would therefore advise external agencies to ensure that they have their own adequate legal cover.

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Appendix

Medication Policy

1. Introduction & Scope

1.1. This policy applies to (and should be read during the induction process by) all colleagues employed or contracted by Christadelphian Care Homes, who support and/or administer medicines to residents.

1.2. This guidance can also be used by colleagues in care homes not directly employed by CCH. However, CCH will not accept liability and would therefore advise external agencies to ensure that they have their own adequate legal cover.

1.3. This procedure is based on the following professional guidance and legislation:

- Managing Medicines in Care Homes. NICE, March 2014
- The Mental Capacity Act 2005
- Medicines Act 1968
- The Misuse of Drugs Act 1971, and associated regulations
- The Misuse of Drugs Regulations 2001
- The Safer Management of Controlled Drugs Regulations 2006

1.4. If there is more than one provider (for example a community nurse), or a provider and a family carer, involved in dealing with medication, their respective roles and responsibilities should be clearly documented in the care plan.

2. Confidentiality and sharing of information

2.1. Medicines records are stored in a locked cupboard or area with restricted access. Emails, faxes, messages, reports, either written or electronic are kept in the resident's care records and stored securely.

2.2. Medication records will be kept for three years from the last date of entry

2.3. If a resident's care is transferred to another care provider, copies of the medication records and administration charts will be made available to the new provider for reference (on a need-to-know basis in line with rules governing confidentiality). Actual records will be retained by the service where they were created.

2.4. When records are then destroyed, they will be shredded/destroyed in a way that preserves confidentiality.

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3. Equality and diversity

3.1. We will recognise any personal preferences a resident may have with their medicines at the assessment stage and make arrangements in their support plan e.g.

- Vegans might not want gelatin capsules
- Some may prefer to have medication given to them by people of the same gender
- Some may prefer medication given at certain times based around religious festivals such as Ramadan (we will check with the prescriber).

4. Medicines reconciliation and establishing if any support is needed with medicines

4.1. We need to establish what medicines a resident needs, or might need, and if they require any support from colleagues to enable them to take/use these medicines. To establish this, we will use a process called medicines reconciliation to record details of these medicines and any support that might be needed.

4.2. The medicines reconciliation procedure set out here, also sets out how to ensure medicines are suitable for use and that you have sufficient supplies.

4.3. The Medicines Administration Record (MAR) and care plan shall be used to record this information.

4.4. Medicines reconciliation should be carried out as soon as a resident arrives at the care service (or ideally the day before they arrive and then checked once they arrive).

4.5. Equally, when they leave our service for long periods (not just for a day trip or to attend day care) we will ensure the MAR and care plan is up to date and a copy is sent to the new service on the day that they transfer (or shortly before they transfer but ensuring that any subsequent changes to the MAR and care plan are communicated).

4.6. If the information needed to carry out medicines reconciliation is not provided on the day a resident is transferred, then the manager has the right to decline admission into their service.

4.7. The MAR should be updated when medicines are started, stopped or altered.

4.8. The local manager must establish who is responsible for medicines reconciliation. This should include who is responsible during out-of-hours periods.

4.9. All colleagues involved in reconciling medicines should receive appropriate training and be signed off as competent to perform the task.

5. The process of medicines reconciliation

5.1. At least **TWO** sources of information should be used and cross-checked when carrying out medicines reconciliation (note that this is the minimum number of sources and more might be needed depending on the circumstances). One of these sources should be the pharmacy labels on the resident's medicines. See below for other possible sources of information.

a. The Summary Care Record
b. The resident, or person currently managing their medicines
c. The resident's own medicines
d. Repeat prescription tear-off slips
e. Hospital discharge summaries/notes
f. The "Insulin Passport"
g. The previous MAR chart
h. Clinic letters

5.2. Always check the date of any information source used to ensure it is current

5.3. The two most recent sources should be used wherever possible. For example, if a resident is being admitted from a hospital, the discharge summary would be the most recently updated source. For a resident being admitted from the community, the repeat prescription tear-off slips may be more accurate.

5.4. People discharged from hospital may have had changes to their medicines. If they have not been provided with a hospital discharge summary, contact the hospital ward they were discharged from to get a list of their current medicines by fax or email. Verbal orders must only be used in exceptional circumstances.

5.5. Copies of any information sources used should be kept on file with the resident's care record.

5.6. It may be necessary to use different sources of information for different medicines. For example, if a medicine is not listed on the repeat prescription tear-off slip it may have been prescribed in hospital and therefore the hospital discharge summary could be referred to. See section 10 for more information.

6. Where one or more sources of information disagree

6.1. Where one or more sources of information disagree, a discrepancy has been identified. Record the details of the discrepancy on the **MAR and daily care notes** and how the matter was rectified. An additional third source should be used to confirm the correct information.

6.2. If the third additional source still cannot confirm the correct medication details, refer the matter to the resident's GP for investigation.

6.3. In some cases, there may be a discrepancy between the information provided by the resident (or their representative) and the information obtained from additional sources. Provided the additional sources agree with each other, this could show that the resident is not taking the medicine in the way the prescriber intended. In this case check with the resident's GP.

7. Check any medicines that the resident arrives with are suitable

7.1. Only accept original containers dispensed and labelled by a pharmacy. This includes monitored dosage systems and multi-compartment compliance aids, which must be filled and labelled by the pharmacist.

7.2. Check the pharmacy label has full directions on it and not "Take as directed" or similar wording (unless the directions vary with blood test results for medicines such as warfarin or insulin).

7.3. If any of the medicines they are taking have not been prescribed (you would know this as they would not have a pharmacy label on them) then the person completing the **MAR and care plan** must contact a pharmacist or prescriber, to see if they are safe to administer (i.e. they would not interact with any other medicines). They must add this information into the care plan and re-check this annually.

7.4. Check that the medicines have sufficient expiry date. Medicine with a limited life span once opened, must have the expiry date written on the container by the colleague who opens it. This expiry date will be listed for the medicine in its Summary of Product Characteristics (SmPC) in the Electronic Medicines Compendium (online).

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8. Ensure you have enough supply

8.1. Once each medicine has been reconciled you will need to make arrangements for ongoing supplies of medication.

8.2. Calculate the number of days until the next monthly medication order will be received and hence the quantity of each medication required.

8.3. Request an interim prescription to ensure the resident has sufficient medication to last for the remainder of the order period.

8.4. The resident's medication should then also be ordered in line with the next monthly medication order.

9. Non-prescribed medicines

9.1. Colleagues should not recommend non-prescribed medicines (e.g. homeopathic preparations, vitamins, minerals or supplements etc.) to residents. If they are asked for advice, they should enable the resident to contact the pharmacist or GP who normally supplies their regular medicines. This pharmacist or GP can then give advice.

9.2. Colleagues can administer (or support a resident, to administer) non-prescribed medicines so long as they obtain authorisation from the pharmacist who normally supplies their regular medicines or the GP and record this in the care plan. This can be a telephone conversation if needs be.

