Central Bedfordshire Council

NHS Bedfordshire Clinical Commissioning Group

JOINT MEDICATION MANAGEMENT POLICY (ADULTS)

FOR DOMICILIARY CARE AGENCIES

Directorate:	Social Care, Health, and Housing (SCHH)		
Division & Service:	Adult Social Care: Care and Support		
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1. Introduction

1.1 The commissioning policy sets standards that are required of care staff and managers in the management of medication in domiciliary care agreed, between Central Bedfordshire Council and NHS Bedfordshire Clinical Commissioning Group. It provides guidance to support care organisations to develop their individual medicines policies.

1.2 Central Bedfordshire Council and NHS Bedfordshire Clinical Commissioning Group are committed to the delivery of excellent health care to vulnerable adults for whom they are responsible, either directly or through contractual arrangements. This means that:

- The council will, in partnership with NHS Bedfordshire Clinical Commissioning Group, ensure that the users of direct and contracted services receive the health care that they need.
- All service users who have the capacity to do so will receive the advice and assistance needed to manage their own health care.
- Carers for people without capacity will, where needed, be supported to manage the person's health care.
- Staff in both direct and contracted services will receive the appropriate training for handling medication and will not undertake any medication tasks outside the boundaries of this policy. (See Appendix 1).

2. Legislation and Guidance

2.1 This policy is based on Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission "Essential standards of quality and safety" March 2010 Outcome 9 Management of Medicines.

2.2 Care provider agencies shall ensure that all staff are working within the above legal framework and that Care Quality Commission registration standards in Outcome 9 are met.

2.3 The operational policy for the agency must include reference to all arrangements for the management of medicines in the service user's home in accordance with Outcome 9B of CQC essential standards. This will include reference to the following:

- roles and responsibilities (organisational / care workers)
- training and competency assessment
- seeking advice about medication issues
- service level agreements to manage medicines
- parameters and circumstances for care workers administering or assisting with medication
- record keeping
- accurate maintenance of personal medication records
- obtaining prescriptions
- disposal of medicines
- non-prescribed (over the counter (OTC) medicines
- safe keeping of medication
- incident reporting

2.4 Where an agency does not provide a service, e.g. it does not order, collect or dispose of medicines, this should be clearly stated in the policy document.

2.5 Central Bedfordshire Council adheres to the Schedule A, Service Specification, Personalised Domiciliary Care Services, contract agreement.

This policy is the agreed standard to which all domiciliary care provider policies and procedures should comply and will be referred to when any issues concerning the management of medication arises.

3. Principles of the joint policy

3.1 Whenever possible, service users should take responsibility for their own medicines. This preserves independence and freedom of choice. They should be empowered to self-administer medication wherever possible and be involved in planning their treatment to the maximum level of their capacity.

3.2 Medicines administration shall be safe, effective and timely and in a way that preserves the dignity and privacy of the individuals.

3.3 The best interests of the service user shall be considered at all times.

3.4 People who use social care services have freedom of choice in relation to their provider of health services and pharmaceutical care including dispensed medicines. Care staff who help people with their medication are trained as required by the Care Quality Commission. Training should include the learning outcomes described in Appendix 1 which fits with Skills for Care and QCF qualification framework including modules HSC3047 and ASM34.

3.5 It is essential that all who handle medicines are competent to do so and regularly assessed by senior staff to ensure good practice is being maintained. Any concerns must be raised promptly with the line manager who will take appropriate action together with healthcare professions in line with policies.

3.6 It is expected that all domiciliary agencies will follow the principles of this Medicines Policy in-line with their own policies and procedures in all aspects of medicines handling.

3.7 Staff shall respect the service user's right of refusal of medication. Any need for covert administration shall be addressed through the policy section on covert administration.

3.8 Staff should aim to minimise the risk to the service user of excess medication in the home environment and also wasted medicines, by identifying the presence of apparent excess medication. This may be indicative of inappropriate ordering of medication and a healthcare professional should be contacted to review.

3.9 If the service user has any unwanted medicines in excess of their need, disposal shall be agreed with the service user and then referred to an appropriate pharmacist. Carers shall not remove medicines from a service user's home without permission.

3.10 Care provider organisations shall maintain a register of signatures used by care staff in medication records

3.11 There should be accurate records kept of every action relating to medicines undertaken by a Carer.

3.12 Adherence to policies and procedures must be systematically audited at least annually or when new legislation is introduced, including identification of risks, to ensure that the agency is meeting the needs of each service user safely

4. Definitions

4.1 For the purposes of this guideline the terms below are explained:

Carers/ Care Staff /Care Worker/Provider The term 'carer' or care worker is used for a paid carer who is commissioned to provide appropriate care and support to a client/service user. For the purposes of this policy the care provided is medicines management.

Commissioners are those individuals who undertake commissioning, which is 'the process used by health services and local authorities to identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated'.

Health and Social Care Practitioners is used to define the wider care team, including care home staff (registered nurses and social care practitioners working in care homes), social workers, case managers, GPs, pharmacists and community nurses. When specific recommendations are made for a particular professional group, this is specified in the recommendation, for example, 'GPs'.

Medicines Administration Record is the term used to describe the chart used to record all current medication which is to be administered together with essential information as illustrated in the example provided.

Organisation includes all commissioners and providers (including care providers), unless specified otherwise in the text.

Pharmacist is used for all pharmacists, primary care pharmacists, care home pharmacists and supplying pharmacists. Primary care pharmacists work in the primary care setting and may have a role working with care homes. Care home pharmacists have a dedicated role working in care homes. Supplying pharmacists work in a community pharmacy or may be more remote suppliers operating from registered premises.

Service User/ Client is the term used for the person/people in receipt of care.

