

# Care Home

## Policy & Procedures for the Handling of Medication

Title	Page
1. Introduction and Scope.....	3
2. Policy Aims.....	3
3. Responsibilities.....	3
4. Obtaining Medication.....	3
4.1 Ordering Procedure.....	3
4.2 Procedure on Receipt.....	4
5. Record Keeping.....	4
6. Audit Trail/Stock Rotation.....	4
7. Storage Requirements.....	4
7.1 Medicines Requiring Refrigeration.....	5
7.1.1 <i>Insulin storage/recording</i> .....	5
7.2 Oxygen storage.....	5
7.3 Storage of Test Kits.....	6
7.4 Expiry Dates.....	6
8. Administration of Medication.....	6
8.1 Procedure for Administration.....	7
8.2 As Required Medication.....	8
8.3 Administration Specialised Techniques.....	8
8.4 The Use of Measuring Devices.....	8
8.5 Anticoagulant Medication.....	8
8.6 Antipsychotic Medication for People with Dementia.....	8
9. Adverse Drug Reactions.....	9
10. Alterations to a Medication.....	9
11. Additional Requirements for Controlled Drugs.....	9
11.1 Procedure for the Administration of Controlled Drugs.....	10
12. Self Administration.....	10
13. Residents' Rights & Preferences.....	10
13.1 Resident Consent.....	10
13.2 When a Resident Cannot Give Consent.....	11
13.3 Emergency Medication.....	11
14. Covert Medication.....	12
15. Crushing Tablets.....	12
16. Disposal.....	12
16.1 Method of Disposal.....	12
16.2 Medical Device/Medicines Alerts.....	13
17. Homely Remedies.....	13
17.1 Individual Resident's Purchased Medication.....	14
18. Staff Training.....	14
19. New Residents/Residents Leaving.....	14
19.1 Resident Arrival.....	14
19.2 Resident Leaving.....	14
20. Medication Error.....	15
21. Misuse/theft.....	15
22. Leave Medication.....	15
22.1 Admission to Hospital.....	16
23. Out of Hours Medication.....	16
24. Use of Nutritional Supplements.....	16
25. Use of Wound Care.....	16
26. Authorised Inspection.....	16

## 1. Introduction and Scope

The policy and procedure covers the prescribing, ordering, storage, administration, and therefore forms an important part of the risk and medicines management strategy. It will be reviewed regularly.

The policy takes into account the requirements laid down by the Medicines Act 1968, The Misuse of Drugs Act 1971, The Misuse of Drugs (Safe Custody) Regulations and subsequent amendments to these, The Nursing and Midwifery Council Guidelines for the Administration of Medicines and The Care Standards Act 2000.

It also reflects the recommendations made in the NPA Guide to Good Practice in the Management of Controlled Drugs in Primary Care (England) Second Edition February 2007, the Handling of Medicines in Social Care - Royal Pharmaceutical Society of Great Britain, The Mental Capacity Act 2005 and the Nursing & Midwifery Council Guidelines.

It applies to all individuals within the home.

## 2. Policy Aims

The aims of this policy are to:

- Set out the principles by which medicines are managed in line with Department of Health standards and legal requirements.
- Ensure that all members of staff working within the home are aware of their roles, responsibilities and limitations.
- Manage the risks that medicines can pose to residents and staff.
- Ultimately ensure that residents receive their appropriate medication safely and effectively.
- Provide a structured framework to enable lines of responsibility to be clear and comprehensible

## 3. Responsibilities

It is the responsibility of the Registered Manager to ensure that all staff are aware of this policy and that suitable training is made available in order that correct and safe practice is carried out at all times.

It is the responsibility of each member of staff to be accountable for their actions in relation to the procedures within this policy.

## 4. Obtaining Medication

All medication will be ordered by the Care Manager, appointed deputy or named staff members.

Staff must ensure that they inform Care Manager if any medication appears to be in short supply.

All medication should be re ordered using the repeat prescription form that comes with each prescription and taken to the GP practice concerned.

Under no circumstance should a verbal prescription be used unless confirmed in writing.

The supplying pharmacy is .....

The pharmacist at this chemist is ..... Tel: .....

The GP practice used is ..... Tel: .....

Out of hours and information can be obtained by contacting – NHS Direct – 0845 46 47

The emergency out of hours service is SHROPDOC 08450 20 21 31

### 4.1 Ordering Procedure

Insert procedure here.

#### **4.2 Procedure on Receipt**

When new medication arrives at the home it must be checked at the earliest possible opportunity by the allocated named member of staff to ensure that all details are correct.

The check will include:

- All of the details on the medication label and on the Medication Administration Record (MAR) chart, these must mirror (See also Record Keeping)
- Storage conditions
- Expiry dates

In addition, any controlled drugs must be recorded in the *Controlled Drugs Register* by two people.