9.3. There is no need to obtain authorisation from a pharmacist or GP for non-medicated topical products (i.e. those applied to the skin) such as moisturisers. You will know if these products are non-medicated, as they will not have a product license (PL) or marketing authorisation (MA) number printed on them.

9.4. Once agreement has been obtained, the non-prescribed medication must be added to the medicines chart (MAR) and administered and recorded in the same way as prescribed medicines.

9.5. Colleagues will need to re-check with the pharmacist or GP again (and if necessary, update the care plan) in the following circumstances:

- If the resident starts any new medicines
- If the non-prescribed treatment is needed for longer than initially agreed
- If the resident needs another course of the same non-prescribed medicine
- If the resident shows any symptoms of a reaction or side effect.

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10. Establishing if any support is needed with medicines

10.1. The term 'medicines support' is defined as any support that enables a resident to manage their medicines. This can be physical support (e.g., help opening the pack) or mental support (e.g., selecting the medication, or reminding them to take medication, or watching to see if they take their medication).

10.2. We will use the self administration risk assessment to establish and record what (if any) support is needed with their medicines. This will also be summarised in their care plan.

10.3. We will not take responsibility for managing a resident's medicines unless an assessment indicates the need to do so.

10.4. If any support with medicines is needed, the aim will be to enable the resident to self-medicate (as far as this is possible). Colleagues should keep this in mind and continually try to teach/support the resident to do as much for themselves as possible.

10.5. Self-medication will not be seen as an 'all or nothing' affair. Some residents may be able to self-medicate with some items for example (but not limited to), creams, medicated shampoos etc. whilst colleagues administer other medicines.

10.6. A resident might be able to manage his or her medicines provided that colleagues provide assistance. For example:

- A resident who has suffered a stroke and is unable to open containers may want to keep medicines and ask colleagues to assist at the time he or she chooses to take the medication
- A resident may be given a tube of cream to apply privately even though colleagues give other prescribed medicines
- A resident who has limited understanding and awareness may be able to cope with one day's supply of medicines in a compliance aid.

10.7. If colleagues are responsible for ensuring that the medicine(s) are used/taken correctly and on time, then they will need to watch the resident to ensure this happens and provide any assistance that the resident needs (e.g. physical support or mental support such as regular reminders). They must then sign eMAR to show that this medicine was used/taken correctly. If there is an exception on eMAR that describes the type of support provided (e.g. made available) then this exception can be used. However, bear in mind that the care plan and self administration risk assessment (not the MAR chart) describe the type of support that is being provided.

10.8. Colleagues will select 'given by self' against any medicines that the resident self-medicates. There is then no need to record the individual occasions when a resident self-medicates with those medicines.

10.9. Colleagues can provide the occasional reminder to a resident, without this being seen as colleagues assuming responsibility for ensuring the medicine(s) are being used/taken correctly. Hence this resident can still be seen as self-medicating and colleagues do not have to record this on a dose-by-dose basis on the MAR chart. However, if the resident needs a regular prompt i.e., they become reliant on these prompts, or the prompts are so regular that they have to be included in a care plan, then colleagues should watch to see that the medication is used / taken correctly and record this on an MAR.

10.10. We will review a resident's medicines support to check whether it is meeting their needs and preferences. This should be carried out at the time specified in the care plan or sooner if there are changes in the resident's circumstances, such as: changes to their medicine's regimen, a concern is raised, a hospital admission, a life event such as a bereavement. This review date will be added to the self administration risk assessment.

10.11. The current care plan and orders information on eMAR should be updated if the resident's support needs change with any of their medicines (e.g., if they deteriorate and need colleagues to administer certain medicines that they were previously self-medicating with, or conversely if they are able to self-medicate with certain items).

10.12. If colleagues receive medicines that a resident self-medicates, they must record the quantity that they then hand over to that resident. This will be recorded in the daily care notes or other approved form that the service wishes to use.

10.13. When a resident self-medicates, colleagues must have a method of checking that the resident is coping. Such methods may include:

- A monthly stock check of remaining doses.
- Keeping an eye out for any tablets, capsules etc. left lying around untaken
- Asking the resident if they are taking their medicines without problems
- Keeping a general eye on the resident and noting if any of their treated conditions worsen

10.14. Mental capacity can fluctuate and therefore colleagues must continually monitor residents who self-medicate. If colleagues have any concerns regarding a resident's ability to self-medicate, colleagues must discuss this with the resident, the care management team and any relevant health professionals, the care plan and info orders on eMAR may need to be updated.

11. Preparing a medicines chart and other medicines paperwork

11.1. The colleague responsible for receiving medication into the home will ensure it is logged onto eMAR as a new medication and the quantity of meds added to the inventory.

11.2. If colleagues have added a new medication to eMAR, they must clearly add the drug, strength (unless there is no strength listed, for example with non-medicated creams) and form of the medicine. They must then add the directions and a schedule to reflect these directions.

11.3. Any medication added to eMAR by a colleague will need to be approved by another colleague who is trained to manage medication.

11.4. Colleagues will upload a photo of the resident to eMAR to ensure the correct medication is given to the correct resident.

11.5. Colleagues should ensure that they record any allergies the resident has experienced with any medicines onto eMAR, they must also ensure that the pharmacy are aware so that they add these allergies to the resident's profile. If the resident does not have any allergies, this should be recorded as 'none known'. The allergies box should not be left blank.

11.6. When preparing the care plan and MAR chart, colleagues (as far as possible) must do this in a quiet environment to minimise the chance of distractions and errors being made.

11.7. All items (e.g. prescribed, non-prescribed, nutritional drinks etc.) administered/supported by colleagues will be recorded on the eMAR.

11.8. The notes on eMAR should be used to detail where creams need to be applied.

12. Using and amending medicines charts

12.1. If community nurses are visiting the care home to administer any medicines, the medicines will be set up on eMAR as given by 'other' with District nurse specified.

12.2. When a family member or colleague gives a medicine (for example, during a day out), agree with the resident and/or their family member or colleague how this will be recorded. Include this information in the care plan (NICE recommendation 1.5.6).

12.3. If a mistake is made when recording on the MAR it may be corrected by editing the administration history and writing an explanation in the notes box.

12.4. The prescriber is encouraged to amend the MAR themselves, if this is not possible then a competent colleague can make the change following the guidance below.

12.5. **Cancelling items of medication on the MAR:** When an item of medication is stopped, colleagues should end the existing medication order on the eMAR, and then the notes box should be used to document the name of the authorising prescriber, explaining why the item was stopped. Written confirmation from the prescriber must be kept in the resident's file, or a record made in the care notes of the conversation witnessed by another colleague to ensure accuracy.

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12.6. **Adding items of medication on the MAR:** Follow the process in section 10 of this policy.

12.7. **Changing doses (only when authorised by the prescriber):** First cancel the item on the MAR (as set out above) then add the item with the revised details as a new medication order. Once an item has been added to the existing MAR, it should be reviewed by a second trained colleague.

12.8. All new medication is identified on eMAR with a green arrow, all colleagues should check these green arrows to ensure they are up to date with any medication changes before starting their shift. When administering medicines, colleagues should always have eMAR right next to them to refer to before they give the medicine(s). This is also important as they must complete the chart as soon as they have administered each dose. Gaps and errors occur when colleagues forget to sign the chart after walking back to it.