5. Responsibilities

5.1 This policy has been produced to clarify the responsibility of domiciliary care staff in undertaking medication tasks for service users. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2009) Regulations 2010 states that "The registered person must protect service users against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the obtaining,

recording, handling using, safekeeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity".

5.2 This policy applies to all agencies providing paid care in a domiciliary situation. This includes sheltered accommodation, supported living and extra care housing where care agencies are managing any aspect of medicines management.

1) Service User Needs Assessment

6.1) The referral process will include specific detail of the support required with medication administration (e.g. to prompt or to administer), all of which will have been part of the initial assessment process.

6.2) Care Agency Assessment

The care agency will complete their own pre - assessment in line with their own protocols. The support plan should be compiled and include clear instruction on the support to be provided which should be agreed with the service users and Carers. This should include:

- Assessment of potential risk factors.
- Consideration of the number and frequency of medicines to be administered and time allocations for carrying out the level of support to achieve this.
- Details of any known allergies and clinical effect (these should be noted on any Medication Administration Record MAR Sheets).
- Mental capacity assessments where appropriate
- Contact details for relevant healthcare service.
- Who is responsible for the collection of prescriptions and completion of MAR sheets.
- A review date as agreed with service users with on-going re-assessment which may be triggered by reports from Carers that service users are not managing their medicines.

The level of support needs around medicines management should be identified at the care assessment stage and recorded in the care plan.

6.3) A risk assessment should be completed at the assessment stage to decide if it is safe for medicines to be accessible to a service user. If an increased level of safeguard is deemed necessary this should be agreed and documented in the care plan.

All supporting agencies must be clear about the level of support they are to provide each individual. The service user must have a risk assessment to establish what the problems are with their medicines and how these problems will be overcome. The level of support is documented in the care plan.

Risk assessments should consider risks to the service user, care worker and care agency whilst maximising independence of the service user.

6.4) It should be recognised that cognitive functions decline with time. Carers should report to their line manager if there is an apparent decline in medication management by the service user so that a full review of risk assessment can be done.

2) Consent to Treatment

7.1) Service users have the right under common law to give or withhold consent to medical examination or treatment. This is one of the basic principles of health care. Service users are entitled to receive sufficient information in a way they can understand about the proposed treatments, the possible alternatives and any substantial risk(s) associated with the proposed course of action, so that they can make a balanced judgment.

7.2) Once the support needs for the management of medicines have been identified and agreed with the service user, the service user must agree to the care worker assisting with their medication in accordance with the agreed care plan. In the case of refusal the care worker must document and inform the line manager who will review and act in accordance with policy, as it may result in a detrimental effect on the service user's health.

7.3) The Mental Capacity Act 2005 (Section 5) makes provision for Carers (both family members and paid Carers) and health and social care professionals amongst others to receive statutory protection from liability for certain acts performed in connection with personal care, health care or treatment of a person lacking capacity to consent to those acts. The Act provides protection from liability, where caring acts or treatment can be shown to be in the best interest of the person for whom they are being carried out

7.4) Section 25 of the Mental Capacity Act enables anyone aged 18 or over while still capable to refuse treatment for a time in the future when they may lack capacity to consent or to refuse that treatment. The advance decision must be valid and applicable to current circumstances. If it is, it has the same effect as if the person has capacity. Healthcare professionals and any social care staff involved in providing treatment must follow that decision.

7.5) The assessment of an adult's capacity to make a decision about their own medical treatment, along with all other aspects of their care is a matter for assessment of capacity under the Mental Capacity Act 2005[i]. It is the responsibility of a doctor proposing to treat a service user, to determine whether the service user has capacity to give a valid consent and if they do not, whether it is in their best interest to receive the treatment.

7.6) As a final course of action when all other options have been tried unsuccessfully the ultimate best interest decision to administer medicines covertly must be one that has been informed and agreed by the team caring for the service user and relatives or advocates. Clear documentation must be available to Carers to support the individual decisions for covert administration and the continued need must be reviewed by the healthcare professionals on a regular basis. (See section on Covert Administration.)

7.7) A service user may be mentally incapacitated for various reasons. These may be temporary reasons, such as the sedating effect of medicines, or longer-term reasons such as mental illness. It is important to remember that capacity may fluctuate, sometimes over short periods of time, and should therefore be regularly reassessed by the clinical team treating the service user/client. This should be reflected in the care plan reviews.

3) Obtaining Medication

8.1) If the assessment determines that the service user does not have capacity to manage this task the care plan will include reference to procedures that are in place which cover:-

- Ordering medicines
- Obtaining medicines from a pharmacy or dispensing doctor

- Actions to be taken if medicines are unavailable
- Actions to be taken if medicines go missing
- Actions to be taken following transfer from other care settings like hospital discharge.

8.2) Specific arrangements shall be documented in individual service users care plans and the date of each intervention carried out by the agency will be recorded in the care plans.

4) Levels of Support

9.1) Providing any level of support in managing medication requires training. Care agencies are responsible for ensuring that their staff access appropriate training and are deemed competent to carry out the support that is necessary for the service user (see also section 19 Training and Appendix 1 Learning outcomes and assessment criteria).

9.2) It is possible that a service user may require several levels of support depending on their physical capacity. For example, they may be able to manage their tablets and liquids but unable physically to administer their eye drops or to apply their creams. This must be clearly identified in the personalised care plan.