#### **5. Record Keeping**

A *MAR chart* will be maintained for every resident in the home. The *MAR charts* will contain the following information:

- Resident's name
- Name of home
- Allergies (including 'non known')
- Name of GP
- Medication prescribed
- Route of administration
- Time of administration
- For 'when required' medicines, the maximum dosage in twenty four hours

A record as to whether the resident can usually consent must also be retained.

Any hand written entries on the *MAR charts* must be checked for accuracy and signed by a second trained, designated person.

Details of the administration of medicines will be recorded for each resident on his or her *MAR chart* at the time of administration and not prior to or at a later date.

The care manager is responsible for making sure that all records relating to medicines are kept correctly and retained for at least 3 years after date of the last entry.

#### **6. Audit Trail/Stock Rotation**

All medication retained within the home must be accounted for at all times with a paper trail as verification.

Regular, weekly audits will be documented on the *Audit Sheet Appendix A*

For eye preparations (and others where indicated) the date of opening must be recorded on the label and the contents discarded and recorded after the specified time has lapsed.

Advice from the supplying pharmacist must be sought if there is any doubt as to the expiry of any medication. Where a medicine has an inner and an outer container, such as liquids, creams and ointments, the pharmacy label must be applied to the item instead of, or as well as the outer box.

#### **7. Storage Requirements**

When a resident chooses to administer their own medicines, a lockable drawer or cupboard will be provided in their room for this purpose. The resident is responsible for the security of the key. A spare key will be kept to use for emergencies with the permission of the resident.

Other medication not requiring cold storage or controlled drug requirements will be stored in the designated robust cabinet secured by lock and key. This will provide space for each individual resident to have their medication grouped together and internal and external medicines stored separately. This cabinet will be used only to store medication.

The keys to this cabinet will be on a separate ring reserved solely for this purpose and be kept by the Care Manager or designated senior person, on their person. Duplicate sets of keys will be limited and any unresolved loss of keys must be followed with a change of locks.

For certain conditions, such as asthma, it may be necessary for residents to carry their medication with them at all times. The GP will advise when this is the case and this must be documented on the *MAR chart*.

Non fridge items must be stored according to conditions required by the manufacturer. This is commonly below 25°C however, information pertaining to storage requirements can be found on the packaging or in the *Patient Information Leaflet* provided with the medication.

(See also *Special Requirements for Controlled Drugs*).

### **7.1 Medicines Requiring Refrigeration**

Medicines requiring refrigeration will be stored in the specified medication fridge which must remain locked. When medication is in this fridge it must be maintained at a temperature of between 2-8°C. A maximum/minimum thermometer must be used to ensure this. The fridge temperatures are to be checked and the minimum and maximum reading recorded daily on the *Fridge Temperature Recording Sheet Appendix B*. It must be remembered to re-set the minimum/maximum thermometer on each occasion. The fridge must be defrosted regularly and a record of this maintained.

In the event of the thermometers highlighting the fridge not maintaining the correct temperature, advice must be sought from the pharmacist and if necessary all stock must be disposed of as outlined in *Disposal of Medicines* and a new supply obtained with as little disruption to the continuity of care of any residents as possible.

#### **7.1.1 Insulin storage/recording**

Unopened insulin it is to be stored in the refrigerator but should be removed for at least an hour prior to administration for better comfort and efficiency, and can be stored safely for up to twenty eight days or 6 weeks (depending on the manufacturer) out of the refrigerator once it is in use.

Some manufacturers suggest that, to prevent constant fluctuation of temperature, it is good practice to store all opened insulin at room temperature within the recommended time scales. However care must be taken to ensure that the temperature of the room remains below 25°C.

As with all other medications, it is essential to check the expiry of insulin when it is received into the home and prior to administration.

When records of insulin are made it must be ensured that the wording 'units' rather than abbreviations i.e. 'U' or 'UI' are used.

**In all cases the manufacturer's recommendations for storage must be adhered to.**

### **7.2 Oxygen storage**

Oxygen will be prescribed for each individual Resident if the prescriber considers it necessary. Advice on storage and administration may be obtained from the supplier but the following guidelines should also be followed:

- Cylinders must be stored under cover and not subject to extreme temperatures
- The storage area must be clean, dry, well ventilated and away from highly flammable liquids, combustibles and sources of heat and ignition
- Cylinders must be stored upright and secured by way of a chain to the wall
- Empty cylinders must be stored separately and easily distinguished from full cylinders
- The statutory warning notices must be displayed in any room/area where oxygen is used or stored
- Oxygen therapy must only be discontinued or the flow rate altered by the direction of the prescriber

- Equipment must be handled by trained staff or under the supervision of trained staff only
- Regular stock checks will be carried out with particular attention paid to expiry dates
- A record should be made on the MAR chart the same as with any other medication

In addition the pharmacist may be contacted by the Care Manager to discuss any further recommendations regarding the use of Oxygen.