12.9. Managers must check for missed medicines daily (or delegate this task) ensuring they are followed up within seven days and an entry inserted into the admin history to explain what happened with this dose.

13. Verbal orders

13.1. Verbal instructions to stop medicines or amend doses must only be accepted when the resident's health would be put at risk if they were not acted upon immediately. If taking a verbal order, colleagues must record:

- the time and date of the call,
- the name of the prescriber they are speaking with,
- the medication name and dose
- the new instructions.

13.2. The colleague should repeat the instructions back to the prescriber to confirm that they have heard them correctly, spelling out any drug names if they are unsure. It is best practice that a witness be present to confirm the information.

13.3. During the call, colleagues must ask the GP to send written confirmation (via fax, email or a letter) within 24 hours (or within 72 hours at weekends or bank holidays).

13.4. When written confirmation is received, this must be kept on file as evidence of the change.

13.5. Text messages from telephones can be used as written confirmation in exceptional circumstances. They should check that the sender is a prescriber for the resident and the message is received from their designated number. Colleagues must record the details of any text message received, including the content of the text message, telephone number it was sent from (it should be a pre-agreed designated number), the time sent, any response given. The recipient of the text should then sign and date this record. They should then delete the text from the phone.

13.6. Verbal orders to change warfarin will not be accepted due to the risk of mistakes occurring. Warfarin doses can only be altered with written instructions.

14. When required medicines

14.1. Medicines prescribed on a 'when required' basis (also called 'PRN' medicines) will need a **PRN protocol** in place. This can be filled in by colleagues, after being discussed with the prescriber, pharmacist or other health professional. It includes guidelines for each resident. This protocol will state under what circumstances the item should be given.

14.2. PRN protocols must be reviewed annually.

14.3. PRN medication must be listed on eMAR with the maximum 24 hour dosage check box ticked and the dose entered, and the 'wait between admins' check box ticked and the time inserted.

14.4. Colleagues should always check the time that the previous dose was given to ensure that they are adhering to the minimum time gap between doses set out in the 'when required' protocol.

14.5. It should be established if any 'when required' items need to be offered to the resident (or assessed for need) or whether the resident will request the item themselves (e.g., a painkiller in a resident with sufficient capacity and communication skills) or make it obvious that the item is needed (e.g., exhibiting behaviour seen as challenging, experiencing a seizure etc.). This should be recorded in their PRN protocol.

14.6. Items that need to be offered (or assessed for need) are termed **scheduled** 'when required' medicines in that they are scheduled on eMAR to be offered/assessed/taken at certain times. If these items are not needed by the resident, then colleagues should use an appropriate exception on eMAR to record and evidence the fact that the item was offered/assessed for need at the scheduled times.

14.7. Items that do not need to be offered/assessed for need are termed **non-scheduled** 'when required' medicines. These are set up on eMAR as PRN and do not need to be recorded if they are not needed.

14.8. If PRN medication is taken on a regular basis the prescriber should be informed to review the resident's medication as their condition may have changed and the treatment may need altering.

14.9. If the resident attends a day service, then colleagues will need to inform the day service if any when required doses have already been given that morning. This is to reduce the likelihood that too many doses are given in 24 hours.

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15. Time sensitive medicines

15.1. If there are any time sensitive medicines such as treatments for Parkinson's disease, antibiotics, ant-epileptic medicines, then the pharmacist should be asked to state the actual time of administration (or a time range) on the pharmacy label. These times should then be added to the medicines chart and a '-15 minute alert' set on the mediation order.

16. Ordering medicines

16.1. On a set day each month (no later than day 8 of the cycle), a nominated colleague at the home should produce a medicines order. Medicines should be ordered on eMAR using the 'batch reorder' function. Colleagues should check stock of any medicines that will be left over from the previous month to reduce over ordering. They should only order what they need for the month.

16.2. The service should save a PDF of the monthly medication order so that they can check off the medicines received from this record (the order will only stay on eMAR a week).

16.3. There are certain medicines such as oral liquids, creams, eye drops etc. that might have "period after opening" dates after which the medicine should be discarded. Medicines should be checked to see if the manufacturer has specified any "period after opening" dates. If they have, these medicines should be discarded and re-ordered. The colleague completing the medicines order should check with the pharmacy to see if there is smaller pack size available to reduce wastage. If the manufacturer has not added a "period after opening" date, then the medicine can be used up until the manufacturer's expiry date.

16.4. The service must send the order (the monthly order form) to each surgery. It is best practice to then receive back the prescriptions and check them against the order before sending the prescriptions to the pharmacy for dispensing (unless in the case or e-prescriptions in which case the pharmacy should send copies of the prescriptions). This gives more time to correct any mistakes on the prescriptions before the medicines are supplied by the pharmacy.

16.5. It should be clear who is responsible for ordering prescriptions for each resident.

16.6. Colleagues can help self-medicating residents order prescriptions or order them on their behalf.

16.7. Colleagues must make efforts to check a resident does not run out of their medicines. Colleagues must order a new prescription at least seven days before the resident runs out (or earlier depending on what is agreed with the surgery and pharmacy).

16.8. If the resident runs out of medication and a new prescription cannot readily be obtained, the resident's regular pharmacy may supply up to 30 days-worth of medication as an emergency supply (but not controlled drugs) if the supplying pharmacist concludes that it is appropriate to do so.

16.9. If a pharmacy is out of stock or cannot obtain a supply in time for the resident, the pharmacist may be asked if there is an alternative pharmacy who can supply the medication. If unable to obtain from another pharmacy the prescriber may need to be contacted and asked to prescribe an alternative treatment.

16.10. Colleagues should have protected time for ordering and checking medicines delivered to the home (NICE recommendation 1.10.2).

16.11. The service should have at least two colleagues who are competent to order and receive medicines, although at any one time, ordering and receiving can be carried out by one colleague (NICE recommendation 1.10.3).

16.12. The service should have a process for ensuring they have enough stock of anticipatory medicines (for example, those used in end-of-life care) when these are used by a care home.

17. Receiving medication

17.1. Colleagues will complete 'data reconciliation' on eMAR to ensure the new MAR is the same as the current MAR.

17.2. Medicines collected or received from the pharmacy will be checked against the order to ensure the correct medicine and quantity has been received.

17.3. The expiry date will be checked when medicines are received, as well as every 28 days before being reordered. It is recommended colleagues check the expiry date when administering if they open a new box, if the item is a rarely used PRN or the colleague has been away from work for an extended period of time.

17.4. Medicine with a limited life span once opened, must have the expiry date written on the container by the colleague who opens it. This expiry date will be listed for the medicine in its Summary of Product Characteristics (SmPC) in the Electronic Medicines Compendium (online).

17.5. All medicines received will be recorded on eMAR. The quantity of medication must be recorded for all medicines where a measurable quantity is administered, this would include liquid oral medicines but would not include topical preparations.

17.6. **For respite services:** colleagues signing to confirm receipt of medication should consider the length of the planned stay and whether the supply received is adequate for the whole of the stay.