9.3) Level 1 Support – General Support

1a) Prompt

- To prompt means to remind a Service User who has capacity to make their own decisions to take their medication or carry out a task. For example, to remind them to take their medication at a particular time or with food. The Service User will be responsible, in whole or in part, as detailed in the Care Plan for the safe management of their medication.
- A prompt could be the Care Worker saying to the Service User 'have you taken your medication yet?' or 'is it time to take your medication?' or similar and help the Service User as detailed in the care plan. For example, passing a container for the client to self-administer.
- Every instance of prompting should be recorded on the Daily Communication Record. There is no expectation of completion of a MAR Sheet.
- Any refusal of medication or evidence of confusion in the service user should be recorded in daily records and reported to the line manager for review of the care plan. This includes evidence of mismanagement, excessive medication and loose medication found in service users home.
- Family members or unpaid Carers could be asked by agency staff to highlight any deterioration also.

1b) Assist

- To assist means to physically help a Service User who has capacity and ability **to instruct the Care Worker on what it is they require**, for example, preparing Items for continence maintenance, opening a medication container or removing tablets from a pharmacy filled compliance aid. For someone unable to use their arms/hands this can include 'passing' the tablets to the Service User using a container **following the instructions of the service user**.

- All medicines are supplied in child resistant containers which can present a barrier to self- administration and can easily be rectified by informing pharmacy or dispensary that the service user cannot open the container. The pharmacist or dispenser can then supply a more suitable container which meets the needs of the client e.g. non child resistant closures.

- The Service User will be responsible, in whole or in part, as detailed in the care plan for the safe management of their medication. Assisting and prompting are not appropriate for service users who do not have the capacity to make decisions.
- Every instance of Assisting should be recorded on the Daily Communication Record sheet. There is no expectation for completion of a MAR Sheet.
- If a care worker suspects any confusion from the service user in instruction it should be reported to the line manager to review the care plan.

9.4) Level 2 Support – Administer

- To administer means to select, measure and give medication to a Service User or carry out a related task as specified in the Care Plan and in accordance with the directions of a prescriber. The Care plan will specify the tasks the Care Worker is able to undertake and their responsibility for ordering, recording, storing and disposing of the medication, in whole or in part.
- Administration of medication will only be agreed in special circumstances where an assessment under the Mental Capacity Act has determined that the a service user does not have capacity to make decisions for themselves regarding medication and cannot self-medicate, instruct others to prompt or assist or manage their medication. They do not have an appropriate family member or friend to help them and cannot be supported by assisting or prompting.
- Every medication administered by whatever route must be recorded on the MAR sheet and signed appropriately utilizing codes where necessary.
- Administering means taking full responsibility for ensuring that the service user is given medicine as prescribed.
- Staff must be appropriately trained and evidence of training and competency assessments available (see appendix 1).
- If the service user instruction appears unreasonable which has the potential to harm the service user this should be reported immediately to the line manager and documented in the daily record. For example, “can I take all of my Paracetamol at once?”.

9.5) Level 3 Support – Specialist Administration

Following an assessment by an appropriate healthcare professional, there may be a need for a care worker to administer medication by a specialist technique (listed below) which falls outside of the core learning outcomes (see appendix 1).

- Feeding through a naso-gastric tube or gastrostomy tube
- Administration of a prescribed medicine via a naso-gastric tube or gastrostomy tube
- Tracheostomy suction and emergency change of tracheostomy tube
- Injections (intramuscular or subcutaneous) with a pre-assembled, pre-dose loaded syringe; including insulin
- Testing of blood sugars for type 1 diabetes

- Catheter care
- Stoma care
- Rectal administration
- Vaginal administration
- Assistance with oxygen administration
- Buccal midazolam use
- Epipen® device

9.6) All of these procedures must be clearly identified by the care manager to ensure the care agencies can determine if they have appropriately trained care staff before accepting the care package.

9.7) If a service user needs specific support for a procedure listed above then the Carer must undertake training to meet the required competencies. This level of support needs to be agreed by the Service User where they have capacity or alternatively if a best interest decision needs to be made and include, their Carer where appropriate, the Commissioner, Healthcare Professional and the Provider. These are tasks in addition to core competencies and identified as specific to that Service User.

- The Care Worker will be trained by an appropriate Healthcare Professional to carry out the identified specialist task for the identified Service User, and signed-off as competent for this task by the healthcare professional. This is NOT a generic competence and CANNOT be applied to other Service Users. Care Workers must agree to provide the assistance and have the specialist training with the individual Service User they are to assist.

- The need for training would be identified by health and social care professionals and appropriate actions taken to support the needs of the service user and Carer.

- Monitoring and review must be carried out throughout implementation as deemed appropriate by the Health care professional. The dates for monitoring and reviewing must be recorded. The Healthcare Professional will continue to monitor and guide the Service User's health, Support Plan Summary, tasks and relevant activities relating to the Service User.

9.8) <u>Procedures not to be carried out by Care Agency Staff</u>

The following shall only be carried out by a registered health care professional:

- Injections which involve the preparation of medicines.
- Administering intravenous medicines
- Programming of syringe drivers.

Prompt or Assist only with

- Pre-assembled injection devices e.g. insulin in a pen-device

9.9) <u>Principles of Administration</u>

Wherever possible people in their own home should be responsible for looking after and taking their own medicines independently or with assistance as needed. The level of assistance required will have been assessed (see service user's needs assessment). This section covers only medicines that are administered by a route which falls within the core competencies of care workers.

The provision of medication is planned for a service user as part of their initial assessment plan. Details of current medication are determined from the most accurate sources as possible preferably the GP surgery or a medicines administration sheet produced by the pharmacist at the time of dispensing the current medicines. Where this is not possible care agencies will produce their own MAR sheets to record current medication (*See Appendix 3 for a sample MAR Sheet; See also Section 13, Record Keeping*).

9.10) Medicines Containers

Care workers will only provide medication directly from bottles or containers dispensed and labelled in accordance with the Medicines Act from a registered pharmacy or dispensing doctor.

