ADULT CARE SERVICES

ACS 021

Medication policy

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Authorised by: Chris Badger - Operations Director Older People

Signature: 

Author: Arnold Sami - Head of Service, Older People East and North Herts

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Comments and enquiries about this document to

acs.documentmanager@hertfordshire.gov.uk

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1. Introduction

1.1 This document outlines the roles, responsibilities and procedures for assisting people living in their own homes in receipt of regulated and non-regulated homecare and community support with prescribed medication as part of their care and support plan. It sets out the procedure for handling and administering medicines, and for their safe storage and disposal. It also outlines what documents should be used and how records should be kept.

1.2 This document operates in the context of the Care Quality Commission (CQC) Fundamental Standards which have been in force since April 2015. They state:

- Care and treatment must be appropriate and reflect individuals' needs and preferences
- Individuals must be treated with dignity and respect
- Care and treatment must only be provided with consent
- Care and treatment must be provided in a safe way
- Individuals must be protected from abuse and improper treatment
- Individuals' nutritional and hydration needs must be met
- All premises and equipment used must be clean, secure, suitable and used properly
- Complaints must be appropriately investigated and appropriate action taken in response
- Systems and processes must be established to ensure compliance with the fundamental standards
- Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed
- Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (Fit and proper persons requirement)
- Registered persons must be open and transparent with individuals about their care and treatment (Duty of Candour)

1.3 The document should be used in conjunction with NICE Guideline NG67 'Managing Medicines for adults receiving social care in the community'.

2. Scope and Aims

2.1 Hertfordshire County Council (HCC) aims to encourage and support people to self-medicate and independently manage their own medication. Wherever possible, individuals should take responsibility for their own medicines. **The Policy must only be used having carefully considered if people can self-medicate,** including with appropriate use of assistive technology**.**

2.2 HCC is keen to encourage care providers to consider assistive technology solutions wherever appropriate in order to provide the least intrusive option and maximize an individual's independence – for example, medication dispensers and technology that can provide prompts and reminders to take

medication at certain times of the day.

2.3 Medicine support where possible should be short-term and with a focus on reablement. This is with the exception of individuals who are incapable of managing their medication due to a disability or mental capacity issues.

2.4 This policy has been developed in order to:

- Ensure that individuals' health, wellbeing and independence is promoted regarding management of their medicines, and that their needs and preferences are taken fully into account
- Provide a framework for the delivery of consistently safe and secure management of medicines in an individual's own home
- Facilitate collaboration between care providers, the individual and their family members/carers.

2.5 Medicines should be delivered in a way that respects the dignity, privacy, cultural and religious beliefs of individuals and takes into account their needs and preferences, including their social, cultural, emotional, religious and spiritual needs, and as specified in their care and support plans.

2.6 This policy has been developed by HCC's Adult Care Services (ACS) department with support from health partners. Policy implementation is dependent on close collaboration between these partners, independent providers and with agreement of the individuals using the service and their family members/carers. It applies to all home care providers who are regulated with the Care Quality Commission providing homecare and community support to people over the age of 18. It also applies to some non-regulated providers delivering lower levels of medicines support (e.g. level 0).

2.7 In line with NICE Guideline NG21 (Home care: delivering personal care and practical support to older people living in their own homes) care providers should have a medicines management policy in place. This should reflect and build on this ACS medication policy and staff should be trained in line with it.

3. Levels of Medication Support

3.1 HCC is working with regulated and non-regulated providers in support of safe medicines management for individuals. One of these measures includes working with local social enterprise providers to deliver low level support (level 0). In every case (level 0 to 3) individuals will benefit from an assessment and from information and advice beforehand. Self-referrals are not an available option except for where individuals make their own arrangements independent of ACS as is the case of self-funders.

3.2 **Level 0 – Reminder to take medication**

This support can be delivered by an organisation which is not CQC registered or regulated. This support is only appropriate for individuals who have not been assessed as lacking the mental capacity to manage their own medicines.

- Option 1 (by telephone)
    - For individuals who need a reminder to take their medication and a telephone call will be sufficient.
- Option 2 (in person)
    - Reminder to take medication for an individual who has the ability to self-administer.
    - Individuals will need to select their own medication and take it out of the packaging.
    - Support can be provided to unscrew lids or boxes (individual blister packs cannot be opened) under the direction of the individual.
    - Medication Administration Record (MAR) charts should not be completed as these are only required to record medication that has been administered
    - The provider should record they have reminded in the care plan and/or own paperwork as appropriate but do not need to record that they have observed the medicines being taken.
    - For individuals with short term memory issues in the first instance a check should be made to see if the monitored dosage system (MDS) has been opened for that day/time before reminding the individual to take their medication.

3.3 **Level 1: General support/assisting with medication**

The individual using this service takes responsibility for self-medicating but with general support or assistance from the care practitioner. The care practitioner will work under the direction of the individual receiving the care. Care practitioners will document support provided in the daily diary log. A MAR chart should not be completed.

3.3.1 The support given may include the following:

- requests for repeat prescriptions from the GP
- collecting prescribed medicines from the community pharmacy
- disposal of unwanted or out-of-date medicines (see section 11)
- reminding or prompting by the care practitioner at times to the individual to take their medicines (constant reminders could indicate that the individual does not have the ability to take responsibility for their own medicines and should prompt review of the care plan)
- manipulation of a container of prescribed medicine under the direction of the individual, for example opening a bottle of liquid medication
- reading dispensing labels to the individual using the service
- assistance applying creams or ointments

3.3.2 Any staff providing level 1 support with medication must understand the limits of support provided and work strictly within the instructions of the care plan. Any concerns a care practitioner has about this must report this to their manager.

3.4 **Level 2: Administering medication**

A care practitioner is administering medication when they are taking responsibility for confirming they have selected the correct medication, i.e. the right medicine, for the right person, selected the right dose, to give at the right time and via the right route or method (see section 10). This may be required due to impaired cognitive awareness or physical disability of the

individual.

3.4.1 The support given may include the following:

- The care practitioner selecting and preparing medicines for immediate administration.
- The care practitioner selecting and measuring a dose of prescribed liquid medication for immediate administration
- The care practitioner applying prescribed medicated cream/ointment/patch, inserting ear, nose or eye drops and administering inhaled medication. In exceptional circumstances, selecting and preparing medication for the individual to take themselves at a prescribed time to enable independence and in accordance with their risk assessment (see section 9.6). Instructions will be clearly detailed in the care and support plan along with any necessary guidance or further information.

3.4.2 A record of all medication administered must be kept on the MAR chart (see section 12). A record that medicines have been administered should be included in the daily diary log.

3.4.3 In accordance with the Health & Social Care Act 2008, only trained, competent, medication management assessed care practitioners can be assigned to individuals requiring help with the administration of their medicines (see section 7). Care practitioners should not administer medication if instructions are unclear or they do not feel competent.

3.4.4 Care practitioners should only administer medication from its original container, dispensed and labelled by a pharmacist/dispensing GP. Care practitioners must not administer medicines from a carer/family-filled compliance aid. Care practitioners must be able to individually identify each medicine they administer and record it separately on the MAR chart in line with CQC and NICE guidelines. This means the routine use of MDSs is not advocated unless it is at the individual or their legal representative's request and is considered to enable the individual to remain more independent, e.g. the individual does not need a care practitioner to administer medication at level 2. There must be agreement from the individual's supplying pharmacist or GP and it must be in line with the individual's care and support plan. A MDS must not be requested from the pharmacy by the care provider unless in consultation with the individual and/or their representative and agreed by the case manager / worker.

3.4.5 Individuals discharged from hospital and returning to a previous care provider may have differing medication from those used prior to admission. The case manager / worker should advise the care provider when this occurs for the MAR chart to be updated appropriately (see section 10).

3.5 <u>Level 3: Administering medication by specialist techniques</u>

Following an assessment by an appropriate healthcare professional there may be a need for a care practitioner to administer medication by a specialist technique. These may include the following:

- Administration of a prescribed medicine via a naso-gastric tube or gastrostomy tube (PEG)

- Injections with a pre-assembled, pre-dose loaded syringe including insulin
- Testing of blood sugars for type 1 diabetes
- Assistance with oxygen administration
- Buccal midazolam use
- Epipen® device

3.5.4 All of these procedures must be clearly identified by the case manager / worker to ensure the care providers can determine if they will be able to have appropriately trained care staff before accepting the care package. If an individual needs specific support for a procedure listed above then the care practitioner must undertake training to meet the required competencies.

3.5.5 This level of support needs to be agreed by the individual where they have capacity or alternatively a best interest decision needs to be made and include their family members/carers where appropriate, the case manager / worker, healthcare professional and the provider.

3.5.3 The care practitioner must be trained and signed-off as competent by an appropriate healthcare professional to carry out the identified specialist task and for any devise used. This competency must be reassessed annually or whenever there is cause for concern such as in the case of medication management review, change in treatment plan, safeguarding or a change in mental capacity to consent. This is NOT a generic competence and CANNOT be applied to other individuals. Care practitioners must also agree to provide the assistance.

3.5.4 Monitoring and review of the safety and effectiveness of an individual's medicines remains the responsibility of the healthcare professional and dates for monitoring and reviewing must be recorded. The healthcare professional will continue to monitor the individual's health. The outcome of reviews and any changes in treatment must be shared by the health professional with ACS and the care provider including recommendations about existing and new risks as well as measures for mitigating these issues.

4. Capacity and Consent

4.1 When determining the level of support, the case manager / worker will give consideration to the individual's mental capacity, for example:

- Is the individual suffering from mental impairment which affects decision making about when to take their medication?
- Does the individual have other difficulties with their medication?
- Is the individual running out of medicines regularly or having too much left?

4.2 The individual must consent to have care staff support with medication to the level assessed and the consent form should be completed where an individual has capacity. This should be recorded on the correct form. The case manager / worker should send a copy of this form to the provider when services are commissioned.

4.3 In keeping with principles of the Mental Capacity Act 2005, it should be assumed that individuals are able to give consent to care practitioner's

administering their medication as a specific activity. Where capacity is in question case managers / workers are expected to assess and record an assessment of capacity including the reasons and rationale for making a Best Interest Decision.

4.4 In some cases it may be appropriate that the case manager / worker (in consultation with other professionals) undertakes a full Mental Capacity assessment to establish informed consent in relation to activities and actions affecting an individual's care.