17.7. When medicines are received, they must be stored immediately in the appropriate place and not left out insecurely.

17.8. The local manager should keep (and allow the resident to access) the latest copies of the Patient Information Leaflets for each medicine supplied by the pharmacy. They can keep an online copy using the Electronic Medicines Compendium if they wish.

17.9. If the care service orders medicines on behalf of a self-medicating resident, then they must record the total quantity handed over to the resident to self-medicate with.

18. Storage and security of medicines

18.1. Self-medicating residents should be advised to keep medication safe and not accessible to any other people using the service. They should be provided with a personal lockable drawer or cupboard that only they and designated colleagues have access to, with the permission of the resident.

18.2. Medicines can either be kept in a resident's room or stored centrally depending on each care home. If medicines are stored centrally, avoid keeping medicines in busy environments such as the main office (if possible) as there is a greater risk of distractions which can lead to medication errors.

18.3. If stored centrally, all medicines relating to a particular resident should be stored together on the same shelf which must be named. The resident's name should be removed when the medication is returned. If people using the service's medication share the same shelf in the medication cabinet, they should be separated by storing them in a bag or a box and clearly labelled with the resident's name.

18.4. A system of stock rotation must be operated (e.g., first in, first out) to ensure there is no accumulation of old stock. Only one packet/container of a named medicine should be use at any time.

18.5. Medicines that colleagues administer must be kept in a locked cupboard, room, trolley, or refrigerator. They should only be accessible to those administering medication.

18.6. Rooms where medicines are stored are kept below 25 degrees C. The temperature should be checked and recorded daily.

18.7. If a trolley is used, it should be secured to an immovable object (if it is stored outside of the locked room). When the cupboard and trolley are unlocked, they should never be left unattended.

18.8. Care must be taken to ensure that the keys are properly controlled. Only colleagues that are trained and authorised to handle and administer medicines should be able to access medicines. Keys should be kept by the local manager or a nominated deputy, either on their person or in a secure place. A list of authorised key holders should be kept.

18.9. If keys are kept on their person, there should be a procedure for handing over keys which is clearly understood by all colleagues. Medicine storage keys should be kept on a separate key ring from other keys and the number of duplicate keys available should be restricted.

19. Refrigeration of medicines

19.1. If there is a constant need to refrigerate medicines, a separate and secure refrigerator should be used. The refrigerator temperature must be monitored and recorded on a daily basis using a minimum/maximum temperature monitoring device to ensure temperatures are maintained within the accepted temperature range +2 to +8 degrees centigrade. Care must be taken to ensure the device is reset after each reading. Colleagues must report temperature readings that are consistently outside of the accepted range so that action can be taken.

19.2. Ensure eye drops are promptly returned to the fridge after being administered. Note that some eye drops do not need to be kept in the fridge once they are opened and in use.

20. Administration of medicines

20.1. Gloves are needed when administering any medicines that might mean contact with body fluids (WHO Glove Information Leaflet, 2009) e.g., eye, ear or nasal medicines where secretions (other than tears) are present, or if they are spreading topical medicines onto the skin (excluding transdermal patches).

20.2. Gloves are also needed if handling cytotoxic medications such as methotrexate and cyproterone - seek advice from the supplying pharmacist on any prescribed medications that may be cytotoxic. Occasionally chlorpromazine can cause rashes in some people who touch it, in which case wear gloves.

20.3. Gloves should be disposed of immediately after administering medicines for each resident (see Infection Control Policy).

20.4. Oral medication should be given to residents using the service in containers such as a measuring cup. Make sure these are dry inside, otherwise tablets and capsules can stick to them.

20.5. When a new tube or jar of cream or ointment is opened the date should be recorded ensuring that instructions on the label have not been covered.

20.6. Colleagues must check and administer medication for one resident at a time in accordance with the medicines administration training. On every occasion, the process will include checking the 6 R's of administration (right resident, right medicine, right route, right dose, right time, resident's right to decline).

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20.7. The colleague responsible for preparing and checking the medication must also be the colleague to administer and record it.

20.8. If the resident has eaten a meal, colleagues should check the pharmacy labels to see if any of the medicines should be given on an empty stomach. If this is the case, they should seek advice from the pharmacist. The timing of the medicines or their meal might need to be changed.

20.9. If the resident is regularly asleep when the medicine is due, colleagues should seek advice from the pharmacist. The timing of the medicines might need to be changed. There would be no need to wake someone up for some medicines such as sleeping tablets.

20.10. Follow the procedures for administration of medication as described in the **medication competency assessment**.

20.11. Some medications, such as warfarin and prednisolone, may have variable doses, which will need to be checked with separate charts or booklets. In this case the colleague must check the separate booklet for the current dose (prior to administration) and this dose should be recorded on eMAR.

20.12. When applying a transdermal patch always check the **notes box on eMAR and the 'last site' on the 'admin history'**. Check that the previous patch has been removed before applying the new one (it may be in a different place on the body e.g. the other arm). Refer any rashes at the site of administration to the prescriber.

20.13. For certain time critical medicines, it may be necessary to interrupt their meal or wake a resident to administer the medication. Where the resident has the capacity, this should be explained to them when the medication is prescribed.

20.14. The resident still maintains the right to decline the medication. If the medication is not taken on time or declined this must be recorded using the correct exception and reported to the person in charge.

20.15. When supporting or administering medication to the resident, it is important that they are treated with dignity and respect and wherever possible their preferences are respected. However, we will explain to them that there will be times when medication must be given at these times and gain their consent to do so.

21. Fire risks and emollients

21.1. When emollients (moisturising creams, ointments, gels and lotions) are applied to the skin, the oil they contain can be transferred onto any fabric that is in contact with the skin. For example: clothing, sheets, towels, bedding, bandages, chairs and other soft furnishings. The more these fabrics are in contact with emollients on the skin, the greater the risk of transfer.

21.2. If this happens, the fabric is then more likely to catch fire if it comes into contact with naked flames or other sources of ignition. The resulting fire burns more easily, fiercely, and is harder to extinguish.

21.3. The risk is increased in emollients with a higher oil content, applied to large areas of skin, in large amounts, repeatedly for more than a few days.

21.4. These fabrics should be changed regularly and washed at a hotter temperature to reduce the buildup of oil in the fabric.

21.5. Residents who have these products applied regularly (and staff who support them) should be warned of the risks of any fabrics that have been in contact with the emollient, and the danger of them coming into contact with sources of ignition, for example:

- Cigarettes (this is the main risk)
- Lighters
- Matches
- Candles
- Electric heaters
- Gas hobs

21.6. If the resident wants to smoke despite the risk, take steps to ensure they are safe. For example, using a flameless lighter or e-cigarette, removing long-sleeved or baggy clothing before using a gas hob.