### 7.3 Storage of Test Kits

Testing kits for urine and blood are stored in the cupboard used to store external preparations. The expiry dates of these kits will be checked on a regular basis and prior to immediate use.

### 7.4 Expiry Dates

Particular attention should be made to the expiry times for medications. Frequently these are not displayed on the outer packaging of certain items such as eye drops and eye ointments. Most eye drops need to be discarded after four weeks of opening however some expire after two weeks therefore, as with all medications; it is essential that the patient information leaflet is consulted. If in any doubt the supplying pharmacy should be contacted for advice.

## 8. Administration of Medication

Staff will only be permitted to administer medication to residents once they have been suitably trained and deemed competent by the person in charge. *The Staff Competency Audit Sheet Appendix C* will act as a record of this competency. Administering staff will be asked to familiarise themselves with this *Medication Policy and Procedures* manual and sign an agreement entitled *Confirmation of Policy Appendix D*.

Medication administered to residents must be done so in the way and at the time that the prescriber intends. The prescriber's directions will be on the printed label attached to the medication. Additional information can be found in the *Patient Information Leaflet* provided with the medication. If there are any queries regarding the way in which the medication is to be given, the prescriber or pharmacist must be consulted for advice.

To avoid errors with the administration of medication, the following MUST be adhered to:-

- Medication must only be administered when prescribed and not left in pots on the side/tables/trays etc.
- When not in use the medication cupboard must be locked and the key held by the person responsible.
- Any medicines which appear to be in short supply must be reported to the Care Manager immediately.
- A record must be made on the *MAR chart* directly AFTER they have been taken. If for any reason medication is not given or refused, the reason for this must be marked clearly on the *MAR chart*. Any refusal should also be documented in the resident's *Care Plan* and the Care Manager informed. A key at the bottom of the *MAR chart* shows the correct symbol to use. Regular refusals must be reported to the resident's GP by the Care Manager or nominated member of the care team.
- Administering staff must confirm the identity of the resident that is to have the medication. This can be done by checking the *Care Plan* or *MAR chart* where a photograph is held, asking the resident to confirm their name and asking another member of staff to confirm the identity. Under no circumstances should medication be given if there is uncertainty as to the resident's identity.
- The *MAR chart* should be used to check the residents' name, medication, its dose and frequency against the name, medication, its dose and frequency on the medication label. The two must mirror. If there is any discrepancy, clarification must be sought from the prescriber before medication is administered.
- All staff should note how each medication that they deal with is given i.e. oral, inhaled etc.
- It must be ensured that the correct device used for the process, i.e. British Standard stamped measuring spoons/oral syringes. And if the manufacturer states that these are to be used for single use only, this must be adhered to.

- Where there are several drugs in one slot of a monitored dosage system, staff should ensure that the correct number is in each slot before and after administering and report any discrepancies immediately to Care Manager prior to administering the medication.
- Any discrepancies will be dealt with by the Care Manager who will liaise with the appropriate authorities i.e. GP, pharmacist.
- Controlled drugs must be administered involving two members of staff, one to administer and one as a witness. A record must be made on the *MAR chart* **and** in the *Controlled Drug Register*. (See also *Procedure for the Administration of Controlled Drugs*).
- If a medication error should occur it must be reported to the Care Manager immediately. (See *Medication Error* for the procedure to follow).
- It is the responsibility of all staff to ensure that they are familiar with the policy and the system of medication administration.
- Careful consideration to the necessary time lapses required between medications must be made.
- Provision must be made for medicines required at times out of the usual round times.
- Staff should be aware of the medication they are administering to residents, monitor the condition of the resident following administration and call in the GP if there is concern about any change in condition that may be a result of medication.
- Medication reviews must be prompted on a regular basis.

### **8.1 Procedure for Administration**

Assemble all equipment before starting the round i.e.

- Appropriate monitored dosage pack (if used)
  - regular medication which has not been provided in the monitored system
  - PRN or short course treatment
  - Medicine cups and water to drink
  - The *MAR chart* folder and pen
- Identify the first resident and check allergy and care notes.
  - Ensure resident is comfortable and ready to receive their medication.
  - Obtain consent from the resident (see paragraph 10.1 regarding consent)
  - Check the *MAR chart* entry against the medication label – it is imperative that the *MAR chart* mirrors the medication label.
  - Clearly identify medication and understand dosage requirements.
  - Place the correct dose directly into a medicine cup and offer immediately to the resident.
  - Once taken by the resident, sign the *MAR chart* in the correct column by the correct medication and administration time.
  - If a dose is not taken or has been missed for any reason, note this using the codes on the base of the *MAR chart*.
  - After checking that all medication has been given to the resident and correct entries made on the *MAR chart*, repeat for the remaining residents.
  - In the case of “as required” medication, a check that the medication is required should be made with the resident and if so the amount and time given must also be documented on the *MAR chart* and in the *Care Plan*. Extra care must

be taken in these cases to ensure that the medication has not already been administered by another care worker. (See also As Required Medication).