4.5 Individuals who lack capacity to manage their own medication may have capacity to consent to care staff administering their medication. In cases where individuals lack capacity they still may be able to give consent.

4.6 When appropriate, the case manager / worker should seek advice from the GP/hospital doctor or other appropriate health professional as to whether the individual is able to take responsibility for their own medication. This will be particularly important where capacity is unclear or there are differing views, such as from family members/carers.

4.7 Where the individual is assessed as lacking mental capacity to give informed consent to receiving assistance with medication or to managing their own medication, the reasons and circumstances of this decision must be recorded in the care and support plan. This record must include the reasons that support with medication is seen as being in their best interests and who has made this decision.

4.8 Care providers should have a policy in place on what to do should the individual have declining or fluctuating mental capacity.

5. Roles and Responsibilities

See Appendix 1 'Glossary' for definitions of roles listed below.

5.1 Case manager / Case worker

It is the **case manager / worker's** responsibility to:

- Carry out an assessment of needs to identify eligible social care needs and outcomes including the required level of support with medication, if any, and record on the care and support plan.
- Complete a risk assessment, with GP input when appropriate, identifying the level of support required and any additional safeguards such as the secure storage of medication.
- Consider the individual's mental capacity, carrying out a mental capacity assessment if required. If necessary they will seek advice from the GP/hospital doctor as to whether the individual is able to take responsibility for self-medication. The outcome of a mental capacity assessment should an individual be deemed to lack capacity will be shared with the care provider.
- Engage with the individual (and family members/carers if agreed with the

individual) when assessing medicine support needs.

- Discuss with the GP whether there are options for dispensing the medication differently in order to support the individual's independence wherever possible. They should also seek pharmacist advice on options available to support self-administration, e.g. large labels, reminder charts.
- Discuss the number and pattern of any existing home visits, to avoid increasing 'medication only' visits if possible
- Obtain and record the individual's consent for assistance with their medication. If an individual is unable to communicate their consent then the reasons for making a Best Interest Decision must be recorded. Best Interest decisions and any recommendations around risk assessment will be shared with the care provider.
- Record on the care and support plan details of all medicines support required including arrangements for ordering prescriptions, collection of medicines from the pharmacy and whether secure medicines storage is required.
- Send the GP a copy of the care and support plan.
- Commission the care package with the appropriate allocation of time for all identified tasks to be completed
- Ensure that all those who may be involved with the care package such as family/carers, district nurse, GP, supplying pharmacist, day care service, are aware of the care practitioner's role in administering medicines and understands the procedures.
- Ensure that any agreements for family members/carers to assist the individual with their medication are clearly recorded in the care and support plan and home care service plan. Family/carer input should not be included on the MAR chart.
- Inform the GP and supplying pharmacist of the contact numbers of the care provider in case of any urgent communications regarding the individual's medication.
- Ensure that a review is completed prior to ceasing involvement and that a date is set for a scheduled review.
- The case manager / worker must ensure that the special factors are completed on ACSIS to identify where people are in receipt of support with their medication.
- Reviews are to be undertaken jointly with the care provider. This is with the exception of the Specialist Care at Home (SCAH) pathway (see 5.2.1).

5.2 Care Provider:

It is the **care provider's** responsibility to:

- Comply with all necessary regulations regarding homecare and community support medicines management and have robust policies in place to do so – providers may wish to use the Baseline Assessment Tool in appendix 4 to help meet NICE guideline recommendations (NG67).
- Ensure that, when agreeing to provide assistance with medication, they have the capacity and capability to do so safely
- That they have the appropriate insurance.
- Establish, document and maintain an effective system by which medicines are managed safely and securely to meet individuals' needs and designate an experienced senior member of staff to be responsible for its management.

- Ensure that all staff follow this policy, have appropriate training to meet its requirements and that competency is reviewed at least annually (see section 7) – staff must not be asked to administer medication without the appropriate training or assessment of their competence.
- Ensure an adequate supply of Medicines Administration Record (MAR) charts are available for staff to record level 2 or 3 assistance, with a system in place to assure the accuracy of information contained (see section 12)
- Ensure medication and the MAR chart is stored in a safe place in the individual's home as recorded in the risk assessment. Ensure that completed or discontinued MAR charts are returned to the provider when finished.
- Ensure there are clear arrangements for the collection of prescriptions, where this has been commissioned.
- Immediately take medical advice in the event of missed medication or a mistake occurring, and to fully investigate, document and take necessary measures to prevent recurrence. This means contacting the GP/111/See & Solve/SOOHs team/supplying pharmacist/allocated practitioner as appropriate (see section 13).
- Monitor care provision and requirements to ensure that care continues to be delivered and is appropriate for an individual – this includes an at least annual review of the care plan regarding medicine management needs or if there has been a significant change in circumstances
- Respond to concerns raised by care staff and others about an individual's medicines management or health.
- Share and keep information about an individual's medicines and treatment in accordance with the care provider's communications and confidentiality policy. This includes any communication with the individual, family members/carers, other care practitioners, health professionals e.g. the individual's supplying pharmacist, GP or and any other agency.
- Respect the individual's right to refuse medicine on any occasion, and to report refusals and missed doses appropriately.
- Seek clarification from the supplying pharmacy or GP if in any doubt about medicine instructions.
- Put in place appropriate quality assurance systems to record and monitor the effectiveness of their medication arrangements.
- With regard to people who have a learning disability and/or autism, help meet the aims of the stopping over-medication of people with a learning disability, autism or both (STOMP) project by:
    - Encouraging individuals to have regular check-ups about their medicines
    - Making sure GPs and other health professionals involve the individual, family members/carers and support staff in decisions about medicines
    - Informing everyone about non-drug therapies and practical ways of supporting individuals so they are less likely to need as much medicine, if any

5.2.1 The Specialist Care at Home (SCAH) pathway is Hertfordshire's reablement homecare service offering short-term interventions of up to four weeks which are designed to maximise an individual's independence. The service responds to hospital discharge as well as community referrals to prevent avoidable hospital admission. With no identified case manager / worker, the Specialist Care at Home provider will act as the responsible organisation for the

management of medicines and take on responsibilities as outlined in 5.1. This is with the exception that the care provider will not carry out MCAs or make decisions in the best interests of the individual without the input of the case manager or worker / GP or other health professionals. This remains the responsibility of the case manager / worker. In the event of any concerns or queries, these should be directed back to the ACS Operational Teams.

5.3 Care Practitioner:

It is the **care practitioner's** responsibility to:

- Read and understand the medication policy and procedures
- Attend induction and training and be assessed as competent to provide medicines support and assistance
- Provide the level of support required by the individual as specified in the care and support plan and have a clear idea of what they can and cannot do to assist people:
    - Level 1 support (e.g. prompting) in accordance with the care plan and the individual's instructions.
    - Only give level 2 or 3 support in accordance with the care plan **and** the prescriber's instructions.
- Record that medicines have been taken in the daily diary log and for all level 2 or 3 assistance given (including missed medication) on the MAR chart provided
- Preserve the dignity and respect the wishes of the individual, including cultural practices, when assisting with medication
- Report any refusal of medication, mistakes, suspected side effects or any other medicine-related concerns in the support or administering of medicines to their manager
- Be alert to any factors that may pose a risk to the individual and to report concerns or any other queries to their manager. This includes concerns about availability or accuracy of the MAR chart.

5.4 Health Professionals:

5.4.1 It is **health professionals'** responsibility to provide ongoing advice and support about an individual's medicines when needed by the care provider. In addition:

5.4.2 It is the **GP's** (or other prescriber's, e.g. psychiatrist, diabetic nurse) responsibility to:

- Check if any changes or additional support may be helpful, for example, if the individual's medicines regime can be simplified.
- When notified that an individual is receiving medicines support from a care provider, general practices should record details of the individual's medicines support and who to contact about their medicines (the individual or a named contact) in their medical record
- GPs should communicate any changes in an individual's prescribed medicines (e.g. when stopping or starting a medicine) to at least the individual and/or family members/carer – it is a future aspiration that the GP will also contact the care provider and the supplying pharmacist.

5.4.3 It is other **health professionals'** responsibility to:

- On level 3 support, the health professional (e.g. registered nurse) should train and assess the care practitioner as competent to administer medication as well as continue to monitor and evaluate the safety and effectiveness of an individual's medicines.
- A pharmacist or supplying doctor must provide a PIL (patient information leaflet) for all medicines supplied in line with the Human Medicines Regulations 2012.
- A pharmacist or supplying doctor should make reasonable adjustments to the supplied packaging of medicines (e.g. child proof tops) in line with the Equalities Act 2010.
- A pharmacist or supplying doctor should provide advice and support about an individual's medicines when needed by the care provider

6. Reviews

6.1 The care provider should review the care and support plan and make any necessary changes at least once a year and should include:

- Reassessment of the level of support required.
- Updating of the risk assessment.

6.2 The care provider should also:

- Check the MAR chart regularly to see if there are recording omissions or errors. If so, these must be reported immediately to the homecare manager.
- Determine if any breaches triggers a safeguarding concern referral.

6.3 Reviews should be arranged whenever there is a significant change in the individual's circumstances and after discharge from hospital, ensuring the MAR chart reflects any changes in prescribing when applicable. Where there is no change reviews must take place within the timescales specified in the care plan, and at least once a year

6.4 Reviews by the care provider should be undertaken jointly with the case manager / worker. The outcome of the review is shared by the case manager / worker with the care provider, GP and, as appropriate, the individual using the Review Template Letter (Appendix 2).

6.5 The case manager / worker should ensure that a review is completed prior to ceasing involvement.

7. Training & Competency

7.1 Care staff providing **level 1** support with medication must clearly understand the limits of support to be provided and work strictly within the care plan. The care practitioner should report any concerns, including if the individual appears to require a greater level of support, to their manager.

7.2 Care staff can provide **level 2** support with medication once they have:

- Received the appropriate training in medicines management at this level
- Been assessed as competent – see appendix 5 Competency Framework for example competency assessments.

7.3 Care staff can only provide **level 3** support with medication if they have received the necessary specialist training for the task from an appropriate healthcare professional and are deemed by them as competent. Care providers will not be obliged to accept individuals requiring this level of support without the corresponding training. Once trained, this competency must be reassessed at least annually. It is not a generic competence and cannot be applied to other individuals with a similar condition. If preferred, Herts Care Providers Association (HCPA) can provide access to approved training providers and care providers may be able to claim a certain amount of costs back through the HCC mandatory training grant.