If instructions for administration are unclear this must be reported to a line manager to obtain clarification from a healthcare professional.

If a compliance aid has been filled by a relative or friend of the service user, care workers shall not administer these medicines as their source and identity cannot be determined. This should not be confused with 1b assisting a service users who has capacity.

Any labelling must not be altered or removed. Where labels become detached the contents must be returned to the pharmacist.

There is no requirement for a compliance aid to be requested as all care staff should be adequately trained to administer medicines from a professionally dispensed and labelled source.

Identification of medication is most accurate from the original container labelled from the pharmacy or dispensing doctor. In addition, not all medicines are suitable for packing in compliance aids.

9.11) Awareness of Side Effects

CQC Outcome 9A prompts all providers to consider awareness that the medicines on occasions will have unwanted side effects upon a service user's health. Carers should be alert to unexplained changes in a service user's health especially if there have been recent changes in medication and report to their line manager to review and contact the prescriber or pharmacist.

9.12) When Required Medicines (prn)

Some medication is administered irregularly; "when required" medications (prn) are medicines which are given according to fluctuating medical need. Carers can only

administer these when there is a clear protocol for each medicine as a decision is required to administer. This direction will be supplied by the GP and will specify:[1]

- what it is needed for
- full dosage instructions
- and a maximum daily dose.

Intermittent dosing is often used for pain killers, laxatives and some creams (see appendix 3-template protocol for prn drugs). This dosage instruction is reliant on an assessment of need which may be appropriate for service users who have capacity but is more difficult for Carers to assess. **Difficulties with managing this direction should be reported to the line manager to review with GP as soon as possible.**
See also Record-Keeping section.

9.13) Practical Considerations

All domiciliary care agencies must be clear about the level of support they are to provide each individual. The service user must have a risk assessment to establish what the likely administration problems are with their medicines and how these problems will be overcome. The level of support is documented in the care plan.

- Prescribed medicines must not be administered to service users for whom these have not been prescribed. A medicine prescribed for a service user becomes his/her personal property as soon as it is dispensed and it is not permissible to administer it to another service user. This is particularly important when a husband and wife are being cared for in the same setting as it is easy to make an error. Particular care is needed in such situations.
- Care workers will only provide medication directly from bottles or containers dispensed and labelled in accordance with the Medicines Act from a registered pharmacy or dispensing doctor.
- Before administration, it is essential that the Carer checks the MAR Sheet to ensure that the medication has not already been given (or if appropriate check with client).
- Doses must not be varied from those specified.
- Offer the medication to the service user recognising the right of refusal.
- Medicines prepared for administration and subsequently not used or refused should be placed in a suitable container (e.g. envelope) and stored away from the service user's medicines. The unwanted medicines should ideally be returned to the pharmacy for disposal. Medicines not taken must be recorded on medication records together with reasons why medication has not been taken in care plan. (See section on disposal.)
- A drink of water or flavoured cold drink should be offered to assist administration of oral medication.

9.14) The Six Rights of Administration

- For Levels 2 and 3, support in administering medication the recommended procedure for the administration of drugs and medicines is to ensure that the 6 "rights"[2] are observed.

[1] NICE Guidance SC1 – Managing medicines in Care homes
[2] *Dimond 2003- Principles for correct administration of medicines British Journal of Nursing 12.11 682-5*

- **Right Service User:** It is essential that Care Workers correctly identify the Service User. The usual checks are name, address and date of birth.
- **Right Medication:** Select all of the correct medication for the Service User for the time of day. Even when medication is supplied in a Monitored Dosage System, there may be other medication in the fridge. Check all medication is within the expiry date which indicates when the medication is no longer to be used. Treatment with medication that is outside the expiry date is dangerous as medication deteriorates.
- **Right Dose:** Check the amount and frequency that the medication is to be taken. The directions from the prescriber are transferred to the Pharmacist's label and the MAR. These should match and be followed exactly.
- **Right Route:** Care should be taken NOT to make assumptions. Check the medication label and information leaflet which will explain HOW the medication should be taken. Some tablets, for example, are dissolved under the tongue or between the lip and top gum, not swallowed.
- **Right Time:** The Pharmacist label will detail the prescriber's instructions and should be supported by the medication information leaflet. As before, check this and if there is any doubt about the directions, contact the supplying pharmacy.
- **Right of Refusal:** A service user has the right to refuse to take their medication and this decision must be respected. However, refusal must be reported to a line manager and documented appropriately on the MAR sheet and daily record in order that healthcare professionals are made aware for any necessary actions to be decided.

10. Specific Medication

10.1) Controlled Drugs (CDs)

- These are medicines defined under the Misuse of Drugs Act 1971 and are subject to a range of additional legislation. CDs are categorised into Schedules which determine their level of control. When administering to someone in their own home the only significant CDs for the purposes of extra requirements are those in Schedule 2. They have the potential for abuse and consequently accountability is of particular importance. Best practice guidance suggests that the administration of Schedule 2 CDs should be witnessed.
- If there is any doubt of the level of control for a CD, team leaders must check with a community pharmacist. (Examples of Schedule 2 CDs are: d*iamorphine, morphine, fentanyl, oxycodone, methylphenidate, dexamfetamine, methadone* - this is not an exhaustive list).
- As part of an agreed package of care, it may be necessary for care workers to be involved in the management of controlled drugs.
- For administration purposes they should not be considered any different to any other medication and the same procedures should be followed.
- Care workers should be made aware of the issues relating to controlled drugs in the service users home. In particular, where a care worker is required under the care plan agreement to collect supplies of controlled drugs for service users, they will be asked for proof of identity and authorisation to collect the medication on behalf of the service user.
- Records of receipt and return to the pharmacist for disposal should be kept as an audit trail. If Carer notices CDs are going missing highlight this to the line manager.