21.7. Complete the Fire Risk Assessment: Emollients form and provide relevant information to the resident, care workers and anyone they come into contact with. Please refer to appendix 4 for the form. This should be reviewed regularly, or in the following circumstances:

- Changes in the resident's condition, such as cognitive decline, reduction in mobility or changes in their skin integrity/condition
- Changes to the prescribed emollient treatment
- Initiation of oxygen therapy
- Increased risk of contact with smokers/exposed flames

21.8. Resources (stickers and posters) highlighting the risks are available here:
Safe use of emollient skin creams to treat dry skin conditions - GOV.UK

22. Consent

22.1. In line with legal and best practice, when administering medicines (or providing a resident with support) consent must be obtained. Consent can be verbal or non-verbal (e.g. the act of opening their mouth to receive oral medication or offering an arm to receive a cream).

22.2. Consent can be withdrawn by the resident at any time and colleagues should look and listen for these verbal or non-verbal signs that the resident does not want their medicine(s) and respect the resident's right to decline their medicines.

23. When a resident declines their medication

23.1. Where a resident declines any medication, this should be respected. If colleagues feel that the resident lacks capacity, they can try the following:

- Try again a few minutes later (the resident may have forgotten that they declined)
- Try a different colleague
- Explain to the resident what the medication is for

23.2. Colleagues should be sensitive to the situation, for example, if a resident is doing an activity they may not want to stop to take their medication; wait until the activity is finished and offer the medication again. Try offering another type of drink to take with the medication.

23.3. If the resident still declines after all the attempts outlined above a record should be made on eMAR using the appropriate exception. The reasons for refusal and any action taken (for example, when the prescriber was informed) should be recorded in the notes box.

23.4. The colleague in charge should be told at the earliest opportunity who should then inform the prescriber. The time taken to inform the prescriber may vary depending on the nature of the drug and the resident's illness. However, if the refusal continues for 48 hours then the prescriber and/or pharmacist should be contacted for further advice.

23.5. A pharmacist can always be asked for advice when medicines are refused, especially if the prescriber is not contactable (for example in out-of-hours situations).

23.6. Record any follow up action in the medical notes.

24. Covert administration of medicines

24.1. If the resident repeatedly declines their medicines and you feel that they lack capacity, then in line with the Mental Capacity Act 2005 Code of Practice and guidelines from the Nursing and Midwifery Council, a decision can be taken to give medicines covertly (e.g., hidden in food or drink). This must be in a resident's best interests when they lack mental capacity and are unable to properly understand the consequences of not taking their medication. Covert medication should only be used in exceptional circumstances.

24.2. Use the **'Covert administration form'** to carry out and record the above.

24.3. Record the steps you have taken to help the resident decide if they want to take the medicine(s) For example:

- explain the benefits of the medicine(s) (in a way they can understand)
- explore/discussing their reasons for refusing
- Talk to a pharmacist to see if the timing and or form (like a patch or a liquid etc.). of the medicine can be changed.

24.4. Ask the prescriber and/or pharmacist to review the medication to establish which medicines are absolutely necessary.

24.5. Consider if the resident is likely to regain capacity (i.e. do they have a temporary illness affecting their capacity?).

24.6. Check to see if they have made a valid verbal or written "advance decision" to decline medical treatment". If no, proceed to the Mental Capacity Assessment.

24.7. **Mental Capacity Assessment:** An assessment of whether the resident has adequate mental capacity to understand that taking the medicine is in their best interests must be carried out. This must be carried out by someone who has received training in the Mental Capacity Act 2005. This is carried out where the resident has an impairment or disturbance of the functioning of their mind or brain which affects their ability to make the decision. It is to assess whether the resident understands what the medication is for and why they should take it.

24.8. **Best Interests Decision:** If it is established that the resident lacks adequate mental capacity to understand that taking the medication is in their best interests, a best interests decision will need to be taken. This is to decide the best course of action for the resident and to explore all options, including the risks/benefits of not taking the medication.

24.9. **Best Interests Decision:** The decision must involve the relevant resident's representative (RPR) who will be (in order of preference):

- any Care Attorney appointed under a Lasting Power of Attorney by the Court of Protection. If this does not apply, then
- anyone previously named by the resident lacking capacity as someone to be consulted, if this does not apply, then
- a close relative or close friend or anyone else interested in the resident's welfare. If there is no one then,
- an Independent Mental Capacity Advocate (IMCA)

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24.10. The Best Interests Decision must also involve:

- representatives from the Health or Social Care Service (the multidisciplinary team (MDT))
- the prescriber
- the registered manager (or a nominated deputy or a social worker)
- The person who made the mental capacity assessment

24.11. The following must be addressed at the Best Interests Decision:

- What has been found out about the resident's past and present wishes about taking these medicines? Is there anything that would affect the decision to give these medicines covertly?
- If medicines are to be given covertly, why is this considered to be in the resident's best interests?
- If giving medicines with food or drink, check with a pharmacist to see if you need to change the formulation (for example to a liquid) and check that the medicine(s) is/are not affected by food or drink.

24.12. Record the regular attempts you make to give the medicines normally (i.e. not covertly) on the **Covert Administration form**.

24.13. **Best Interests Decision:** a date should be set as to when to review this Best Interests Decision (maximum 12 months, although reviews may be needed as often as monthly if agreed by the best interest group).

24.14. Clear triggers should be identified that would require this decision to be reviewed sooner than this set review date. These triggers would include (but may not be limited to):

- any increase in dose (strength or frequency of administration)
- any additional medicine that needs to be given covertly
- any medicines that are substituted
- any fluctuation in mental capacity
- the physical state of the resident
- the type of medication

25. Crushing tablets/opening capsules

25.1. If it is felt that any tablets need to be crushed or capsules opened, then the pharmacist should be contacted to check if tablets can be crushed or capsules opened and medicines are stable enough to be mixed with food or drink. This can be verbal authorization, which can be written in the resident's care plan and backed up with a written signed and dated statement.

25.2. If a resident is crushing or opening their medications, or asking colleagues to do this then they should report this to the colleague in charge. This may indicate that the resident is experiencing swallowing difficulties or another problem that may need investigation by a relevant health care professional.

26. Disposal of medicines

26.1. Medicines which are due for return, for example expired medicines, completed courses and dropped medicines, should be kept separate from medicines in use. They should be clearly labelled and kept secure.

26.2. **Care homes without nursing:** Medicines should be returned to a pharmacy (preferably the pharmacy that supplied them). It is good practice to ask for a receipt of any medicines returned to the pharmacy. Colleagues must witness the returns log.

26.3. **Care homes with nursing:** The home is responsible for making arrangements with a clinical waste company for the removal and safe disposal of waste medicines. Two colleagues must witness the disposal.

26.4. Returned/denatured medicines should be disposed of on eMAR. Controlled drugs that are disposed of must also be recorded in the CD register.

26.5. In the event of the death of the resident, medicines should be retained securely for seven days in case they are required by the Coroner's office or courts.

27. Transportation of medicines

27.1. Medicines will only be collected if the pharmacy can't deliver them in time and treatment would therefore be delayed.

27.2. When collecting medicines, the colleague must take them straight back to the care home in case it's urgent.

27.3. During the journey medicines must be kept safe (e.g. out of sight in a vehicle) and not left unattended.

27.4. Medicines requiring refrigeration should be stable enough for a short single journey, but the colleague must check with the pharmacist in case it's a medicine that can't go over a certain temperature, make note of any advice given and actions taken in the transport log.