7.4 Assistance with specialist equipment, e.g. nebulisers, inhaler devices, and oxygen cylinders, must only be given by care practitioners who have received instructions on the use of the particular device.

7.5 Care staff should undertake training and competency assessments at least annually. Appendix 5 details the core learning outcomes for care practitioners to be assessed against. A record of the assessment should be evidenced in their personal training records. An on-going training plan must be implemented as part of staff development.

7.6 All training and competency assessments should be recorded by the provider for auditing purposes.

8. Supply of Medicines

8.1 Any instructions for the supply of medicines such as the ordering or collection of repeat medicines should be agreed with the individual and/or family members/carers and clearly recorded in the care and support plan. Any requests for the supply of medicines not recorded in the care and support plan must not be undertaken. Any concerns should be reported by the care practitioner to their manager.

8.2 Only care practitioners trained and assessed as competent to do so should order medicines. Quantity of existing supplies and their expiry date should be checked first to avoid over-ordering. Care practitioners should check for any discrepancies between medicines ordered and medicines supplied. Any discrepancies should be reported to their manager.

8.3 When a care provider is responsible for ordering an individual's medicines they must ensure the correct amounts of the medicines are available when required. They should not delegate this responsibility to the supplying pharmacist unless this has been requested and agreed by the individual and/or their family members/carers. If there is an excess amount of medication in the home, the supplying pharmacist / GP should be notified.

8.4 Over-the-Counter Medicines

8.5 GPs, nurses or pharmacists will not generally give a prescription for over-the-counter (OTC) medicines (including vitamins, minerals, probiotics, rubefacients and food products) for self-limiting conditions, promoting self-care where possible even for patients who qualify for free prescriptions. OTC medicines are available to buy in a pharmacy or supermarket.

8.6 This follows national guidance from NHS England and local guidance from both Clinical Commissioning Groups (CCGs) in Hertfordshire. It applies to treatments for a number of conditions which can be found on the CCG websites.

8.7 Exceptions to the CCG OTC medicines policies: An individual may still be prescribed a medicine for a listed condition if:

- They are prescribed an OTC treatment for a long-term condition e.g. regular pain relief for chronic arthritis or inflammatory bowel disease.
- They need treatment for more complex forms of minor illnesses, e.g. migraines that are very bad and where OTC medicines do not work.
- They need an OTC medicine to treat a side effect or symptom of a more complex illness and/or prescription only medicines, e.g. constipation when taking certain painkillers.
- The medicine has a licence which doesn't allow the product to be sold OTC to certain groups of patients, e.g. babies, children or women who are pregnant or breast-feeding.
- The person prescribing thinks that the individual cannot treat themselves, for example because of mental health problems or severe social vulnerability.
- Treatment for complex patients (e.g. immunosuppressed patients)

8.8 In line with CQC guidance 'Treating minor ailments and promoting self-care in adult social care' (2018), care providers must have robust processes in place for managing over-the-counter medicine requests by an individual or family members/carers. This includes making sure the individual or family members/carers as appropriate understands and accepts any risk associated with taking the medicine and what information needs to be recorded, e.g. the name, strength and quantity of the medicine. Some medicine that can be bought without a prescription may still be prescribed by the individual's GP if the above exceptions apply.

8.9 Individuals receiving medicines support may ask care practitioners to assist with the purchasing or the taking of over-the-counter medicines. Further advice should always be sought from the pharmacist or GP before purchasing or administering any other medicines. OTC medicines should not be purchased or administered by a care practitioner unless clear guidance has been given by a pharmacist or GP. Details of all OTC medicines given with the assistance of the care practitioner must be recorded on the individual's daily diary log and MAR chart (if level 2 or 3). The care practitioner should assist the individual with their approved OTC medicines where possible and at the individual's request.

8.10 If purchased or administered following pharmacist or GP advice, OTC medicine should be checked to make sure it is in date and stored according to the manufacturer guidance. It is encouraged that the purchase of any OTC

medicines is from the same pharmacist providing dispensing services to the individual. It is also recommended that a photocopy of the MAR chart, repeat prescription or equivalent is presented to the community pharmacist to enable a safe supply.

8.11 Care practitioners must not offer advice on OTC medicines or remedies at any level as it may be dangerous to do so. The individual may be allergic to the treatment or be taking other medicine that may result in harm to themselves.

9. Storage of Medicines

9.1 Medicines must be stored to ensure they cannot accidentally be mixed up with other people's medicines and out of the reach of children. They should be kept away from damp and heat sources. All prescription medicines must be provided and contained within the original pharmacy produced labelled packaging or monitored dosage system,

9.2 Certain medicines have defined storage requirements that must be followed. Medicines requiring refrigerated storage should be kept away from food. If it becomes clear that the specified storage conditions have not been adhered to, or, for example there has been a failure in refrigeration, the care practitioner or their manager should seek advice from the supplying pharmacy or GP.

9.3 The need to store medicines in a locked container will only occur where the case manager / worker has assessed that this is required to protect the health and safety of the individual. This decision should be taken following discussion with family members/carers and health care professionals as appropriate and recorded in the risk assessment. It should be considered when controlled drugs are to be administered. If the care practitioner feels that there is a genuine and urgent risk to the individual's wellbeing, medication may be placed in a location where the individual cannot find it on a temporary basis. This should be reported promptly to the homecare or community support manager who must ensure that other care staff are aware of the situation and refer the individual for an urgent review of their care and support plan. Updated information must be transferred onto the risk assessment and care plan kept in the individual's home.

9.4 **Covert Administration**: Similarly the covert administration of medicines (medicines administered in a disguising format without the knowledge or consent of the individual receiving them, e.g. in food or a drink) must only be considered in exceptional circumstances. This must follow discussion with family members/carers, the health professional prescribing the medicines and other care professionals as appropriate taking into consideration the capacity of the individual to consent or refuse treatment as documented in the risk assessment. The individual's GP or other prescribing health professional must provide written confirmation that a medication can be given covertly and how it can be dispensed (e.g. whether a medicine can / cannot be crushed). Any instructions on administering must be recorded on the MAR chart. The supplying pharmacist can also supply additional advice regarding the pharmaceutical suitability of medicines for administration this way.

9.5 Decisions to administer medicines covertly must not be taken by any party in

isolation but must be informed and agreed by the team caring for the individual, the prescriber together with family members/carer(s) and be documented appropriately. Medicines must not be administered covertly to anyone who is deemed to have capacity to make a decision on whether or not they wish to take medication.

9.6 **Removal from Original Packaging:** In exceptional circumstances, removal of medicines from their original packaging to be left out for the individual to take themselves at a later date – classed as level 2 support – may be allowed if it aids their independence. Assistance of this nature must be clearly specified along with instructions in the care plan and risk assessment and must:

- Take account of the stability of the pharmaceutical preparation with pharmaceutical advice sought
- Be clearly recorded on the MAR chart
- Be closely monitored by the provider
- Medicines must not be left out for longer than 24 hours

9.7 Care practitioners are not permitted to remove medication from its original packaging for later administration by a third party, such as another care practitioner or family member/carers. Care practitioners must not administer medication that has been removed from the packaging by another person. This includes family-filled dosette boxes.

10. Administration of Medicines

10.1 Wherever possible and appropriate, the individual should self-administer their medicines.

10.2 **Essential information for care practitioners assisting and administering medication**

10.2.1 Care practitioners must follow the below procedure for people in receipt of level 2 support:

- Take medication and the MAR chart from storage point.
- Check MAR chart and medication relates to the individual.
- Check the special notes section on the MAR Chart, and any other notes such as daily diary logs that may relate to medication.
- Check whether any short term medication has been prescribed.
- Locate the appropriate date column.
- Ensure medicine has not already been given.
- Select medication, checking label on the container against the MAR Chart – if there are any discrepancies in instructions the medicine should not be given.

10.2.2 Follow the ‘6 Rs’ of administration (right individual, right medicine, right route, right dose, right time, individual's right to refuse) and ensure understanding of the medication to be given:

- The correct dosage and form to be given.
- How often it is to be given.
- How it is to be given as described in the route.

- Other directions such as ‘after food’.
- Check for any discrepancies between the label on the medicine and the MAR Chart before administration.
- Check the medicine has not exceeded its expiry date by checking the date on the dispensing label – if it is in its original packaging, the manufacturing expiry date should also be checked.
- Administer medicine(s) and then immediately tick and initial the MAR Chart clearly in the appropriate box.
- Confirm that the medicine has been taken. If giving orally, check the dose has been swallowed.
- The reason for any non-administering should be immediately recorded on the medication record form MAR Chart, using the keys indicated, as well as in the individual’s daily diary log.
- Do not administer medicine to an individual who clearly refuses it.
- Keep medicines in their original container and never alter the label.
- Inform the homecare or community support manager, GP or nurse if there is any difficulty, uncertainty, or incident arising out of the administering of medicine.
- Notify the homecare or community support manager when the MAR Chart is nearing completion.
- Only give medicines by mouth or external application unless specific training has been provided by a healthcare professional and the care practitioner has been assessed as competent by the healthcare professional.
- Care practitioners may refuse to administer medication if they have not received suitable training, if instructions are unclear or they do not feel competent to do so but they must inform their manager.

10.2.3 Medicines must only be administered in accordance with the prescriber’s specific instructions. Care practitioners may only assist with administration of medicines that are correctly labelled by a pharmacy or dispensary with the individual’s full name and date of dispensing. The medicine name, prescribed dose, route and frequency should also be included. The exception to this may be non-prescribed (over-the-counter) medicines (see 8.4 and CCG Over-the-counter Policies). They should not administer from any carer or family-filled dosette boxes.

10.2.4 If medication is labelled with imprecise or ambiguous directions, e.g. ‘take as directed’, ‘take as before’, ‘apply to the affected part’, or with unclear abbreviations, the care practitioners must seek clarification from their manager who must ensure clear written directions are obtained and recorded appropriately. Any discrepancies with the MAR Chart must also be reported to their manager.

10.2.5 If the label becomes detached from the container, is illegible, or has been altered, medication must not be administered. Advice should be sought from the homecare or community support manager who should seek further advice where necessary.

10.2.6 Medicines have an expiry (use by) date. The expiry date must be checked before each administering of the medicine to ensure that the medicine may still be used.