- When a variable dose is prescribed e.g. “one or two tablets” the quantity taken must be documented on the MAR chart.

### **8.2 As Required Medication**

In the case of Medication prescribed to be taken “when necessary” or “when required” (PRN) the indication must be made clear on the medication label, on the MAR chart and in the Care Plan. In addition the maximum dosage in twenty four hours and the necessary time interval between dosages must be annotated on the MAR chart. Clear instruction must be obtained from the prescriber as to the indications for the medication and under what circumstances it may be administered. It must be agreed between the resident and care team as to how this medication will be requested and/or offered. As with other medications a check must be made that a dose has not already been administered by another care worker.

Following administration of a PRN medication the outcome for the resident should be noted and monitored in order to form a comprehensive picture of care and support future consultations with the prescriber.

It is recommended that any PRN medication must not be supplied in a Monitored Dosage System (MDS) but supplied by the pharmacy in its original packaging. Current, surplus PRN medication which is still within its expiry date should be carried over to the next month. It must be ensured that a record of the medication carried over in this way is made on the MAR chart to complete the audit trail.

### **8.3 Administration using Specialised Techniques**

Care staff in the home must not undertake any tasks which properly fall within the responsibilities of the community nursing services e.g. the administration of injections and enemas and the insertion of catheters. With specific training from the appropriate healthcare professional certain procedures such as the injection of insulin or rectal administration of diazepam for an epileptic seizure may be carried out by care staff. However the member of staff involved must be willing and comfortable with the procedure and reserve the right to decline the responsibility of medication administration using specialised techniques if they feel they are not wholly prepared and comfortable in doing so.

### **8.4 The Use of Measuring Devices**

It must be ensured that any measuring device is accurate and that if it displays the symbol for single use only, this must be adhered to. Generally oral syringes supplied with medication are for single patient use and not single use, but if there is any doubt the supplier must be contacted for advice.

It is essential to use the correct type of syringe for the route of administration. An appropriate oral/enteral syringe should be used to measure oral liquid medicine if a medicine spoon or graduated measure cannot be used. An intravenous syringe must not be used to administer oral liquid medicine and enteral feeds.

### **8.5 Anticoagulant Medication**

Additional information will be provided when this type of medication is prescribed and regular INR (blood clotting) monitoring will take place. It may be necessary for residents requiring dental or foot treatment to have a blood test prior to treatment, therefore the healthcare professional i.e. dentist/chiropractor or other should be notified of the medication as soon as possible and at least three days prior to treatment. The literature provided with the medication must be consulted for additional guidance and the prescriber/supplier contacted for further advice.

It must be ensured that care staff communicate with the relevant healthcare professionals and seek specific training in this area if needed.

### **8.6 Antipsychotic Medication for People with Dementia**

It is possible that these types of medication may need more frequent monitoring and it must be ensured that the prescriber is consulted to determine this. There are serious concerns over the widespread prescribing of antipsychotic medication over

long periods of time and therefore the home must prompt a review if necessary. It is a requirement of the Mental Capacity Act that the resident and those involved in the care of the resident should be available to discuss the situation, such as the risks and benefits of the medication. Directions must be full and complete and care staff must understand when it is necessary to administer the medication. Dementia training must be available to all the care staff.

## 9. Adverse Drug Reactions

Medication is chosen to produce a specific effect, however unwanted side effects may also occur. In the event of an adverse reaction to medication the senior in charge must be notified and advice sought from the appropriate source:

- Resident's GP
- SHROPDOC
- NHS Direct
- Renal or Anticoagulation unit at the Royal Shrewsbury Hospital

Healthcare professional advice must be followed and the resident's progress monitored. The event must be documented on the MAR chart and in the resident's care plan.

## 10. Alterations to a Medication

Direction by a GP to alter a dose or stop medication may occur either during a GP visit or via a telephone conversation. Written confirmation of the change must be requested whenever possible.

Instruction given over the telephone by the doctor must be noted by the Care Manager on the resident's care plan and MAR sheet and the doctor requested to initial this change on his/her next visit to the home.

Where possible a conference/speaker facility on the telephone in a private room should be used to enable two senior care workers to verify the direction. In any case, to limit the possibility of misinterpretation a second member of the care staff must be asked to repeat the direction back to the GP.