10.2) Warfarin

- Service users who are administered Warfarin must have an oral anticoagulation therapy record card 'yellow book' issued from the hospital on discharge. They are more at risk of bleeds and bruise easily

- This yellow book records an important blood monitoring record called an INR which is controlled by dose changes.
- This yellow book must be available for administration. Warfarin medication must be given as prescribed and instructed in the yellow book.
- If the yellow book is not available the line manager should be contacted.
- The line manager should contact the appropriate anticoagulation service immediately if service is open or as soon as possible. Directions for dosing from the anticoagulant clinic/ nurse or doctor must only be accepted in writing (fax), signed & dated by the prescriber. The MAR Sheet must be updated clearly and the written confirmation must be filed in the service user's care file.
- In the event that warfarin dose is unclear and the yellow book is unavailable and no clinical guidance can be obtained (e.g. out of hours) the previous dose of warfarin should be given until the dose can be clarified. The care manager must obtain guidance from the service user's GP or anticoagulant clinic as soon as possible, ideally within 2 working days.
- The actual warfarin dose administered (indicating the number of tablets of each strength) must always be documented on the MAR Sheet (in addition to the Carer's signature and the time administered).
- The Warfarin record card (yellow book) is always needed when blood tests are done
- Carers who notice signs of excessive bruising should notify their line manager as soon as possible, who should inform the GP. Ideally these service users should be supported with a domiciliary anticoagulation service.

11. Swallowing Difficulties

If a service-user is experiencing difficulties swallowing any of their medication, the care worker should report this to their line manager who should then contact the pharmacist or GP to discuss options.

It is not acceptable for a care worker to crush or alter medication in any way without the instruction of a healthcare professional as detailed in the care plan. This is not covert administration as the service user is aware and in agreement.

12. Covert Administration

12.1) Covert administration is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. By disguising medication in food or drink, the service user is being led to believe that they are not receiving medication, when in fact they are.

The ultimate decision to administer medicines covertly must be one that has been informed and agreed by the team caring for the service user together with relatives or advocates who represents the service user's best interest. The care agency does not make this decision but can follow instructions provided they are supported by the appropriate documentation.

12.2) Disguising medication in order to save life, prevent a deterioration, or ensure an improvement in the person's physical or mental health, cannot be taken in isolation from the context of the rights of the person to give consent. Where it is clearly evidenced from

medical professionals that refusal to take medication will be extremely detrimental to the life and well being of the person being supported, appropriate guidance will be given to staff in administering medication. This will only be done following a capacity assessment of the person supported.

12.3) A clear distinction should always be made between those service users who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity. If the supported person does not have capacity then a Best Interest decision will be made by a Best Interest Assessor and the multi-disciplinary team involved in the supported persons care.

The Best Interest decision will be formally documented in the persons support plan. Guidelines will be completed on how medication will be administered and continually reviewed in this circumstance.

12.4) A clear distinction should be made between service users who request their medication to go into food or drink as this is not covert administration as client requested this.

12.5) Reference should be made to the Bedfordshire Clinical Commissioning Group Covert administration best practice guidance which provides details of legislation and templates for mental capacity assessments and best interest decisions documentation.

13. Self-Administration

Service users should be empowered to self -administer medication wherever possible and be involved in planning their treatment to the maximum level of their capacity.

13.1) Self-administration can include an element of prompting or assisting. (see also Level 1 support)

- A service user who wishes to self-administer their medication should be risk assessed for this task
- There are a number of ways in which medication can be supplied to facilitate self-administration. The community pharmacist should be consulted to advise on how to enable the service user to retain their independence for as long as possible
- Although the service user may be assessed as able to self-administer they may need assistance with other tasks such as ordering their medication.
- The risk assessment and support plan must clearly state the responsibilities being undertaken by the care agency.
- Suspected changes in capacity must be reported to the line manager for review.

14. Record Keeping

14.1) A record of the administration of medication by the Carer should be made on the MAR Sheet. This is applicable to Level 2 and Level 3 support.

Each service user must have a medication record on which must be recorded details of all medicines to be administered and the time of administration .This record should ideally be printed by the dispensing pharmacist or doctor.

14.2) It is important that only the current medication is recorded on the MAR Sheet as determined by the GP or pharmacist.

14.3) A MAR Sheet will not be required if care workers are prompting or assisting - level 1 (see section levels of support). The intervention should be recorded in the Daily Record.

14.4) For Level 2 and 3 support the MAR Sheet must be signed in the appropriate place at the time of administration. If an error is made in recording it should be noted in the daily records and the line manager notified

14.5) The label on the medication should correspond with the instruction on the MAR Sheet. Any discrepancies should be reported to the line manager for clarification. Instructions should be followed in line with administration policies.

14.6) "*When required*" medication should be offered to the client in line with the protocol and only signed on MAR Sheet if administered. Declining is not refusal as it is in accordance with clients needs at the time

14.7) The MAR Sheet will be the formal reference for the administration of medicines and must not be destroyed. When completed the record should be placed in the care notes of the service user and archived in line with care agency policy.

14.8) If a service user does not take his/her prescribed medicine, this must be recorded on the record sheet together with the reason in the daily record. In a case of vomiting or spitting out of the medication a further dose should not be administered and this should be reported to the line manager. If this is a regular occurrence the GP should be informed through the line manager as soon as possible.

It is important that records are accurate and auditable and that Carers recognise their accountability.