Note: many medicines have a reduced expiry date after opening. If in doubt,

check with the pharmacy.

10.2.7 Some medication causes side effects and the home care practitioner should be alert to this possibility and report any concerns to their manager. In an emergency they should contact the GP, pharmacist, or NHS 111.

10.2.8 The care practitioner must contact the homecare or community support manager for advice in the event of an individual refusing to take prescribed medication. This should be recorded on the MAR Chart.

10.2.9 The care provider should have in a place processes on what to do if an individual is having a meal or sleeping of if they are going away for a short time e.g. visiting family.

10.3 Monitored Dosage Systems

10.3.1 Monitored dosage systems (MDSs) supplied by a pharmacy should only be used as an aid to compliance for the individual to self-administer. These are to be considered only at the request of the individual and not of the care provider. Supplying pharmacists should provide a description of the appearance of each individual medicine supplied in a MDS.

10.3.2 Care practitioners who administer medicines are expected to be able to individually identify each medicine they administer and record it separately on a MAR chart. Because of this MDS are not routinely advocated for level 2 support.

Note: Any selection of tablets from a MDS, including selecting and/or opening a particular section, is considered to constitute level 2 support.

10.4 Anticoagulant tablets

10.4.1 The most commonly prescribed anticoagulant is warfarin. However new types of anticoagulants are now available and are becoming increasingly common. Rivaroxaban (Xarelto®), Dabigatran (Pradaxa®), Apixaban (Eliquis®) and Edoxaban (Lixiana®) belong to a group of drugs called New/Direct Oral Anticoagulants (NOACs/DOACs) which do not need regular blood tests. It is very important that individuals prescribed any form of anticoagulant are given their medication every day. All individuals on anticoagulants should have had a risk assessment done and included in their care plan. Careful monitoring is required while taking warfarin. A blood test called an International Normalised Ratio (INR) is required to measure how long it takes for the individual's blood to begin to form clots. This result is then used to adjust the warfarin dose accordingly.

10.4.2 ACS will not commission care practitioners to administer Warfarin for individuals until a stable fixed dosage pattern has been established for a period of two months by the district nurse. If the dosage pattern is not stable but subject to regular changes then the responsibility for administering will rest with the district nursing service and care practitioners would not be expected to administer.

10.4.3 If a stable dosage pattern has been established then care practitioners may

administer Warfarin once they have received training and been assessed as competent. This must be within a framework of support and regular review agreed with the district nursing service and recorded in the care plan. Administration of Warfarin should be recorded in the MAR chart as normal.

10.4.4 Warfarin and other anticoagulants can increase an individual's likelihood of bleeding. If an individual taking an anticoagulant develops any bruising or bleeding their GP or the NHS 111 service should be contacted for advice before administering a dose of Warfarin or any other anticoagulants.

10.5 As required medication, also known as PRN

10.5.1 Most medication will be prescribed for use on a regular basis. As required medication (PRN) is administered when the individual presents with a defined intermittent or short-term condition i.e. not given as a regular daily dose or at specific times such as medicine rounds. Where an individual is prescribed PRN medication, a specific plan/protocol for administering this must be documented in their clinical records. The individual's capacity should be taken into account.

10.5.2 Some treatments may be prescribed on an 'as required' or PRN basis for people on level 1 assistance. 'As required' medication should not normally be included on the MAR Chart for people on level 2 support as they will be unable to make informed decisions about their medication. Instructions and guidance should be clearly records in the care and support plan. If a GP does prescribe PRN for someone on level 2 support, the circumstances must be recorded in the risk assessment including what it is for and how often it should be taken. Non-specific prescribing instructions (e.g. 'take 1 or 2') should be referred back to the supplying pharmacist or GP.

10.6 Controlled drugs

10.6.1 There is no legal requirement for controlled drugs to be treated differently from other prescribed medicines when prescribed and administered in an individual's own home. Controlled drugs such as morphine are usually prescribed to treat severe pain. The doctor should specify the dose and maximum frequency. If these drugs are required on an 'as required' basis by individuals needing assistance (level 1) additional written guidance may be needed for care practitioners. People who lack capacity and are on level 2 can only receive administered measured doses and cannot be given controlled drugs on an 'as required basis' (see 10.5).

10.6.2The risk assessment may require the secure storage of such medication (see section 9).

10.6.3 Care practitioners must refer any requests about additional pain relief to their manager.

10.7 Food supplements

10.7.1 Where food supplements have been prescribed by a doctor, they should be recorded on the MAR Chart. If these are not being taken on a regular basis, this should be reported to the homecare or community support manager.

10.8 **Variable dosage schedules**

10.8.1 Some medication is prescribed on a reducing or variable dosage regime and should be reflected on the MAR Chart. These are used to increase or reduce the dose of a drug over a defined period of time. Additional information about this should be shown on the label or provided through additional instructions which must always be referred to.

10.8.2 **Dosing intervals**

10.8.3 Individuals may need assistance with the administering of medication at specific time intervals. In these cases the case manager / worker completing the assessment should check with the pharmacist or GP and homecare or community support provider to see if the dosing schedule of the medications can be realigned and coordinated within the existing patterns of home visits. If the dosing intervals are an essential component of treatment, for example in a 6 hourly regime for antibiotic treatment, or evening doses, and the service provided does not cover these requirements, this should be referred back to HCC. This is also the case should additional medicines support be required (e.g. antibiotic treatment, eyes drops following a cataract operation)

10.9 **Medications outside the scope of this policy**

10.9.1 The following medications must NOT be administered by care practitioners, for example:-

- Injections (other than as specified in section 3.5)
- Suppositories
- Pessaries
- Enemas
- Rectal creams
- Vaginal creams
- The application of dressings involving wound care
- The application of medication to broken skin.

10.9.2 The administration of these medications is the responsibility of a health care professional such as a district nurse.

10.10 Changes in Medication

10.10.1 On receiving communication from prescribers regarding changes to an individual's medicines (e.g. when stopping or starting a medicine) or on any other alteration to medication, the care provider is responsible for ensuring the MAR chart is amended or a new one produced as follows:

- The original direction is cancelled – this original direction should remain legible but clear it is no longer to be followed
- The new directions are recorded on a new line in the MAR Chart
- The entry is signed and dated
- Where possible, changes are double-checked and signed by another staff member of the care provider

10.10.2 Discharge from Hospital

10.10.3 When an individual leaves hospital it is likely that changes have been made to their medicines. The care provider should have a system in place to ensure this information is received, documented and acted on. This includes reviewing in conjunction with the case manager / worker and updating the MAR chart where appropriate.

10.10.4 A labelled supply of medicine sent home with the individual is the authority to administer those medicines and supersedes any previous instructions. If a new MAR chart is not yet available, medicines should be administered according to the instructions on the label and all doses given must be recorded in the daily diary log with full details of medicine name, strength, dose and time and date administered. The updated MAR chart must be made available as soon as possible.

10.10.5 Verbal Instructions to change medication or doses

10.10.6 Care staff should only assist with medication according to written instructions unless changes to an individual's medicines are passed verbally (e.g. by telephone or video–link) by a GP or other health professional to avoid delays in treatment. Prescribers should give written confirmation as soon as possible by an agreed method (e.g. secure email).

10.10.7 Care providers must ensure robust processes for handling changes to an individual's medicines received verbally from a health professional including:

- Recording details of the requested change, including who requested the change, date and time of request and who received the request.
- Reading back the information that has been recorded to the prescriber requesting the change to confirm it is correct including spelling the name of the medicine.
- Asking the prescriber requesting the change to repeat the request to someone else, e.g. the individual and/or a family member/carer wherever possible.

11. Disposal of Medicines

11.1 Medicines belong to the individual for whom they were prescribed and cannot be removed without that individual's consent. The individual or their family members/carers are responsible for disposing of their own medicines safely unless the individual lacks capacity. The individual or family members/carers should be encouraged to return unused, unwanted or expired medicines to a pharmacy for disposal. They should not be added to their household waste or flushed away.

11.2 Where there are no family members/carers the care practitioner must obtain approval from their line manager to return the medicines to the pharmacy. They should request a receipt to keep on the service user's file. The homecare or community support manager may also need to notify the GP if medicines are not being used. The names and quantities of all

medicines removed should be recorded and a copy retained in the individual's care notes.

12. Record Keeping

12.1 Care providers should have robust processes are in place for recording an individual's current medicines and ensure records are accurate and kept up-to-date and accessible in line with the individual's expectations for confidentiality.

12.2 Where a MAR Chart is required, the care provider is responsible for the completion of the MAR Chart.

12.3 Instructions for recording on the MAR Chart

12.3.1 For people on level 2 and 3 support the MAR chart is the formal, confidential record of administration of medicines. It will be kept in the individual's home, with a copy of their care and support plan, in a safe and accessible place. The MAR chart must detail:

- The individual's name, date of birth and any other person-specific identifiers such as their NHS number.
- The name and formulation of all medicines to be administered by the care practitioner.
- How often and the time they must be given.
- The day of the week, if not daily, with dates crossed through on the day(s) medication is not required.
- The dose and route.
- Any stop or review date.
- Any important special information such as specific instructions for giving a medicine and any known allergies.
- The names of those preparing and checking the MAR chart and the date prepared.

12.3.2 The names of all care practitioners visiting an individual, together with their signatures and initials, must be recorded on the care providers' files.

12.3.3 All assistance with administering medication must be initialed at the time of the visit. The care practitioner must record on the MAR Chart all medicines given, missed or refused for both short term and long term medication. They must record the time of their visit and their full name on the daily diary log.

12.3.4 Care practitioners can only carry out this level of support once they have received training and been assessed as competent. They must never change or tamper with the instructions written on the MAR Chart. They can only use a MAR Chart that has been filled in by the GP, hospital doctor, nurse prescriber, pharmacist, or the senior member of staff designated by the provider.

12.3.5 Care practitioners should administer the medicines shown on the MAR chart using the checks below for each medicine as detailed in section 10. The care practitioner must then:

- Enter their initials clearly and the correct date and time immediately after it has been administered, to show it has been given.
- If the medicine is not given enter the appropriate reason code in the box. A detailed explanation should be entered in the daily diary log and the refusal reported to the care provider management who should inform the individual's GP. Managers must communicate regular refusals to the GP and case manager / worker.