27.5. Colleagues must complete the transport log before leaving to collect medicines, so that it details what they are expecting to collect so it can be checked against at the pharmacy.

27.6. When collecting, the colleague should check the medicines and if there are any discrepancies between expected and received medicines, speak to the pharmacist to rectify, before they leave.

27.7. If collecting CDs, the colleague will need to take identification with them and sign for receipt.

27.8. When the colleague has returned to the destination, store them as per the care plan and book them in on the MAR and CD register (if needed)

27.9. Report any loss, delay, or damage to the manager who can investigate and arrange a new supply if needed.

28. When a resident leaves the service (on a long or short term basis)

28.1. When a resident attends a medical appointment outside the service, a copy of their MAR should accompany them, together with any other documents required. We do not send any medication with the resident, unless it is a medication that may be needed in an emergency, before the hospital pharmacy has a chance to dispense medication for that resident i.e., inhalers / EpiPen etc.

28.2. When a resident needs to go to hospital, all currently available prescribed medication should go with them (in the original container) along with a copy of the current MAR.

28.3. When a resident leaves the service, the colleague in charge should ensure they have enough medicines to take whilst they are away.

28.4. Any medicines handed back to the resident or a new care provider must be disposed of on eMAR with the disposal method 'returned to resident/family'. It is good practice to get a receipt from the resident/new care provider.

28.5. If possible, when medication is taken out on short trips, it should remain in its original packaging (with the pharmacy label on). There may be occasions when this is not practical or safe (e.g., large boxes and bottles). If this is the case, then a smaller supply must be obtained from the pharmacy, which can be taken on trips. Medicines must not be placed in envelopes or other types of temporary containers.

28.6. The medicines and their quantities should be recorded when they leave and return, using eMAR.

28.7. The medicines should be signed as 'social leave' and any exceptions added or edited on their return.

29. Controlled drugs

29.1. In line with legal and national best practice guidelines, the controls outlined in this section only apply to the following controlled drugs:

a. All schedule 2 controlled drugs (CDs)

b. Just these schedule 3 CDs: temazepam, buprenorphine, flunitrazepam and diethylproprion

29.2. Colleagues can check the British National Formulary (BNF) online which prints a CD symbol plus which schedule it belongs to (CD2) (CD3) (CD4) and (CD5) next the drug entry. This is the safest way of working out if it's a CD and which schedule it belongs to.

29.3. If colleagues collect CDs from a pharmacy, they may be asked to provide identification.

29.4. If the pharmacy delivers CDs, the driver must make colleagues aware that CDs are present so that colleagues know to record these in the CD register and store them in the CD cabinet.

29.5. CDs that are received, administered, and disposed of/returned, must be recorded in a CD register (CDR). This is a bound book or register with numbered pages. Each CD, for each resident, must be recorded on a separate page, with the name, dose and strength of the drug written clearly at the top of the page.

29.6. There is no need to keep a record in the CD register when the resident is wholly independent i.e., he or she is responsible for requesting a prescription and collecting the controlled drugs from the pharmacy.

29.7. CDs should be received, administered, and disposed of by two colleagues, one acting as a witness. The witness is there to protect their colleague from accusations of theft of the CD.

29.8. Both the colleague handling the CD and the witness must have received medicines training as well as training in managing and administering controlled drugs. They must have been assessed as competent using the **controlled medication competency assessment.**

29.9. When any entry is made in the CD register, the amount (the balance) of the CD must be checked and recorded in the CD register before and after each transaction. This should be done in the presence of the witness who will check the entry in the CD register is correct and then sign to say that they have witnessed this. Each entry shall be countersigned individually. Signing against groups of entries bracketed together must not occur.

29.10. For oral liquid CDs, measuring out what is left in the bottle after each administration is not required as some liquid remains behind in the measuring cylinder. Colleagues should wait until the bottle is empty and then check that the quantity signed out in the CD register matches the total amount taken out of the bottle.

29.11. When CDs are administered, the witness must accurately check the CD against the MAR and countersign the MAR after administration. The resident should not go without their CDs because there is not a suitable witness available, however administration without a witness should only ever be carried out extremely rarely (not as routine). The colleague must contact the manager on call for authorisation and the circumstances for administering without a witness must be recorded.

29.12. If a community nurse administers controlled drugs and they use a record that is not left in the care home, and they are not willing to make a duplicate record in the CD register, the witness (colleague) should complete this entry.

29.13. If CDs are stored, then the local manager is responsible for ensuring that the care home has a legally compliant CD cabinet. The requirements are of a technical nature requiring expertise and knowledge of construction. Therefore the manufacturer or vendor of the CD cabinet will specify that the product complies with the Safe Custody Regulations.

29.14. The manager (or someone delegated to) should undertake a regular audit to check entries have been made correctly and that the balance is correct; if a discrepancy is noted, the manager (or someone delegated to) should investigate and establish what has happened.

29.15. CD discrepancies should be immediately reported to the manager to undertake a full investigation and where appropriate inform the regulated authority/ the local CD Local Intelligence Network accountable officer and/or the police.

29.16. CDs that are self-administered by a resident do not need to be stored in the CD cabinet. They can be stored with the resident's other medicines in their locked cupboard/drawer. They do not need to be signed out of the CD register each time the resident self-administers a dose. If the colleagues order/collect CDs for a resident they should be logged into the CD register and logged out when given to the resident, even if this is a few minutes after receiving them.

29.17. **Care homes without nursing:** CDs that are no longer required or have expired must be promptly disposed of by returning them to the pharmacy. This must be recorded in the CD register and witnessed. A receipt of their return to the pharmacy must also be obtained. Their disposal must also be recorded on eMAR.

29.18. When disposing of a CD from a resident who was self-medicating, the CD must be received into the CD register before recording its return to a pharmacy.

29.19. **Care homes with nursing:** CDs that are no longer required or have expired must be promptly denatured. This must be witnessed and recorded in the CD register. Their disposal must also be recorded on eMAR.

29.20. When denaturing a CD from a resident who was self-medicating, the CD must be received into the register before recording its disposal.

29.21. CDs that are returned to the resident when they leave the service or when they transfer to hospital must also be recorded in the CD register.

29.22. The CD Register Book shall be retained for two years after the date of last entry (in line with regulation 23 of The Misuse of Drugs Regulations 2001), after which it may then be disposed of as confidential waste.

30. Training requirements and competency checks

30.1. All colleagues who provide general support or administer medication must receive medicines training from a training provider approved by the Learning and Development department.

30.2. Medication training should be attended every 18 months to two years as part of the Social Services mandatory training.

30.3. Colleagues must have their competence to administer medication checked at least annually using the appropriate competency check forms **(medication competency check form or topical / ophthalmic medication competency check)**.

30.4. Epilepsy training (including the administration of emergency rescue medication) must be updated every two years (in line with recommendations from the ESNA – Epilepsy Nurses Association).

30.5. Supervisors and competency assessors require training that provides guidance for safe handling of medicines in social care settings and for assessing competency of administration, risk assessments on medicines, carrying out audits and problem solving e.g. dealing with questions asked by colleagues.