Where the GP refuses to confirm the alteration or discontinuation in writing or by adding a signature to the MAR chart following a visit or telephone conversation, the procedure must be witnessed by two senior members of the care team, documented and signed by both on the resident's MAR chart and care plan stating the alteration, instructing GP, time and date.

Although the label on the corresponding medicine container must not be altered, an identifying mark can be placed on the container to indicate that a change in dosage has occurred.

A new medication must not be initiated without a prescription.

## 11. Additional Requirements for Controlled Drugs

Designated and appropriately trained staff only, must administer Controlled Drugs. A second, appropriately trained designated member of staff must witness the administration of Controlled Drugs.

Controlled Drugs administered by staff must be stored in a metal cupboard which complies with the Misuse of Drugs (Safe Custody) Regulations 1973. This includes the use of a heavy gauge metal cabinet with a double locking mechanism.

Receipt, administration and disposal of Controlled Drugs must be recorded in a (bound book) Controlled Drug Register. A running balance, checked by another care worker, must be maintained. There must not be any cancellations, obliterations or alterations. Corrections must be made by a signed and dated entry in the margin or at the bottom of the page.

Controlled Drugs for disposal must be recorded in the *Controlled Drug Register* and a signature of receipt obtained.

The balance of Controlled Drugs will be checked on each administration and also on a weekly basis by the Care Manager.

If there is any doubt as to whether or not a medication within the home is a Controlled Drug, advice must be sought from the pharmacist or prescriber.

### **11.1 Procedure for the Administration of Controlled Drugs**

The *Procedure for Administration* must be followed with the additional requirements as outlined below:-

- Authorised staff member and witness take the Controlled Drug from the Controlled Drug cupboard. They agree the stock balance with the *Controlled Drugs Register*.
- The authorised staff member place the controlled drug in a small medication pot directly from the dispensed container and offer to the resident with water to drink.
- Once the Controlled Drug has been taken the authorised staff member signs *MAR chart* and *Controlled Drug Register* to this effect, the witness must check that the balance is correct and sign to agree this.
- Authorised staff and designated other will return the remaining medication and *Controlled Drug Register* to the Controlled Drugs cupboard and lock them away.
- Record any refusal or omission as defined in *Procedures Administration*.
- Record any error as defined in *Policy and Procedures for Error*.

### **12. Self Administration**

When individuals come into the home they should be given charge of their medicines wherever possible. This will help them to keep control of their own lives.

On arrival of a new resident it must be reasonably assessed as to whether the resident has a wish to and may be competent to administer their own medication. This could be wholly or partially such as with the use of some inhalers. Where self administration shows to be a possibility the *Self Administration Protocol Appendix E* must be completed by the Care Manager to ascertain the ability of that resident to self administer.

Documentation must be made in resident's *Care Plan* and on the *MAR chart* that they are self administering.

Self administering residents' ability to administer their own medicines must be reviewed monthly. This will be achieved by way of verification of amounts of medication and discussions with the resident. If at any time the resident is at risk from misuse of medication, approval will be sought to take over the administration by the care staff. This will be noted in the *Care Plan* and on the *MAR chart*. If staff obtain medication for self administering residents the quantities of medication handed to those residents should be recorded.

### **13. Residents' Rights & Preferences**

It is the right of the resident receiving care to achieve maximum benefit from their medicines. To facilitate this right, care staff, prescribing doctor, pharmacist, community nurses and any other person involved in their care, must communicate and work together. The Mental Capacity Act 2005 must be taken into account with all aspects of care.

Residents may have a preference in the way in which they take or are given their medicines, or who gives medicine to them and when. This may be due to religion or a number of other reasons. The resident's choices and preferences must be identified and taken into account within a risk management framework. A record of the preference must be kept and documented in their *Care Plan*.

#### **13.1 Resident Consent**

Residents have the right to refuse to take their medication. They must also give their consent for medication to be administered to them by care staff and for medication to be disposed of when it becomes out of use for any reason. A record of the discussion and the way in which the resident has given consent must be made prior to any of these occurrences and reviewed regularly where necessary. If the resident chooses not to take their medication, care staff must not insist but must record the refusal as in *Administration of Medication*. It is the responsibility of the person administering the medication to reasonably assess the person's capacity to consent.

Consent may be described as being the voluntary permission of the resident to receive a particular treatment or medicine, based on an adequate knowledge of the purpose, nature, likely effect and risks of that treatment or medicine.