13. Mistakes and Errors

13.1 If an incident occurs regarding medication, care practitioners must immediately report this to their manager and seek medical advice. This applies to errors that a care practitioner may identify even if they have not made themselves, e.g. by a prescriber or other care practitioner.

13.2 The manager should ensure the following action is taken:

- Seek advice from the GP or appropriate health professional immediately.
- Enter the details of the error on the MAR chart if appropriate.
- Make a note of any changes in the individual's health or behavior.
- Undertake a referral to ACS Safeguarding in all cases regardless of whether or not it is suspected it could cause ill-effect or harm.
- Notify CQC as a 'notifiable incident'.

13.3 If the same or a similar incident occurs that relates to the same individual, this may suggest that a review of the risk assessment or care plan is required. A referral to ACS Safeguarding should also be considered. Providers should have a process in place for keeping track of any incidences and should put systems in place to make sure any patterns are identified and appropriate action taken.

13.4 Any other concerns a care practitioner has including any changes in health or behavior not related to a medicines mistake must be referred to their manager.

14. References and Further Information

14.1 Legislation and related policy framework

- Care Act 2014
- Equalities Act 2010
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12
- The Handling of Medicines in Social Care - Royal Pharmaceutical Society of Great Britain Medicines Management (National Institute for Health & Care Excellence)
- Health & Social Care Information Centre 'A guide to confidentiality in health and social care', 2013
- Human Rights Act (1998)
- Mental Capacity Act (2005)

- Care Quality Commission (CQC) Fundamental Standards November 2014, available at http://www.cqc.org.uk/content/publishing-new-fundamental-standards
- NICE Guidelines
  - NG67: Managing Medicines for adults receiving social care in the community
  - NG21: Homecare: delivering personal care and practical support to older people living in their own homes

- CCG **Over-the-counter policies** – East & North Herts CCG and Herts Valleys CCG (Herts Valleys CCG has also produced a 'Good Practice Guidance: Prescribing Over-the-Counter Medication to Individuals in Receipt of Social Care').
- Patient Information Leaflet 'Prescribing of over the counter medicines is changing'.:
- CQC guidance 'Treating minor ailments and promoting self-care in adult social care (2018)

14.2 Relevant adult care services policies and procedures:

- ACS 042 Mental capacity.
- ACS 037 Assessment and personalisation.

14.3 Other resources

- The **Herts Help** service can help to signpost individuals and professionals to sources of support, such as medication prompt devices, telecare, pharmacists and visiting services. For individuals who need one to one support in exploring their options HertsHelp act as first point of contact including arranging visits from Community Navigators.

Appendix 1: Glossary

Administer
Medicine given to an individual for immediate consumption.

ACS
Adult Care Services, Hertfordshire County Council.

Assessment
Identifying and recording the needs and risks of an individual so that appropriate action can be planned.

Blister pack
Medication in individually sealed compartments as supplied by a manufacturer.

Carer
An informal carer, e.g. family member, providing some level of unpaid care support to the individual. Formal (i.e. paid) carers are referred to in this policy as Care Practitioners.

Care and support plan
An agreed record which sets out the outcomes for any help required, with details of services to be provided, who will be responsible for arranging them and a review date.

Case manager / case worker
The worker responsible for carrying out the assessment, care planning and review of an individual's care needs – usually a social worker, care coordinator or community care officer.

Care package
The combination of services agreed in order to meet the individual's assessed needs.

Care Provider
A registered body who provides care to meet identified needs and is regulated by the Care Quality Commission. In this policy, it may also refer to non-regulated bodies providing level 0 medicines support.

Care Practitioner
Previously known as care worker. Staff employed by the care provider for the purpose of providing care at the following levels:

- Trainee Community-based Health & Social Care Practitioner Level 1 (Care certificate completed)
- Assistant Community-based Health & Social Care Practitioner Level 2 (QCF Level 2 qualified)
- Community-based Health & Social Care Practitioner Level 3 (QCF Level 3 qualified)
- Advanced Community-based Health & Social Care Practitioner Level 5 (QCF Level 5 qualified)

Also known as a support worker in a Supported Living setting.

Compliance Aid
A device used to aid compliance e.g. special bottle tops, reminder charts. They also include reusable plastic containers for taking medicines that are divided into days/time of day usually known as 'multicompartmental compliance aids' (MCAs) or dosette boxes.

Covert Administration
The administration of medicines in a disguising format without the knowledge or consent of the individual receiving them, e.g. in food or a drink

Daily Diary Log
The daily record sheet care practitioners complete during their visit to an individual.

Fixed Dosage
When the dose of a drug has a fixed pattern with no end date.

Health/healthcare Professional
Healthcare staff that are registered with a professional body e,g. a doctor, pharmacist, nurse, pharmacist technician.

GP
General Practitioner

Homecare or Community Support Manager
Senior Manager employed by the care provider, for example the Registered Manager or Care Manager.

Individual
The person receiving support that may also referred to as the service user.

MAR Chart
Medication Administration Record Chart - the chart used for care practitioners to record all administration or refusal of medicines.

Medication/Medicines
The terms drug, medicine and medication are used interchangeably.

Monitored dosage system
A system or device which separates medicine doses to help an individual manage their medication. It must be prepared and sealed by a pharmacist and is only suitable for certain drugs. This may also be known as a pharmacy filled compliance aid.

NHS 111
A 24 hours a day, 365 days a year medical service that can be called if you urgently need medical help or advice that is not a life-threatening situation.

Over-the-counter medicine
Medication that an individual may choose to buy or be advised to purchase by a healthcare professional. Sometimes referred to as non-prescribed medication.

PIL
Patient Information Leaflet – leaflet contained in every box of dispensed medication that gives information about the medication, its use and side-effects.

Prescribing
Act of recommending or ordering, or the use of a medicine or a remedy by an individual.

PRN
Pro re nata is a Latin phrase meaning in the circumstances or ‘as required’ in reference to dosage of prescribed medication that is not scheduled.

Risk assessment
A systematic process used on individuals for checking risks and hazards and how best to manage these safely.

Variable Dose
When the dose of a drug may increase or reduce over a defined period of time but is still scheduled (as opposed to PRN medication). Additional information about this should always be shown on the label or provided through additional instruction

Appendix 2: Review Template Letter

Adult Care Services
Director: Iain MacBeath

Dear (Provider)

RE: SERVICE USER NAME, ACSIS ID, ADDRESS, DOB – CARE REVIEW

Further to the care management review undertaken (date), I write to confirm arrangements with regard to management of medicines for the above service user.

As a result of the review, arrangements will remain the same/have changed* delete as appropriate as follows:

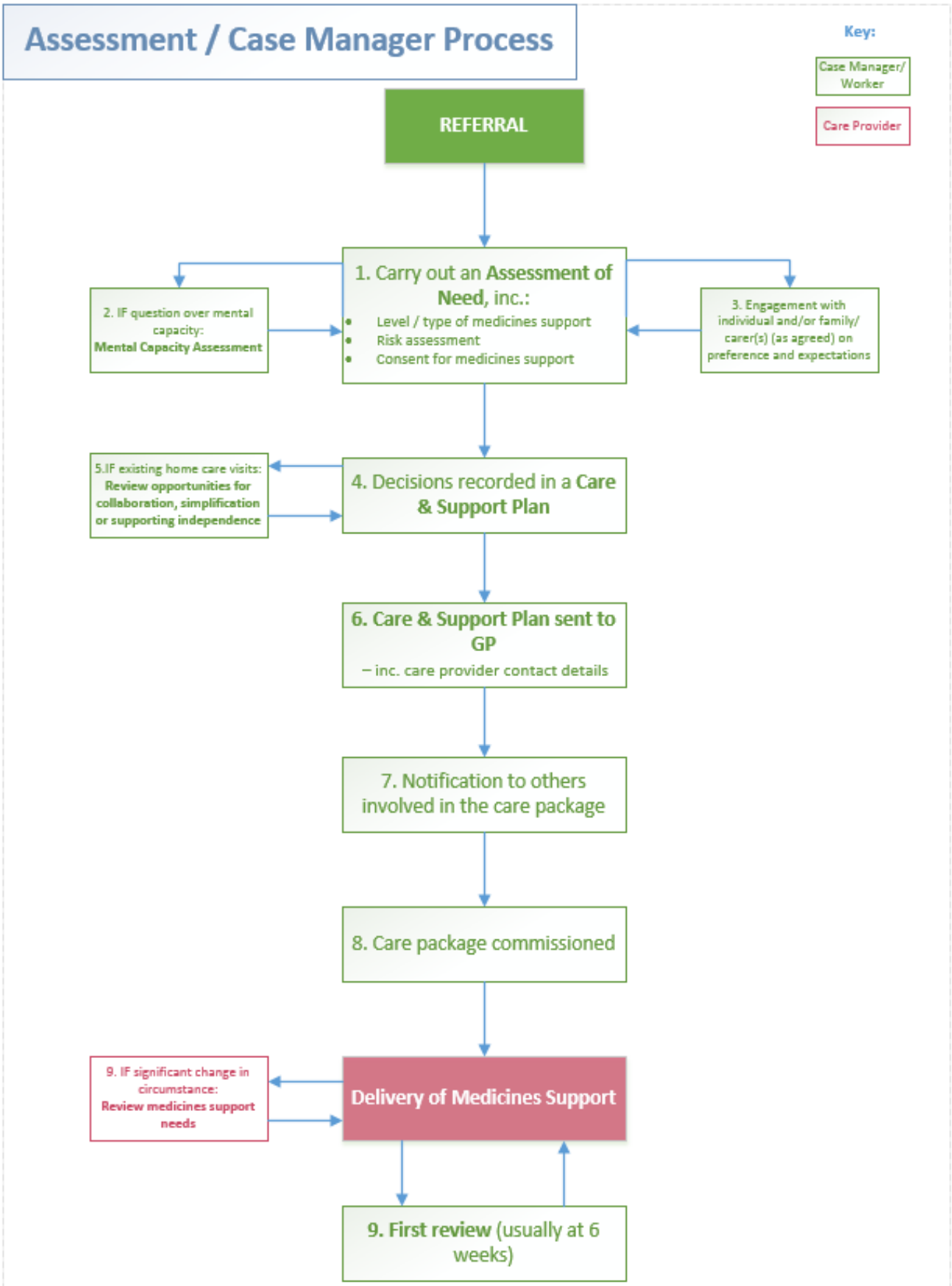
(Level of support)
(Responsibility for repeat prescription/collection)
(Any other relevant information eg storage, service user specific requirements)

A copy of the care & support plan/risk assessment are attached.