31. Administration of medicines by specialist technique

31.1. The colleague should not undertake any duties which fall within the responsibility of a GP or nurse e.g., sutures or catheter removal. Colleagues not trained to prescribe must also not make any clinical decisions or judgments e.g., increase or change of dosage, regarding the administration of medication. If there is any change of circumstances relating to a resident's medication care colleagues must report it to the colleague in charge, a health care professional or a nominated person (e.g. next of kin).

31.2. There are certain medicines that may require training to administer them which has not been covered in colleagues' general medicines training. Examples may include emergency rescue medication for seizures, adrenaline injections, rectal and vaginal administration, injections, oxygen, nebules, medicines given via PEG or naso-gastric tubes. These are medicines that would normally be administered by registered nurses.

31.3. Additional training may be required by a registered nurse or healthcare professional. This training should be approved by Learning and Development.

31.4. The resident must agree that medicines requiring administration by specialist technique can be delegated to care/support workers.

31.5. There should be a care plan in place for any medicines requiring administration by specialist technique. This should detail any specific instructions on how to administer that medicine and manage their particular medical condition.

31.6. The training provider must either assess the competence of the learners on the day of the training or if they are unwilling/unable to do so they must state how competence will be assessed after the workshop and by whom.

31.7. The local manager must ensure that there are sufficient trained colleagues on duty at any one time to administer these medicines if required.

32. Oxygen

32.1. If colleagues are setting up oxygen, changing cylinders, administering oxygen or providing any other type of support with oxygen, they will need to receive extra training as it is considered to be administration by specialist technique. The oxygen supply company may be able to offer extra training.

32.2. Oxygen must not be stored within 10 feet of any naked flames or subjected to extremes of heat or cold. No smoking is allowed when oxygen is being used and warning notices prohibiting smoking and naked lights must be posted clearly in the cylinder storage area.

32.3. Oxygen must be stored in a well-ventilated area that is not used to store any other flammable or combustible materials, ideally this would be a secure outdoor location, however this may not always be possible. It must be stored upright, away from heat and light sources and secured in a way to prevent falling. Empty and full cylinders should be separated, and empty cylinders returned to the supply company promptly.

32.4. The number of cylinders stored should reflect the resident's needs. It is dangerous to store unnecessarily large quantities of oxygen.

32.5. In the event of any problems regarding oxygen, the oxygen supplier should be contacted.

33. Warfarin

33.1. People who are prescribed an anti-coagulant drug such as warfarin must have an 'Oral Anticoagulant Therapy Pack' (sometimes called 'the yellow book'). This is used by the Anticoagulant Therapy Clinic to record blood tests (called an INR test) and dosage directions.

33.2. Where colleagues administer warfarin, colleagues must ensure that they are able to see the resident's current blood test results (INR results). These results will state how many milligrams the resident needs. These blood test results and current dose must be kept with the MAR. The colleague in charge may need to contact the anticoagulant service to ensure that they receive these results.

34. Medication reviews

34.1. In line with NICE recommendations 1.8.2-1.8.5 care homes should request that the prescriber carry out a medication review once a year. This request should be recorded in the contact notes.

34.2. The GP might delegate the medication review to another health care professional (e.g. a nurse or pharmacist).

34.3. The care home colleagues may need to make a GP appointment for a medication review if the resident needs this and the GP is not responding to requests.

34.4. The service should identify people who may need more frequent medication reviews and highlight this to the GP, for example, people:

- entering the end-of-life phase
- with a recent diagnosis of a long-term condition needing frequent or complex monitoring
- who have been transferred to the service (for example, after hospital discharge)
- who are taking an antipsychotic

34.5. The home should try to involve the resident and/or their family or colleagues in the medication review.

35. Adverse effects

35.1. Colleagues should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional (such as the supplying pharmacist). They should also inform the residents' relatives (where appropriate).

35.2. Colleague in charge should record the details of the adverse effect using the yellow card scheme online: https://yellowcard.mhra.gov.uk/

35.3. They should also record this in the resident's care plan stating who was notified and when.

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36. Medication errors and audits

36.1. When an error occurs the most important things to establish are:

- Will the resident have suffered any harm?
- How do we minimise the chance of the error occurring again by learning from this and sharing the learning?

36.2. If an error with the administration of a medicine is identified the following procedure must be implemented:

- Firstly, assess the resident's immediate state of health, reassuring them and ensuring they are comfortable/at ease. Remain with the resident and ensure the error is reported to colleagues and manager.
- If it is felt the situation is a medical emergency, the colleague should dial 999 for the ambulance service. In all other cases:
- Colleagues should contact the pharmacist, GP or emergency doctor immediately for advice.
- Follow any advice given and record the instructions/advice received.
- Colleagues should inform a line manager / senior manager (on call manager if out of hours)

36.3. The family/relatives (as appropriate) should be informed of the error as soon as is practically possible.

36.4. To minimise the chance of the error occurring again, we wish to create a culture where colleagues feel able to report all errors and near misses. This ensures we learn from as many incidents as possible. The local manager is responsible for keeping a log of all errors which is used as a learning resource.

36.5. The colleague should complete the first section of the **Opportunity to Learn (OTL) form** and give it to the manager. The manager would then discuss the incident with the colleague and complete their section of the form. This form should then be stored in the resident's file.

36.6. The local manager (or someone they delegate) will work with any colleagues involved in the incident, to learn any lessons, change any systems, and spread the learning from the incident to other colleagues and managers to ensure continuity of best practice and recording procedures.

36.7. **Who to notify when a medicines-related incident is identified:** For registered services, the regulated authority and the relevant care management team should be notified when any medicines-related incident has caused either:

- **Harm or potential harm** to a resident. By harm we also include significant prolonged psychological harm.
- **Intent:** If the colleague intended the adverse consequences to occur as a result of the incident.

36.8. Services not registered with the regulated authority need only notify relevant care management team (not CQC) for the type of medicines-related incidents above.

36.9. The NHS Incident Decision Tree can be used to help managers decide initial action to take with colleagues involved in a patient safety incident. It is intended to promote a consistent and fair approach. The tool gives guidance through a series of structured questions about the colleague's actions, motives and behaviour at the time of the incident and leads to suggestions for appropriate management action.

36.10. To help with the reduction of errors and to monitor the safe management of medication, audits are conducted throughout the month, colleagues complete fortnightly stock checks of all inventoried medication and a timed medication variance check.

36.11. Every medication in the home where an inventory can be logged (this does not for example include creams and eye drops), is counted once every two weeks using the stock check on eMAR. The balance counted is checked against the balance expected on eMAR. If any discrepancies are found these are investigated.

36.12. If an explanation is found for the discrepancies the procedure for 'medication error' is followed. If no explanation is found, the medicine stock is counted every 24 hours for 10 days and recorded on the 10 day stock check form, this allows any recurrence of the error to be tracked to a 24 hour period which is likely to lead to a more informative investigation into the error.

36.13. Medication that needs to be given at a specific time e.g., medication for Parkinson's or epilepsy will be checked every month to ensure medicines are given within the prescribed period of time.