### **Permission given under any unfair or undue pressure is not consent; neither can consent be implied by the resident's behavior**

In order for care staff who are authorised to handle medicines within the home to administer medication to residents, consent must be obtained by following the procedure outlined below. Staff must be reasonably sure the resident has the capacity to consent:

- Explain the medication, what it is for and potential complications and side effects and their management to the resident. To enable the resident is able to make their decision it must be ensured that the manner, style and pace of discussion is appropriate to the resident's
  - level of understanding
  - culture and background
  - preferred ways of communicating
  - needs
- Answer any questions in an appropriate way making sure the information given is correct.
- Give the resident verbal and/or written information on the medication if requested.
- Give the resident the opportunity to ask questions or seek clarification of any information they have been given.
- Seek feedback from the resident to ascertain their level of understanding.
- Give the resident time to reflect on the information and if necessary or requested, invite other members of the multi-disciplinary team, or the resident's family and an advocate if appropriate to provide support.
- Give the resident time to read the information and encourage them to question anything they do not understand before giving or declining consent.
- Reassure the resident that they can change their mind at any stage and make clear the implications of this in an unemotional manner.
- Make a record the resident's decision.

If there is any doubt about the resident's capacity to consent this must be tested appropriately using the principles of the Mental Capacity Act. It is imperative to recognise when you need help and/or advice and seek this from appropriate sources for example: Clinical Lead, Manager, Healthcare Professional or The Code Of Practice..

### **13.2 When a Resident Cannot Give Consent**

There may be times when a resident is unable to give or refuse consent because they lack the capacity to do so. Capacity is issue, decision and time specific so the resident's ability to give consent must always be time specific. If the resident cannot:

- understand the information relating to the medication,
- retain that information long enough to make a decision
- use and weigh it to arrive at a decision and
- communicate their decision

Then they are said to lack capacity for that decision alone. Where the person lacks capacity to give consent, medication can only be given where it is in the resident's best interests. This decision must be made in line with the Mental Capacity Act (MCA) and in particular by following the statutory checklist<sup>1</sup>.

If the medication could be seen as "serious medical treatment" and the person has no one else appropriate to consult with about the decision then a referral must be made to an Independent Mental Capacity Advocate (IMCA).

### **13.3 Emergency Medication**

In an emergency situation the Code of Practice makes it clear that staff will be protected provided that they have worked in line with the Code of Practice and believe the decision to be in the best interest of the resident. Any best interest decisions made in an emergency situation must be recorded in the resident's care plan.

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<sup>1</sup> [http://shropshire.gov.uk/disability.nsf/viewAttachments/VBUL-8PBKTV/\\$file/making-best-interest-decisions-checklist.pdf](http://shropshire.gov.uk/disability.nsf/viewAttachments/VBUL-8PBKTV/$file/making-best-interest-decisions-checklist.pdf)

## 14. Covert Medication

Medication must not be administered covertly for residents who have capacity. If a resident is refusing their medication it must be brought to the attention of the Care Manager. Every effort will then be made to explain information and support the resident in the reason for taking their medication. (See 12.1) If the resident still refuses to take their medication the decision must be documented and the GP informed.

Administering medication to residents who cannot give consent would require a full assessment of their mental capacity following MCA's Code of Practice and the NMC Covert Administration Guidance.<sup>2</sup> A full report would be produced, and a best interest decision made for each medication prescribed. This would be clearly documented in the resident's notes. A care plan and risk assessment would need to outline how the medication would be given covertly i.e. in food. The GP, resident's family (or IMCA), Social Worker and Community Psychiatric Nurse may also need to be consulted. In addition the pharmacist would need to be involved to ensure that crushing a medication or mixing it with certain food or drink would prove non-detrimental. It is good practice to record any response to a medication administered in this way.

Administering medication covertly could potentially lead to a Deprivation of Liberty – this should be considered and if applicable an application must be made to the appropriate body.

## 15. Crushing Tablets

It must not be assumed that it is safe to crush or cut tablets or to disguise medication in any other way. Where a resident has difficulty in taking a particular medication e.g. a large tablet, advice must be sought from the pharmacist who may be able to suggest an alternative formulation of the medication e.g. a dispersible tablet to the prescriber or if cutting the tablet safely using a tablet cutter to half the tablet is appropriate. If an alternative is not available, the pharmacist may be able to suggest other methods appropriate to that medication.

## 16. Disposal

As prescribed medicines are the personal property of an individual, consent should be obtained to dispose of any medication.

Medicines must be disposed of when:

- The expiry date is reached or on the advice of the pharmacist or medical practitioner.
- Equipment such as fridges or other cooling systems have failed to work.
- There is an excess of medication surplus to a resident's requirements.
- The resident for whom the medication is prescribed dies – In this case the medication must be kept for seven days after the death as details may be required by the Coroner's Officer.
- When a dose of medication is taken from the dispensed container but not taken by the resident, it must be placed in a separately labeled container and sent for safe disposal.
- A course of treatment is completed and there is a surplus to requirements or the Medical Practitioner stops the medication.
- Medication where indicated on packaging or in the *Patient Information Leaflet* that it is to be discarded at a specific time after opening.