14.9) If the MAR Sheet includes a medicine that has not been supplied, care staff must check with line manager whether the prescriber has stopped the medicine, and if so, appropriate actions taken to indicate that it hasn't been administered and why. Ideally the providing pharmacist must be contacted by the line manager to update the service user's record & prevent the MAR Sheet being generated with out of date or discontinued items.

14.10) If the MAR Sheet contains a medicine that has not been supplied, but which the prescriber confirms is to continue, care staff must check why there is no supply.

If a medication has been prescribed, but is not listed on the MAR Sheet (e.g. if a service user has returned from hospital with new medication and no new MAR Sheet has been supplied) the care worker must contact the care manager. The care manager should contact the service user's GP as soon as possible to confirm what medication needs to be given. All communication must be documented.

The care worker can add the details of the prescription to the MAR Sheet following instructions from the line manager. This should be done only under exceptional circumstances where the service user would otherwise not receive their medicines or in line with the domiciliary agency's protocol.

Details of instructions received, with date, time and name of person instructing must be fully recorded in daily record and on the MAR Sheet.

15. Storage

15.1) Medicines should never be stored in areas of high temperature or moisture such as in a bathroom cabinet or near a radiator. Medicines should be stored with regards to service user safety and safety of children. Some medication may require storage in a fridge.

If a Carer notices medicines should be in a fridge but not being stored in fridge this should be reported to the line manager.

15.2) If an assessment has identified a risk of leaving medication accessible to the service user, clear documentation must be made in the care plan how they will be safely stored and the reasons for the extra storage.

15.3) All medicines should be stored in their original container:

- as dispensed and labelled by a pharmacist or dispensing doctor
- as purchased
- medicines should never be transferred by care agency staff from their original container to another container. Labels must never be removed. This is regarded as secondary dispensing and should only be undertaken by dispensary staff, the patient or an informal Carer (e.g. family member).

A few medicines, such as asthma inhalers, sprays for angina and adrenaline pen devices, must be readily available to the service user.

15.4) The apparent accumulation of large quantities of medication should be reported by the Carer to their line manager for review. The care agency managers should liaise with the service user GP and pharmacist in line with individual policies to address the issue of accumulation as this poses a risk and may potentially be a waste of public resources.

Where there are medicines in the home which should be disposed of as they are no longer required but the service user refuses to allow them to be returned to the pharmacy, a record should be made in the care plans and the incident reported to the line manager. The line manager should inform the GP to take further action.

Storage of any discontinued medication should be separate from currently administered medication to minimise the risk of incorrect administration.

16. Disposal

16.1) Unwanted medicines must always be disposed of through a community pharmacy or dispensing doctor.

16.2) It is not the responsibility of a Care worker in a domiciliary setting to remove any medication from a client's home. Relatives should be advised where possible and if it is considered a danger to the service user, the pharmacist or line manager should be informed.

16.3) If it is identified in the care plan as a risk to client, the Carer can take the unused medicines to pharmacy for disposal as directed by Line Manager. A full record of medicines removed must be documented in the daily record for accountability.

16.4) If a Carer identifies that a service user is stockpiling medication, to fit with the principle of minimising risk and reducing waste, a healthcare professional should be informed (via line manager).

16.5) If there are medicines in the home which should be disposed of as they are no longer taken but the service user refuses to allow them to be returned to the pharmacy, a record should be made in the care plans and the incident reported to the line manager. See also section on storage.

17. Dealing with Significant Events involving Medicines

17.1) As soon as incorrect administration is identified the line manager must be informed immediately with details of the service user concerned, the medication that was given incorrectly and whether their regular medication has also been administered.

17.2) The line manager will contact the prescriber or pharmacist for advice on the effects of the incorrect administration and whether the correct medication should be given if it has not been given already. If the incident occurs outside pharmacy/surgery opening hours the out of hours GP service should be contacted for advice.

17.3) The line manager will ensure that an internal incident report form is completed. A SOVA alert SV1 form submitted to SOVA team **if appropriate** in line with CBC SOVA policy. (see also 18.1) Where a procedural problem is identified as a risk, procedures should be reviewed. (See appendix 4 for an example of an incident reporting form.) If the incident involves issues with primary care healthcare professionals liaise with appropriate organisation otherwise ensure that internal procedures are followed.

The incident should be recorded and kept in the service user's care plan.

17.4) It is important that the agency should establish the cause of the incident and procedures may need to be reviewed to reduce risks of a repeated incident. Any incidents should be regarded as a learning process and should be shared with all care staff to raise awareness of safety issues.

17.5) Medication incidents may involve incorrect administration, omitted doses, duplicated doses, administration of discontinued medication and medication being lost or stolen amongst many other issues

18. Safeguarding of Vulnerable Adults

18.1) Any abuse of administration of medication procedures, (including covert administration not authorised by a healthcare practitioner) could be viewed as neglect or physical abuse under the *Bedford and Central Bedfordshire Multi-Agency Safeguarding Policy Practice and Procedures* and should be reported to Adult Services in line with safeguarding procedures.

Please refer to these procedures or contact the Safeguarding Adults team for advice if you are uncertain about whether or not to make a safeguarding alert in relation to medications management. The medication risk assessment flow chart may also assist you, which can be found at http://www.centralbedfordshire.gov.uk/health-and-social-care/safeguarding/safeguarding-adults.aspx

18.2) Any complaints about the standards of care provided by contracted services must be referred to the Central Bedfordshire Council Customer Relations team. Concerns about quality and standards of care providers should be raised with the Central Bedfordshire Council Contracts Monitoring team who will work with the provider to improve standards to the required level.