37. Non-prescribed medicines and homely remedies

37.1. For residents using the service who do not self-medicate, colleagues must obtain authorisation from a pharmacist or prescriber before administering any non-prescribed medicines (homely remedies), homeopathic preparations, vitamins, minerals or supplements and record this authorisation. This form should be re-checked annually and updated with the date this was re-checked.

37.2. Once agreement has been obtained, the non-prescribed medication must be added to eMAR and administered and recorded in the same way as prescribed medicines.

37.3. If the homely remedy is paid for by the resident, it belongs to them, a colleague must write the resident's name on it, and it cannot be shared with anyone else.

37.4. The care service must keep a list of non-prescribed medicines (for which confirmation of advice to administer has been obtained) and who they are authorised to give these to. This list must also record the expiry date of each homely remedy.

37.5. Alternatively, the care service can buy the non-prescribed medicine in which case it belongs to the care service and can be shared with others (so long as the residents using them have GP **authorisation for homely remedies**).

37.6. Only colleagues who have received medication training can administer homely remedies.

37.7. Homely remedies must be checked once a month to ensure that they are in date and the stock balance is correct. If out of date follow disposal of medications procedure.

37.8. A manufacturer's Patient Information Leaflet, where one exists, for each medicine or product administered to a resident, should be stored centrally and made available to colleagues administering non-prescribed medicines, as well as the resident receiving the medicine.

37.9. If the resident leaves the service e.g. to visit their family and non-prescribed medication is given during this time, the resident and/or their family should be encouraged to inform colleagues about this. Colleagues will also need to check if the resident returns to the service with any non-prescribed medication and if so, follow the above procedure.

37.10. If following discussion with the pharmacist the advice is not to give the non-prescribed medication, colleagues should record this on the resident's care notes, discuss with the resident and inform the colleague in charge.

37.11. Family and friends will be asked to inform colleagues of any medicines they bring into the building, so that all the correct procedures can be followed for this medicine.

38. List of forms referred to in these procedures:

- Covert authorisation form
- Opportunity to Learn (OTL) form
- Authorisation for homely remedies

Medication Policy

Forms

Appendix

Homely Remedies:

Home Name: .....

Drug	Use	Dose	Precautions
Paracetamol 500mg tablets and capsules **OR** Paracetamol oral suspension 250mg in 5ml	Mild pain relief Feverishness	1 or 2 tablets to be taken every 4 – 6 hours when required. Maximum of 8 in 24 Hours. Leave at least 4 Hours between Doses. **OR** 10-20ml suspension. Maximum dose of 80ml in 24 Hours. Leave at least 4 hours between doses.	Liver or kidney disease. Alcohol dependence Service user already taking a paracetamol containing product e.g. Co-codamol
Simple Linctus	Dry – irritating cough Sore throat	5ml to be taken three or four times a day	Diabetic – use sugar free version Liver disease May cause headache, upset stomach, diarrhoea
Gaviscon Liquid	Heartburn and acid indigestion	10 – 20ml after meal times and at bedtime	Low sodium diet Avoid taking at the same time as other medication especially special coated formulations, antibiotics, omeprazole, lansoprazole, iron tablets, digoxin. Check with Pharmacist first
Kwells® tablets, chewable 300mg tablet	Motion sickness	One tablet up to 30 minutes before start of journey.	
Strepsils Lozenges	Sore throat	Dissolve one lozenge slowly in the mouth every 2 to 3 hours. Maximum of 12 in 24 hours	Diabetic Allergic to aspirin
Senna Tablets, 7.5mg (e.g. Senokot®) Senokot® Syrup 7.5mg/5ml	Mild constipation	Take 2 tablets at night. Maximum of 2 in 24 hours. **OR** 10mls syrup at night. Maximum of 10mls in 24 hours	May cause mild stomach pains. May also colour the urine or stools
Loperamide 2-4 mg Electrolade® Oral powder	Diarrhoea	4mg followed by 2mg after each loose stool up to max. 16mg/24h 1 sachet in 200mls of water after every loose stool	

I agree to the above list of home remedies being administered at the discretion of the trained member of staff for residents currently residing at .....**for the maximum period of 48 Hours.**

Signed ..... Date ..... Review Date .....

Doctor ..... Practice .....

Covert Authorisation:

Home Name: .....

Name:	Date of birth:
What medication is being considered for covert medicines administration?	
Why is this treatment necessary? How will the person benefit? Could this treatment be stopped?	
What alternatives have been discussed/tried? Why did/will these not work?	
When was the Mental capacity assessment completed and by whom?	

Medication	Form	How to administer

Who is involved in this decision? Print and sign.	Practitioner:
	Relative/advocate:
	Carer:
	Pharmacist:
Review date for this decision:	

10 Day Audit Check:

Medication stock checks		Date:																					
		Time:																					
		Initials:																					
Residents name:	Medication being audited:		eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual	eMAR	Manual

Instructions: Count the number of tablets in stock and record in the boxes above. If the figure does not tally with the inventory on eMAR, highlight the figure and write down the names of the staff trained to administer medication that have been on duty since the last figure entered in the table below. Reconcile the inventory if incorrect. Inform the meds lead or manager.

Investigation:

Date correct figure entered	Date incorrect figure entered	Staff members on duty between two dates	Meds lead/manager informed

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Fire Risk Assessment : Emollients

Resident Name: ..... Room No: .....

Emollient Used:		Date of birth:
Risk Assessment	**Y/N**	**Comments/Actions**
Is the resident aware of the fire risks with emollients?		
Are family members/friends aware of the risks?		
Verbal or written information provided?		
Smoking		
Does the resident smoke?		
If yes, has the resident been offered smoking cessation support?		
If the resident wishes to smoke despite the risk, can we mitigate risk? e.g., flameless lighters		
Does the resident encounter anyone that smokes?		
Confirm and sign for advice provided not to smoke when using emollients		
Oxygen		
Does the resident use oxygen? **Caution: HIGH RISK**		
Does the resident use cream/ointment under their oxygen mask or nasal canula? Recommend a water-based lubricant instead (e.g. AquaGel)		
Smoking		
Risk of sources of flames, fire or ignition?		
How is clothing, bedding cleaned? (wash at higher temperatures more frequently)		
Are soft furnishings cleaned/protected in areas where the resident will be treated with emollients?		
Is fire safety information displayed in areas where the resident will be treated with emollients? See here: Emollients and risk of severe and fatal burns: new resources available - GOV.UK		
Is the resident, their relatives and care staff aware of what to do if they do not comply with fire safety advice during treatment?		

RISK: (circle where appropriate)	HIGH	MEDIUM	LOW
Recorded in the care plan: Y/N		**All actions complete: Y/N**	
Signed:		**Name:**	
Job role:			
Date:		**Review Due:**	

Transportation Log:

• Use this log before leaving to collect medicines – complete it with details of what you are expecting to collect.

• Note any pharmacist advice re. storage requirements for fridge items.

Resident	Medicine	Strength	Quantity	CD	Fridge	Collected Signature Date & Time	Pharmacist Advice	Delivered Signature Date & time

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