### 16.1 Method of Disposal

#### (Non-nursing)

Medication for disposal must be returned to the supplier e.g. the pharmacy or dispensing surgery.

A record of ALL returned medicines must be made and kept in the home. The record of disposal must include:-

- Resident's name

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<http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/>

- Name, strength and quantity of medicines
- Date of return
- Signature of the member of staff returning the medicine
- Signature of the person receiving the medicine.
- For the disposal of Controlled Drugs, see section *Special Requirements for Controlled Drugs*.

### **(Nursing)**

A company with a waste management license to dispose of unwanted medication must be used to dispose of unwanted medication. Controlled Drugs should be de-natured using the appropriate denaturing kit provided by the waste collection company prior to disposal. This must be carried out by a registered nurse with a second person as a witness.

All disposed Controlled drugs must be recorded in the Controlled Drug Register and a signature of receipt obtained, see also section *Special Requirements for Controlled Drugs*.

A record of ALL returned medicines must be made and kept in the home. The record of disposal must include:-

- Resident's name
- Name, strength and quantity of medicines
- Date of return
- Signature of the member of staff returning the medicine
- Signature of the person receiving the medicine.
- For the disposal of Controlled Drugs, see section *Special Requirements for Controlled Drugs*.

### **16.2 Medical Device/Medicines Alerts**

It is the responsibility of the Care manager to ensure that any alerts received by the home are acted on as they are received according to the instruction provided and a record maintained within the home.

### **17. Homely Remedies**

A homely remedy is a medication used for a minor ailment, such as toothache, which can be bought over the counter and used without a prescription. For the purpose of this document the term Homely Remedy relates to an agreed list of medicines which will be kept in the home for the administration to more than one resident.

The list of homely medicines must have been agreed by the visiting GPs. See *Appendix F* for this list.

The list will be reviewed regularly by the GP/s and on the admission of a new resident.

Homely remedies must not be labeled for individuals as they may be used for several residents.

These medicines may be administered at the discretion of the senior trained care staff to residents with their consent taking the Mental Capacity Act into account and following discussion with the Care Manager or deputy.

Any homely medicine given must be recorded in the resident's notes and *MAR chart* with the date, dosage, time given, frequency and signature of care worker administering the medication.

No resident should have a homely remedy for more than 48 hours without advice being sought from the GP.

Due to the risk of cross contamination, there will be no creams or ointments on the homely remedy list.

A record of homely remedies purchased and appropriately disposed of (see *Disposal of Medication*) must be made as with any other medication.

### **17.1 Individual Resident's Purchased Medication**

The home appreciates that residents have the right to purchase their own medicines and foods or to have these brought in for them by friends and family members.

Occasionally other medicines or certain foods may interact with prescribed medicines or have other detrimental consequences i.e. chocolate for a diabetic resident.

Therefore in the interest of the care and safety of the resident visitors will be encouraged to notify a senior member of staff on these occasions.

Medicines purchased either by the home or the resident's or their advocates must be clearly labeled with the individual's name.

A record of these medicines should be maintained and if administered by staff must be included on the MAR sheet.

### **18. Staff Training**

All care staff who administer medication will be provided with the required training to enable them to perform the tasks safely and efficiently. The Care Manager will keep a record of this training and review the proficiency of the care staff on a six monthly basis or more frequently as necessary.

### **19. New Residents/Residents Leaving**

Communication on these occasions is essential to ensure the continuity of care for the residents. When a new resident arrives or prior to their arrival, The Care manager or deputy and any other necessary party will guide the resident in the completion of the *Resident Consent to Medication Administration and Disposal* form Appendix G.

#### **19.1 Resident Arrival**

At the soonest possible point prior to, or on admission, the Care Manager or designated person in charge will verify current medication of the new resident. This could be by way of:

- Hospital discharge sheet
- GP current medication list

The information will be checked against medication arriving with resident.

Any non current medication will be returned, with the permission of the resident to the pharmacy for safe disposal.

In the interim where there is no printed *MAR chart* from the pharmacy, one will be written out by a senior member of the care staff and checked for correctness and signed by a second senior person.

If the resident is re-registering with a new GP, the Care Manager will communicate to make sure all information is up to date.

If there is an excess of current medication this will be communicated to the GP.

In the unusual circumstance where a resident wishes to keep any medication, this will be stored safely away from any current medication clearly labeled and handed back to the resident on discharge.

The Care Manager will discuss the issues of self administration, administration by care staff and consent with the resident and the appropriate consent forms will be completed. See also *Resident's Rights and Preferences*.