19. Interface Issues in Transfer of Care

19.1) On occasion the service user may go into respite care or hospital. It is important to be aware of possible changes to their medication on return to their home.
Service users recently discharged from hospital are at a higher risk of administration errors due to changes in medication. If a care worker notices a discrepancy or change in medication after a service user has been discharged from hospital, the line manager should be contacted.

19.2) If disposal of medicines is included in the support plan, the care agency should return any discontinued medication to the pharmacy as soon as possible.

19.3) If part of their role, the care worker should check arrangements have been made for any new prescription needed following changes in medication.

19.4) Care workers will not be responsible for transferring information when people are admitted to hospital or residential care and will refer this to the line manager.

19.5) Any service user going into hospital or respite care should ideally take their medication with them. Care workers can pack medicines for the service users to take.

19.6) If a client is visiting day care a safe process for the transfer of medicines or doses should be clearly agreed with the healthcare professional and documented in the care plan and absence noted on MAR Sheet as social leave.

20. Training

20.1) Appendix 1 details the core learning outcomes for all care workers and staff must be assessed against these outcomes. A record of the assessment should be evidenced in their personal development records.

20.2) An on-going training plan must be implemented as part of staff development and care agencies must provide appropriate support, training, assessment of competence and specify when reviews and further training are required e.g. spot checks and supervisions

20.3) The purpose of the competency assessment is to ensure the Care Worker can confidently and correctly prompt, assist or administer medication or carry out related tasks for the Service User in line with 'Outcome 9' of the CQC regulations. Organisations governed by other regulatory authorities should follow their own guidance on recording training and competence assessment. All training, observations and assessments should be recorded for service monitoring and audit purposes.

20.4) Once assessed as competent the Care Worker will be able to Prompt, Assist or Administer with the medication and related tasks listed below;

- Inhaled medication (e.g. for asthma)
- Oral medication and homely remedies in the form of tablets, capsules or mixtures. This will include controlled drugs and warfarin
- Medicated cream or ointment
- Patches
- Eye, ear or nose drops

21. Implementation and Monitoring

21.1) A key factor in implementing the policy is to ensure that all those involved in meeting the healthcare needs of service users receive appropriate training and on-going support to meet these needs.

21.2) It is recognised that people are cared for in a variety of settings. It is essential that the training is structured, but sufficiently flexible to reflect the differing ways in which needs are met and adapt to meet changes as they occur.

21.3) Induction training will be delivered when a member of staff/Carer joins the service. Specialist and on-going training will be provided on a one to one basis to meet the individual needs of service users. Healthcare professionals will provide the specialist training required to administer medication. All domiciliary care agencies are required to develop internal standard operating procedures to implement the policy and review its on-going application in practice by staff to reflect the requirements of their specific service user group.

21.4) The care agency must have internal audit processes which can demonstrate that care staff are adhering to processes within the policy. Completed MAR Sheets and daily records should be returned to the agency's central offices for regular audit purposes before archiving. Audits should assist in improving safety and care for service users and should include:

- a check of coding and completion of MAR Sheet for accuracy and at time of administration
- a review of regular administration of a "prn" medication to check understanding with Carer or review with healthcare professional
- a reflection of all medication issues coded on MAR Sheet such as refusal, swallowing difficulties, no medication available etc. on the Daily Record
- a check of the timeliness of Carer reporting problems line managers for discussion with healthcare professionals as detailed in this policy; such as regular refusal, accumulation of medication etc.

References

- Care Quality Commission (CQC) Guidance about compliance: Summary of regulations, outcomes and judgments framework. March 2010

- Commission for Social Care Inspection (CSCI) Professional Advice: administration of medicines on domiciliary care 2007

- Office of Qualifications and Examinations Regulation (OFQUAL) Register of Regulated Qualifications http://register.ofqual.gov.uk

- Regulation and Quality Improvement Authority: Guidelines for control and administration of medicines Domiciliary Care Agencies. January 2009

Appendices

Appendix 1: Learning Outcomes and Assessment Criteria

The following competencies are based on the Qualifications and Credit Framework (QCF) for level 3 assessments HSC 3047 and ASM 34 and should be assessed in line with Skills for Care and Development's QCF Assessment principles.

The training provider must ensure that the learning outcomes are delivered and assessment linked where necessary to the work place.

No.	ACTIONS
1) Understand the legislative framework for the use of medication in social care settings	
1.1	Identify current legislation, guidelines, policies and protocols relevant to the administration of medicines
1.2	Outline the legal classification system for medication
2) Know about common types of medication and their use	
2.1	Identify common types of medication and their effects
2.2	Identify medication which demands the measurement of specific physiological measurements (e.g. International Normalized Ratio (INR)
2.3	Describe changes to an individual's physical or mental well-being that may indicate an adverse reaction to a medication and appropriate action taken
3) Understand roles and responsibilities in the use of medication in social care setting	
3.1	Understand the roles and responsibilities of the GP, pharmacist, District nurse, care agency and care worker in supporting the use of medication
3.2	Explain where responsibilities lie in relation to use of 'over the counter' remedies and supplements
4) Understand techniques for administering medication	
4.1	Apply standard procedures for infection control
4.2	Safely manage medication in line with assessment of need detailed in care plan and in line with legislation and local polices.
4.3	Identify the required information from medication administration charts
4.4	Explain the types, purpose and function of materials and equipment needed for the administration of medication via the different routes
4.5	Explain the appropriate timing of medication e.g. checking that individual hasn't taken medication recently, timing is appropriate for care visits

4) Understand techniques for administering medication ***(Contd.)***	
4.6	Describe the routes by which medication can be administered