Yours sincerely

cc GP
cc SU/carer

Appendix 3: Assessment Pathway Flowchart



Assessment / Case Manager or Worker Process – Action Table

No.	Actions
1.	The **case manager / worker** carries out an **assessment of need** to identify social care needs and outcomes which include medicines support needs. Medicines support assessment will include: • Level and type of medicines support needed • A risk assessment, with GP input where appropriate, noting any additional safeguards such as the secure storage of medicine • Level of consent required (the individual's consent for assistance with their medication should be obtained and recorded)
2.	If a question over mental capacity (including if an individual has cognitive decline or fluctuating mental capacity), the **case manager / worker** will carry out a **Mental Capacity Assessment**. To seek advice from the GP/hospital doctor if required. The individual and their family members/carers should be actively involved in discussions.
3.	The **case manager / worker** should engage with the individual, and family members/carers if this has been agreed by the individual, on how they can be supported when assessing their medicine support needs. This should take account of: • Needs and preferences • Expectations for confidentiality and advance care planning • Their understanding of why they are taking their medications • What they are able to do and what support is needed • How they currently order, store and take their medicines • Any problems taking their medicines • Any nutritional and hydration needs • Any medicine allergies • Who to contact about their medicines • Time and resources likely to be needed
4.	The **case manager / worker** record discussions and decisions on medicine support in the **Care and Support Plan** so that it includes: • The individual's needs, preferences and expectations for confidentiality • How consent for decisions around medicines will be sought • Details of who to contact about their medicines (the person or named contact) • Support needed for each medicine and how it will be given • Arrangements for ordering prescriptions and/or collection from the pharmacy • Whether secure storage of medicines is required • Who will be responsible for providing medicines support and their contact details • When medicines support will be reviewed The care and support plan should detail the agreement and role of family members/carers in assisting the individual with medicines support – family/carer input should not be recorded in the MAR chart, if required for the individual. Where there are specific needs or risks for an individual around a particular condition, these must be fully documented in the care and support plan.

5.	The **case manager / worker** should discuss the number and pattern any existing home care visits to avoid increasing 'medication only' visits where possible. The case manager / worker should also discuss with the GP as appropriate whether there are options for dispensing the medication differently in order to support the person's independence wherever possible.
6.	The **case manager / worker** sends a copy of the Care and Support Plan to the individual's GP. The care and support plan should include the contact details of the care provider in case of any urgent communication regarding the person's medication.
7.	The **case manager / worker** ensures that all others who may be involved in the care package (e.g. family members/carers, registered nurses, day care service, etc) are aware of the care practitioner's role in administering medicines and understand the procedure.
8.	The **case manager / worker** commissions the care package based on the Care and Support Plan with the appropriate time allocation for all identified tasks to be completed
9.	The **case manager / worker** should ensure that a review of the individual's medicine support is undertake prior to them ceasing involvement and that a date is set for a scheduled review. Reviews should then be undertaken by the **care provider** whenever there is a significant change in an individual's circumstances and after discharge from hospital. MAR charts, if used, must reflect any changes in prescribing where applicable. Where there is no change, the **care provider** must undertake reviews within the timescales specified in the care plan and at least once a year.

Appendix 4: NICE Baseline Tool

baseline-assessment
-tool-excel.xls

Appendix 5: Domiciliary Medication Management Framework

Domiciliary Medication Management Framework-
Including Competencies

A medicine is:
'A medication (or medicine) is a substance taken to prevent and/or treat illness and/or maintain or promote health. In relation to this standard, the term medication includes all substances administered for a therapeutic purpose as part of prescribed care. Therapeutic substances include synthetic chemicals, herbal extracts, vitamins, minerals, oxygen and blood/blood products. Therapeutic substances come in many forms and may be ingested, inhaled, injected, inserted or applied'. Reference: Originated from the NBSA Standards for Medication Management.

Medication Management:
The goal of medication management is centred on achieving the optimum health outcomes for the person and must focus on the quality use of medicines. This means:

1. The wise selection of management options for a person's medication regime
2. If a medicine is necessary the most suitable medicine option is chosen, taking into consideration the person's current medication regime.
3. If support is required, what support is available? E.g. if a person requires a medication to be administered by another person at a specific time- are there alternative medications available that have the same affect but do not rely on another person to provide a time specific response. E.g. pain relief patches as an alternative to 4 x a day oral pain relief.
4. That the medicines are used safely and effectively.

Any medication management system needs to consider the following:

1. Are policies and procedures documented and made available to staff?
2. How are staff practices developed and monitored to ensure the understanding of and compliance with processes and procedures? (E.g. are quality audits conducted and reviewed, and does supervision of staff exist) (Refer to Policy)
3. How does the organisation ensure regular evaluations are undertaken e.g. a. Allergies b. The person's cognitive ability c. The person's pain management needs d. Medication side effects e. The proper recording and ordering and delivering of medication orders? E.g. are: Orders current, legible, signed and dated, with the dose and time prescribed Urgent and out of hours orders catered for (Refer to Policy)
4. Does the storage of medication include: a. A level of security of medications appropriate for the medication and circumstances including a copy of the outcome of the MCA for a person if the social worker/ GP has assessed the person as being unsafe. b. Appropriate refrigeration of medications c. Dating of opened medications as appropriate (creams, ointments, etc). (Refer to Policy)
5. Does the administration of medication to the person by staff include:
a. **The 6 rights** Right person, Right medication, Right route,

Right dose, Right time, Right to refuse, b. Assessment of the skills and knowledge of all staff administering medications. (Refer to Policy)
6. Does the administration of medications to the person include: a. Assessment of the person's ability to self -administer or for administration to take place b. Education for the person to self -administer in a safe and correct manner c. Regular monitoring of the person's self-administering d. Consultation with person's/representatives and other, (medical and health professionals), about the self –administration (Refer to Policy)
7. How does the organisation ensure regular evaluation and review of the medication management system including: (Refer to Policy) a. Processes for reviewing the person's medications, b. Regular review/use of multidisciplinary teams where possible including requests for an MCA to be carried out where necessary c. Medication ordering processes, including emergency supplies d. The correctness of medications against medication records and orders e. Medication administration processes including for the person who self -administers
8. How does the Manager ensure medication incidents are documented, reported and appropriately addressed? (Refer to Policy)
9. How does the Manager ensure appropriate disposal of medication including that of ceased, damaged and out of date medications (Refer to Policy) In the case of a person with swallowing difficulties a policy and procedure should include the following: 1. Assessment of swallowing ability of the person 2. Review of the medication regime 3. Which formulations should not be crushed and why 4. Ensuring crushing technique and equipment is suitable 5. Administration to the person 6. Monitoring and assessment
Older people have a higher risk of adverse reactions to medications due to polypharmacy, dependence on others for medication administration and for some, inability to notice changes in medications supplied. Safe medication management involves regular review of medications, examining the entire medication management cycle to improve health outcomes. The health team should provide the care team with information on any allergies noted, side effects/ symptoms that the care team should be observing for and when to report back.

Levels of Mediation Administration:

<table>
<tr><th colspan="2">Level 0 – Reminder to take medication</th></tr>
<tr><td colspan="2">Support workers responsibilities:
This support can be delivered by an organisation which is not CQC registered or regulated. And is only appropriate for clients who have not been assessed as lacking the mental capacity to manage their own medicines.</td></tr>
<tr><td>Option 1 (by telephone)</td><td>• For individuals who need a reminder to take their medication and a telephone call will be sufficient.</td></tr>
<tr><td>Option 2 (in person)</td><td>• Reminder to take medication for an individual who has the ability to self-administer.
• Individuals will need to select their own medication and take it out of the packaging.
• Support can be provided to unscrew lids or boxes (individual blister packs cannot be opened) under the direction of the individual.
• Medication Administration Record (MAR) charts should not be completed as these are only required to record medication that has been administered
• The provider should record they have reminded in the care plan and own paperwork but do not need to record that they have observed the medicines being taken.
• For individuals with short term memory issues in the first instance a check should be made to see if the monitored dosage system (MDS) has been opened for that day/time before reminding the individual to take their medication</td></tr>
<tr><td>A Care Support Worker must:</td><td>• Report if an individual has symptoms or suspected side effects or if any change in physical health, cognitive ability or behaviour is observed.
• Document all assistance given
• Document any deviations from the prescribed care plan and/or own paperwork as appropriate; and comply with medication incident reporting.
• Must notify their manager if a client is suspected to be having difficulty with managing medications safely, regardless of whether or not the client is receiving medication assistance as part of their care package.
Support Workers are only authorised to assist and /or administer medication provided they have been appropriately trained and assessed as competent.</td></tr>
<tr><th colspan="2">Level 1: General support/assisting with medicine</th></tr>
<tr><td colspan="2">The individual using this service takes responsibility for self-medicating but with general support or assistance from the care practitioner. The care practitioner will work under the direction of the individual receiving the care. Care practitioners will document support provided in the daily diary log. A MAR chart</td></tr>
</table>

should not be completed.	
The support given may include the following:	• Requests for repeat prescriptions from the GP • Collecting prescribed medicines from the community pharmacy • Disposal of unwanted or out-of-date medicines • Reminding or prompting by the care practitioner at times to the client to take their medicines (constant reminders could indicate that the individual does not have the ability to take responsibility for their own medicines and should prompt review of the care plan) • Manipulation of a container of prescribed medicine under the direction of the client, for example opening a bottle of liquid medication or removing tablets from a manufacturer's blister pack. • Reading dispensing labels to the client using the service • assistance applying creams or ointments Any staff providing *level 1* support with medication must understand the limits of support provided and work strictly within the instructions of the care plan. Any concerns a care practitioner has about this must report this to their manager.
Level 2: Administering medication	
A care practitioner is administering medication when they are taking responsibility for confirming they have selected the correct medication, i.e. the right medicine, for the right person, including checking DOB and address, selected the right dose, to give at the right time and via the right route or method. This may be required due to impaired cognitive awareness or physical disability of the individual.	
The support given may include the following:	• The care practitioner selecting and preparing medicines for immediate administration. • The care practitioner selecting and measuring a dose of prescribed liquid medication for immediate administration • The care practitioner applying prescribed medicated cream/ointment/patch, inserting ear, nose or eye drops and administering inhaled medication • In exceptional circumstances, the care practitioner selecting and preparing medication for the individual to take themselves at a prescribed time to enable their independence and in accordance with their risk assessment and care and support plan. Instructions will be clearly detailed in the care and support plan. A record of all medication administered must be kept on the MAR chart. A record that medicines have been administered should be included in the daily diary log. In accordance with the Health & Social Care Act 2008, only trained, competent, medication management assessed care practitioners can be assigned to individuals requiring help with