As a part of the health check the resident will be screened to identify risk of malnutrition and take necessary steps as a result – see section 24.

#### **19.2 Resident Leaving**

When a resident is to leave the home the Care Manager must ensure that there is an adequate supply of the correct medicines and relevant information to take with them. A record of any medication leaving the home with that resident must be made.

## 20. Medication Error

Should an error occur it must be reported to the person in charge or their deputy immediately. It is necessary to contact the resident's GP or the out of hours service, ensuring all the information regarding the error is available. Details of the error must be recorded in the accident book and resident's notes and where appropriate, family will be contacted. If the resident has a serious adverse reaction then ring 999 and request an ambulance, again ensuring the information regarding the error is available.

If staff misplace a tablet they must inform the person in charge or their deputy immediately. The GP and pharmacist will be contacted and advice sought regarding the possibility of a one off prescription to cover the loss. The error must be documented in the residents' notes and the *MAR chart* completed as per code at bottom of sheet.

To reduce the chance of errors occurring staff must:-

- Keep their knowledge up to date.
- Avoid distractions whilst giving out medication.
- Pay attention to residents' identification.
- Remain with the resident during the administration process.

If in any doubt do not give the medication until clarification has been obtained.

If a person has been placed at risk of harm or the error involves a controlled drug it must be reported to the Care Quality Commission (CQC). The Decision Making Tool for Medication Errors<sup>3</sup> should be used to establish which errors should be reported and what actions to take on each occasion.

## 21. Misuse/theft

Any suspected misuse or theft of medicine must be reported immediately to the Care Manager/Proprietor who will if appropriate complete an Incident form and report to the CQC who may involve the Primary Care Trust Accountable Officer. The incident must be documented and recorded within the home in all cases. In the case of missing Controlled Drugs the police must be notified.

## 22. Leave Medication

When a resident spends time temporarily away from the home efforts must be made to ensure the continuation of supply of medication. This may give rise to any of the following:

- If the resident is going to be absent from the home for a substantial length of time, for example a holiday, the dispensed containers should be given to the resident or their carer.
- It may be necessary to request an additional supply of medicines for a resident going on holiday.
- In the case of the resident regularly going out of the home, for example each lunch time, the resident's GP may be asked whether an alternative preparation is available which would avoid the need of the lunch time dose.
- Enquiries should be made to establish whether the medication could be taken at a different time.
- If it is established that the medication must be taken whilst the resident is absent from the home, then a separate, suitable container should be requested by liaising with the resident's GP and pharmacist.

Secondary dispensing or the use of unsuitable containers, such as envelopes must not take place.

A record of medication going out with the resident and a record of medication returned with the resident, even if this is zero must be made.

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<sup>3</sup> <http://spic.co.uk/media/Safeguarding/Decision%20making%20tool%20070909%20-%20Final%20Version%20Dec%202010.pdf>

### **22.1 Admission to Hospital**

If a resident is admitted to hospital then the remaining supply of medicines is taken with them or an alternative quantity following liaison with the hospital. This will be documented on the *MAR chart* as well the amount of medicines returned with the resident. The way in which communication will take place following admission to hospital must be established in advance to ensure any changes made to a resident's medication are acted on promptly.

Any information which may be relevant to the care or treatment of the resident must be communicated to the hospital. The Care Manager or designated person must request that any changes made to the resident's medication are communicated directly to the home in written format (such as a faxed copy of the discharge sheet) on discharge and not at a later date so that any alterations can be acted on immediately.

### **23. Out of Hours Medication**

For medical treatment out of the normal working hours of the medical practitioners, SHROPDOC is to be contacted on 08444 06 88 88.

### **24. Use of Nutritional Supplements**

Regular screening for malnutrition will take place and the Shropshire County PCT guidelines *Care Pathway for Adults in a Care Home "At Risk" of Under Nutrition* must be followed. The home takes great care to provide nutritious meals for the residents as a priority. Residents requiring nutritional supplements will be monitored following the guidelines and the BAPEN *MUST* tool used as an aid to this. Staff will attend training in this area wherever possible.

For further guidelines see [www.bapen.org.uk](http://www.bapen.org.uk)

### **25. Use of Wound Care**

The home is provided with a *Wound Formulary* by the PCT medicines management team. Wherever possible this is to be used for guidance in the use of wound care. Dressings must only be requested on an individual patient basis and not ordered for one patient to be used as stock for others. Staff will attend training in this area wherever possible.

### **26. Authorised Inspection**

Every location where medication is stored is open to inspection by an authorised CQC inspector. Medication, records of their receipt, administration and disposal and any other relevant documentation must be readily available on request of the authorised inspector.