4.7	Describe different forms in which medication may be presented
5) Be able to receive, store and dispose of medicines safely	
5.1	Demonstrate how to receive and store supplies of medication in line with agreed ways of working
5.2	Describe how to dispose of out of date and unused or unwanted medication in accordance with legal and organisational requirements
6) Know how to promote the rights of the individual when managing medication	
6.1	Explain the importance of the following principles in the use of medication:- - consent - self-medication or active participation - dignity and privacy - confidentiality
6.1	Explain the importance of the following principles in the use of medication consent self-medication or active participation dignity and privacy confidentiality
6.2	Explain how risk assessment can be used to promote an individual's independence in managing medication
6.3	Describe how ethical issues that may arise over the use of medication can be addressed
7) Be able to support use of medication	
7.1	Demonstrate how to access information about an individual's medication
7.2	Demonstrate how to support an individual to use medication in ways that promote hygiene, safety, dignity and active participation and in accordance with care plan.
7.3	Demonstrate strategies to ensure that medication is used or administered correctly
7.4	Demonstrate how to address any practical difficulties that may arise when medication is used
7.5	Demonstrate how and when to access further information or support about the use of medication
8) Be able to record and report on use of medication	
8.1	Demonstrate how to record use of medication and any changes in an individual associated with it
8.2	Demonstrate how to report on use of medication and problems associated with medication, in line with agreed ways of working

Appendix 2: Example Medication Administration Record (MAR) Sheet

The MAR Sheet lists a service user's medicines and doses along with spaces to record when the doses have been given and to specify exactly *how much* is given when the directions state, for example, 'one or two'.

It is also important to keep a record when prescribed medicine has *not* been given. Reasons for when medicines have *not* been given can be recorded using different letter 'codes'. The MAR Sheet must explain what the codes mean. There should be no 'gaps' on a MAR Sheet.
The information on the MAR Sheet will be supplemented by the person's care plan. The care plan will include personal preferences, including ethnic issues such as whether the worker who gives the medicines should be the same sex as the person.

The MAR Sheet can be a useful tool for the care provider to keep track of medicines that are not requested every month but only taken occasionally. The provider can use the MAR Sheet to record medicines carried over from a previous sheet.

Neither the pharmacist nor the dispensing doctor is required to provide MAR Sheets but may be prepared to provide them on request.

People may choose to select a pharmacy that does provide MAR Sheets.

MAR Sheets used in care homes and home care settings look similar to 'prescription' charts used in hospitals but they are not equivalent to the prescription chart. The MAR Sheet is only a record of what staff administer to people who use care services and belongs to the care provider. It is not a chart for prescribing medicines.

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MAR Sheet (Part 1)

Forename		Start Date	
Surname		End Date	
Date of Birth		Known Allergies	
Address 1		Doctor	
Address 2			
Address 3			
Post Code			

Medication Details	Week Commencing _____									
	Day									
	Time	Dose	Adm	WT	Adm	WT	Adm	WT	Adm	WT
	Received		Returned		Returned by		Returned by		Returned by	
	Received		Returned		Returned by		Returned by		Returned by	
	Received		Returned		Returned by		Returned by		Returned by	
	Received		Returned		Returned by		Returned by		Returned by	

Codes to be used:

R - Refused T - Taken NT - Not Taken Adm - Administrate by WT - Witness by C – Hospitalised

D - Social Leave E - Refused and Destroyed P – Prompt NR - Not Required M - Made Available

Central Bedfordshire Council

NHS Bedfordshire Clinical Commissioning Group

Sample MAR Sheet

Forename		Start Date	
Surname		End Date	
Date of Birth		Known Allergies	
Address 1		Doctor	
Address 2			
Address 3			
Post Code			

Medication Details	Week Commencing _____					
	Day					
	Time	Dose	Adm	Adm	Adm	Adm
	Received		Returned	Returned by	Returned by	Returned by
	Received		Returned	Returned by	Returned by	Returned by
	Received		Returned	Returned by	Returned by	Returned by
	Received		Returned	Returned by	Returned by	Returned by

Codes to be used:

R - Refused T - Taken NT - Not Taken Adm - Administered by C – Hospitalised

D - Social Leave E - Refused and Destroyed P – Prompt NR - Not Required M - Made Available

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MAR Sheet (Part 2)

Date	Reason for Refusing Medication	Action Taken

Date	Information Relating to Medication Issues	Action Taken

Appendix 3: Protocol for PRN Medication Administration

A protocol is needed for EACH client for EACH prn medication

Name of Client: _____

Date of Initial Prescription: _____

When required (prn) medication is medication which is not considered necessary for regular administration and is administered according to need. Service users who have capacity will indicate need for themselves but it can be appropriate for Carers to discuss with client and note in daily plan the outcome of the discussion. **Regular administration of a prn medicine should be reported to line manager as the doctor may need to review the dose and condition of the client.**

PRN medicines may be pain killers, laxatives, creams and it is helpful for Carer to know why they may be needed.

Client should be asked if they require this medication – do not record as a refusal on MAR but note in daily record. Sign only if administered.

Name of Medication:	
Dose and Route (e.g. Oral):	
Frequency of Administration:	
Maximum Dose in 24 Hours:	
Minimum Time Between Doses:	
Reason for Giving Medication: (*including as much information as possible)*	

Appendix 4: Example of Incident Review Form

Incident Review Form		
Client Name:		
Date Incident Occurred:		
Date of Meeting When Incident Discussed:		
Staff Present: *(Team members who were stakeholders in the event)*	Name	Post Held
Meeting Chaired By:		
Minutes Taken By:		
Date Incident Occurred:		
Summary of Effect Client and/or Carer:		
Describe what happened to cause the incident.		
Why do you think it happened?		
Did it involve GP access, District Nurse access or Pharmacists (or medication access)? *(If YES, please liaise with appropriate organisations and note date and who)*		
What actions (if any) were implemented?		