	the administration of their medicines.
They should not administer medication if instructions are unclear or they do not feel competent.	
Care practitioners must:	• Only administer medication from its original container, dispensed and labelled by a pharmacist/dispensing GP. • Not administer medicines from a carer/family-filled compliance aid. • Be able to individually identify each medicine they administer and record it separately on the MAR chart in line with CQC and NICE guidelines. The routine use of monitored dosage systems is unless it is at the individual or their legal representative's request and is considered to enable the individual to remain more independent, e.g. the individual does not need a care practitioner to administer medication at level 2. There must be agreement from the individual's supplying pharmacist or GP and it must be in line with the individual's care and support plan. A MDS must not be requested from the pharmacy by the care provider unless in exceptional circumstances and agreed by the case manager/worker.
Level 3: Administering medication by specialist techniques	
Following an assessment by an appropriate healthcare professional, there may be a need for a care practitioner to administer medication by a specialist technique.	
These may include the following:	• Administration of a prescribed medicine via a naso-gastric tube or gastrostomy tube (PEG) • Injections with a pre-assembled, pre-dose loaded syringe; including insulin • Testing of blood sugars for type 1 diabetes • Assistance with oxygen administration • Buccal midazolam use • Epipen® device
Manager/ provider to consider	All of these procedures must be clearly identified by the case manager/worker. to ensure the care providers can determine if they will be able to have appropriately trained care staff before accepting the care package. If an individual needs specific support for a procedure listed above then the care practitioner must undertake training to meet the required competencies. This level of support needs to be agreed by the client where they have capacity or alternatively a best interest decision needs to be made and include their family members/carers where appropriate, the case manager/worker, healthcare professional and the provider. The care practitioner must be trained and signed-off as competent to carry out the identified specialist task for the client and for any devise used by an appropriate healthcare professional. This competency must be reassessed annually or

	whenever there is cause for concern such as in the case of medication management review, change in treatment plan, safeguarding or a change in mental capacity to consent. This is NOT a generic competence and CANNOT be applied to other individuals. Care practitioners must agree to provide the assistance. Monitoring and review of the safety and effectiveness of an individual's medicines remains the responsibility of the healthcare professional and dates for monitoring and reviewing must be recorded. The healthcare professional will continue to monitor the individual's health. The outcome of reviews and any changes in treatment must be shared by the health professional with ACS and the care provider including recommendations about existing and new risks as well as measures for mitigating these issues.

Competency Checking:
Why competencies are important?

NICE recommends an annual review of staff knowledge, skills and competency.

A competency framework is a structure, which sets out and attempts to define the key knowledge, skills and behaviours required for a member of staff to be able to perform a particular task. They may be used as a flexible tool to help care practitioners and their managers improve performance to work more effectively. A well trained and competent workforce is vital for the delivery of safe and effective person centred careof high quality and that is consistent amongst the workforce.

Please find below some example of competency checklists that you can utilise within your service. (Note, as medicines support is assistance rather than administration, checklists for Level 0 and 1 are not included)

Key:
C = Competent
NYC = Not Yet Competent

COMPETENCY ASSESSMENT FOR administration of medicines – Tablets
Level 2

Staff Member's Name .....Service:.....

Assessor:.....……Assessor signature……Date……

Staff Member's signature……..Date……

Competent: Yes / No Comments:

Steps to be followed when administering Tablets

		C	NYC
1	Refers to the individual's care plan for instructions regarding level of support required when administering medication		
2	Can recall the 6 rights • Right client- Name, Address, DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
3	Checks the MAR with the pharmacy label on the bottle • Before commencing check CARE NOTES AND MAR CHART to ensure individual has not already taken • Expiry date • Allergy/drug sensitivity checked on MAR Label also against any Allergies listed in care plan		
4	Washes own hands		
5	Positions the individual in the upright and comfortable position		
6	Administers tablets to client with at least ½ cup of preferred fluid (If appropriate)		
7	Checks that all medication has been swallowed		
8	Immediately records and signs the MAR/signing sheet to record administration or enters correct code if the individual refuses		

Questions

1	What do you do if the number of tablets does not match the MAR *Do not proceed with medication administration for the client.* *Notify the manager for further advice, document*	
2	What would you do if the client refuses to take all their medications *Notify the Manager, If manager not available, notify clients GP.* *Document and provide further information*	
3	What is the correct procedure for dealing with a medicine error *Check individual, CONTACT 111, inform Manager if manager not available contact GP*	

Comments:

COMPETENCY ASSESSMENT FOR ADMINISTRATION OF EYE DROPS/OINTMENTS Level 2

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……..

Competent: Yes / No Comments:

Steps to be followed when administering EYE DROPS/OINTMENTS:

		C	NYC
1	Correctly locates the individual's order for eye drops/ointment by referring to the current MAR		
2	Refers to the individual's care plan for instructions regarding physical assistance required when administering medication		
3	Correctly identifies the individual's medicine and confirms they are ready to have it administered		
4	Removes the individual's eye drops/ointment from storage location Checks the MAR with the pharmacy label on the bottle Can recall the 6 rights • Right client- Name, Address, DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed In addition checks: • Expiry date • Which eye/ both eyes		
5	Washes own hands		
6	Positions the individual in the upright position		
7	Clears any discharge from the individual's eyes with warm water swab or saline		
8	Gently tilts the individual's head back and pulls the lower lid down to form a pouch Uses tissue to side of eye to mop up excess moisture		

9	Agitate the eye drops and instils ONE drop into the pouch or applies 1cm ointment		
10	Encourages the individual to close their eyes		
11	If administering eye drops places pressure on the tear duct beside the nose for 1-3 minutes		
12	Completes the MAR/signing sheet to record administration		
13	Replaces the lid securely on the medication and returns to the correct storage location		
14	Checks if there are any other medications to be administered. Waits 5 minutes and repeats above steps as required		

Suggested questions and answers for assessment

1	Why do you need to block the tear duct after instilling eye drops? *To minimise systemic side effects and/or taste disturbances*	
2	If the client has two types of eye drops how long should you wait between each one? *At least 5 minutes*	
3	How long can eye drops be used before they must be discarded? *Usually one month. Check directions on bottle or packaging if unsure*	
4	What would you do if you find the eye drops have expired *Don't give. Discard and locate new stock. Complete incident report if >1 day out of date*	
5	Chloramphenicol and Systane eye drops are required to be administered. Which one would you administer first and why? *Chloramphenicol because it is a medicated eye drop and should be administered before any artificial tear preparation*	

Comments:

COMPETENCY ASSESSMENT FOR administration of medicines – Liquid medication
Level 2

Staff Member's Name .....Service:.....

Assessor:..... ……Assessor signature……Date……

Staff Member's signature……..Date……..

Competent: Yes / No Comments:

Steps to be followed when administering Liquid medication

		C	NYC
1	Refers to the individual's care plan for instructions regarding level of support required when administering medication		
2	Can recall the 6 rights • Right client, Name, Address DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
3	Checks the MAR with the pharmacy label on the bottle • Ensure individual has not already taken • Checks Expiry date • Allergy/drug sensitivity checked on MAR Label also against any Allergies listed in care plan • Checks the dose in ml.		
4	Washes own hands		
5	Uses an appropriate clean measuring device		
6	Shakes the liquid medication, holds the bottle with hand over the dispensing label		
7	Pours the medication into the medication cup that is on a flat surface at eye level • If using an oral syringe, removes air gap		
8	Positions the individual in the upright and comfortable position		
9	Administers to individual and provides glass of water to rinse mouth		
10	Checks that all medication has been swallowed		
11	Immediately records and signs the MAR/signing sheet to record administration or enters correct code if client refuses		

12	Replaces the lid securely washes up used containers		

Questions

1	If the dose on MAR chart is in mg, not in mL, what would you do? *Check with GP, Request that chart be updated to minimise risk of error or confusion, refer to manager*	
2	If two liquid medications are to be given, one with a 20mL dose and one with a 5mL dose, would you: • ***Double check with manager*** *Why? to minimize risk of dosing error.* • ***Pour both doses into the one medicine cup to save time?*** *No, liquid medications must be measured and administered separately*	

Comments:

COMPETENCY ASSESSMENT FOR administration of medicines – Creams
Level 2

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……

Competent: Yes / No Comments:

Steps to be followed when administering creams

		C	NYC
1	Refers to the individual's care plan for instructions regarding level of support required when administering medication		
2	Can recall the 6 rights • Right individual, Name, Address DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
3	Checks the MAR with the pharmacy label on the bottle • Ensure individual has not already taken • Checks Expiry date • Allergy/drug sensitivity checked on MAR Label also against any Allergies listed in care plan • Checks the application site • Writes date of opening on cream if new container opened or checks within opened date timing		
4	Washes own hands and puts gloves on		
5	Locates the site for application and correctly estimates the amount of cream/ointment to be applied Prepares skin to remove any previous build-up of cream • If applying moisturiser, applies cream down the limb in the direction of hair growth using a cupping action with both hands • If applying a medicated cream, administers a small amount using 'fingertip unit' method • If applying a steroid cream, applies cream thinly		
6	Follows correct procedure if any signs of skin reactions		
7	If creams are applied to hands / feet ensures these are left non-greasy to prevent slipping, dropping of items – feet are covered with socks/ shoes, palms of hands are patted to remove excess cream/ oils.		
8	Immediately records and signs the MAR/signing sheet to record		

	administration or enters correct code if client refuses		
9	Replaces the lid securely		

Questions

1	How is a dose of medicated cream/ointment measured? *'In fingertip units'*	
2	How is a 'fingertip unit' measured? *The amount of cream/ointment squeezed out along an adult's finger from the very end of the finger to the first crease in the finger*	
3	If a medicated cream and Sorbolene Cream are required to be applied which one is applied first? *The medicated cream.*	
4	How long until the Sorbolene Cream can be applied? 30-60 minutes Why? *So that the medicated cream/ointment is not "diluted" – this will reduce its efficacy*	

Comments:

COMPETENCY ASSESSMENT FOR administration of medicines – Nose drops
Level 2

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……

Competent: Yes / No Comments:

Steps to be followed when administering Nose drops

		C	NYC
1	Refers to the individual's care plan for instructions regarding level of support required when administering medication		
2	Can recall the 6 rights • Right individual, Name, Address DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
3	Checks the MAR with the pharmacy label on the bottle • Ensure individual has not already taken • Checks Expiry date • Allergy/drug sensitivity checked on MAR Label also against any Allergies listed in care plan • if unopened writes date on bottle		
4	Washes own hands		
5	Shakes the bottle prior to insertion		
6	Encourages individual to blow their nose		
7	Ensures the individual is upright		
8	Gently tilts the individual's head back. Instils required number of drops into the nostril without allowing the dropper to touch the nose Uses tissue to wipe up any excess moisture		
9	Encourages individual to remain in current position for 2 minutes to allow penetration of nose drops		
8	Immediately records and signs the MAR/signing sheet to record administration or enters correct code if client refuses		
9	Replaces the lid securely		

Questions

1	Why do you need to position the care recipient with their head tilted back? *To allow nose drops to penetrate up into the nose*	
2	Why do you need to ensure that nose drops are stored completely separate from clients eye drops? *To minimise risk of accidentally instilling them into eyes*	
3	Why do you need to ask the care recipient to blow their nose first? *To clear the nostrils*	

Comments:

COMPETENCY ASSESSMENT FOR administration of medicines – Metered dose inhalers
Level 2

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……

Competent: Yes / No Comments:

Steps to be followed when administering metered dose inhaler

		C	NYC
1	Refers to the individual's care plan for instructions regarding level of support required when administering medication		
2	Can recall the 6 rights • Right individual Name, Address DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
3	Checks the MAR with the pharmacy label on the bottle • Ensure individual has not already taken • Checks Expiry date • Allergy/drug sensitivity checked on MAR Label also against any Allergies listed in care plan		
4	Washes own hands		
5	Positions the individual in an upright position		
6	Removes the mouthpiece cover Holding the inhaler upright, shakes it 3-4 times		
7	Asks individual to breath out places the mouthpiece in the mouth ensuring lips are sealed around it		
8	Asks individual to breath in and at the same time presses top of inhaler downwards to release ONE dose of medication. Asks individual to hold their breath for 5-10 seconds before breathing out through their nose If a second puff is required, waits 30 seconds before starting again and re shaking the device		
9	Immediately records and signs the MAR/signing sheet to record administration or enters correct code if client refuses		
10	Replaces the cap on the inhaler		

Questions

1	How do you tell if a metered dose inhaler is empty? *Check dose counter.*	
2	Why do individuals need to rinse their mouth after steroid inhalers? *To reduce side effects such as hoarse voice and oral thrush*	
3	How often should metered dose inhalers be cleaned? *Once a week*	
4	If administering a preventer and reliever inhaler at the same time which do you administer first? *Use a reliever first*	

Comments:

COMPETENCY ASSESSMENT FOR monitoring Blood Glucose levels
Level 3

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……..

Competent: Yes / No Comments:

Steps to be followed when monitoring Blood Glucose levels:

		C	NYC
1	Correctly locates the individual's order/chart for recording BGLs		
2	Refers to the individual's care plan for instructions regarding physical assistance required		
3	Locates the individual's diabetes supply box Correctly identifies the client and confirms they are ready to have their BGL tested Can recall the 6 rights • Right individual, Name, Address DOB • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
4	Washes own hands and puts gloves on		
5	Washes individual's hands in warm soapy water and dries them thoroughly		
6	Removes glucometer and test strips from supply box		
7	Ensures glucometer is calibrated according to manufacturer's instructions		
8	Carefully removes ONE test strip from the vial without touching the test pad. Replaces lid on vial		
9	Prepares lancet device		
10	Places the lancet on the side of the individual's finger and presses trigger button		
11	If finger needs to be "milked" to generate blood flow, it is done gently and according to procedure		
12	Wipes away first drop of blood with tissue and then allows a second drop to form		
13	Touches the blood from the finger to the test strip and inserts into glucometer. Wipes puncture site with gauze		
14	Records result on BGL chart and in the care plan		

Questions

1	Why do individual's hands need to be clean and dry before taking a BGL? *To avoid a false reading*	
2	Why is it important to wash a individual's hands with water rather than using an alcohol swab prior to taking a BGL? *Alcohol swabs do not effectively remove fruit juice residue which may give a false reading*	
3	What would you do if you accidentally touched the test pad on the glucose test strip? *Discard the strip and get a new one* Why? *To ensure a false reading is not returned*	

Comments:

COMPETENCY ASSESSMENT FOR administering medications via a PEG tube
Level 3

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……..

Competent: Yes / No Comments:

Steps to be followed when administering medications via a PEG tube:

		C	NYC
1	Correctly locates the individual's MAR chart to verify that all solid oral dose medications to be administered have been verified by a pharmacist as suitable for crushing		
2	Refers to the individual's care plan for instructions regarding physical assistance required		
3	Correctly identifies the MAR chart/signing sheet and confirms they are ready to have medication administered		
4	Ensures individual is comfortable either sitting upright in a chair or at a 30° angle in bed		
5	Washes own hands and puts gloves on		
6	Removes individual's medications from the medication supply box. Checks the MAR chart care plan/ /signing sheet with the pharmacy label: Can recall the 6 rights • Right individual DOB, Address, • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed		
7	Stops any enteral feed and verifies tube placement. Checks for patency before flushing with 30mL water		
8	Ensures that the PEG tube and administration set is clamped. If no separate port for medication administration, carefully separates administration set from PEG tube		
9	Cleans the port as per manufacturer's instructions and flushes with 30mL water		
10	Prepares various medication formulations correctly prior to drawing up into syringe: • i) Correctly measures liquid medication dose and dilutes with 30mL water • ii) Crushes tablets and adds at least 10-15mL water • iii) Opens capsule/s and mixes with 10-15mL water		

11	Gently pushes medications in via medication port If more medications are required, flushes tube with 10-15mL water before repeating Steps 10-11		
12	Flushes tube with 20-30mL after administration of last medication then reclamps tube		
13	Completes medication administration record on care plan or completes medication chart/signing sheet		
14	Cleans syringe in mild detergent, rinses and dries thoroughly		

Questions

1	What would you do if the medication that needed to be administered through a PEG tube was not suitable for crushing? *Withhold administration, complete MAR chart appropriately, contact Manager*	
2	List ways that PEG tubes can become blocked and how they can be minimised: • *Inappropriate medication administration* • *Poor flushing techniques –* ○ *flush with 20-30mL water before and after checking for residuals and before and after medication administration* • *Reflux of gastric contents up into the tube - regular flushing* • *Thick formulas - select the correct tube size to maximise flow rate*	
3	What is the best flushing solution? *Water*	
4	Why should cola beverages or cranberry juice NOT be used to clear a blockage? *They are acidic and exacerbate tube clogging through protein denaturation. [Altered pH from digestive enzymes and the acidic solution mixing with the formula's intact protein in the tube tip causes protein denaturation and formation of a clog in the tip.]*	
5	List the steps you would follow to clear a PEG tube blockage: • *Check that there are no kinks in the tube* • *Instil warm water into the tube and apply gentle pressure alternating with suction to clear - this will clear most blockages*	

Comments:

COMPETENCY ASSESSMENT FOR Administration of Insulin - Using pre-dose loaded syringes
Level 3

Staff Member's Name .....Service:.....

Assessor:..... Assessor signature……Date……

Staff Member's signature……..Date……..

Competent: Yes / No

Comments:

Steps to be followed when administering Insulin Using pre-dose loaded syringes Level 3:

		C	NYC
1	Checks BGL and checks with GP order on MAR chart and is within range for insulin administration		
2	Correctly locates the individual's order for insulin for current time referring to current MAR Refers to the individual's care plan for instructions regarding physical assistance required		
3	Correctly identifies the individual's MAR/signing sheet and confirms they are ready to have medication administered		
4	Obtains pre-filled insulin pen 8mm needle (recommended for the majority of clients)		
5	Double checks individual's name and expiry date on insulin pen (1 month after opening)		
6	Removes individual's medications from the medication supply box. Checks the MAR chart care plan/ /signing sheet: Can recall the 6 rights • Right individualDOB, Address, • Right time • Right medication • Right dose • Right route • Right to refuse NB Mental Capacity check and support plan in position if needed Washes own hands		
7	• Attach a pen needle. • Prime pen by dialing up 2 units, Point pen upwards and depress injector button into the air		

	• Ensure insulin is expelled from needle – repeat priming process if no insulin seen • Turn the dose knob to the number of units to be administered • If using cloudy insulin gently roll the pen ten times and invert the pen ten times. The liquid should look evenly mixed		
8	• Correctly locates a suitable administration site • Carefully pinches the skin before inserting needle • Depresses the push-button fully ensuring that dose indicator returns to zero. • Keeps needle in the skin for 10 seconds before removing		
9	Discards needle safely into sharps container		
10	Adds BGL reading to care recipient's Blood Glucose Chart		
11	Completes MAR chart and care plan /signing sheet		

Questions

1	Why do you need to leave the needle in the skin for 10 seconds when injecting insulin from a pen? *To allow time for the full dose to be delivered from the pen*	
2	Why must insulin be at room temperature when administered? *To minimise stinging and to ensure rapid onset of action (cold insulin is slower to work)*	
3	What is an 'airshot'? *A test using 2 units of insulin to ensure that the insulin pen is working correctly and to remove air from needle prior to injecting*	
4	What would you do if the BGL reading was 2.5mmol/L? *Do not administer insulin. Give the care recipient a tube of Glutose Gel/small glass of juice/2-3 tsp sugar dissolved in water. Repeat BGL monitoring in 15-20 minutes. Contact GP if BGL is still <4mmol/L after 20 minutes. Remain with the client at all times until BGL >4mmol/L*	
5	What are some symptoms of low blood sugar levels in an elderly person? *Confusion, dizziness, drowsiness, seizures, weakness; sweating, increase pulse rate, hunger.*	
6	What would you do if you only managed to get the GP's voicemail? *Call 999*	

Comments: