

# Medication Policy and Procedure



## Purpose

To comply with current legislation and best practice in the administration of medicines, including:

- Relevant evidence-based guidance and alerts about medicines management and good practice.
- Published by appropriate expert and professional bodies, including:
  - National Patient Safety Agency
  - National Institute for Health and Clinical Excellence
  - Medicines and Healthcare products Regulatory Agency
  - Department of Health
  - Royal Pharmaceutical Society of Great Britain (RPSGB)
  - Social Care Institute for Excellence
  - Medical and other clinical royal colleges, faculties and professional associations.
- The safe and secure handling of medicines: a team approach (RSPGB, 2005)
- Safer management of controlled drugs: Guidance on strengthened governance arrangements (DH, 2007)
- Safer management of controlled drugs: Guidance on standard operating procedures for controlled drugs (DH, 2007)
- The handling of medicines in social care (RSPGB, 2005)
- Research governance framework for health and social care: Second edition (DH, 2005)
- The Mental Capacity Act 2005
- Mental Capacity Act Code of Practice 2007
- Misuse of Drugs Act 1971
- Health and Social Care Act 2006
- NICE Guidelines - Managing Medicines in Care Homes 2014

## Scope

- All medications, drugs.
- All persons delivering Care or Support, and persons ordering, receiving, managing, administering, disposing and recording medicines.

## **Policy**

- This policy must be read in conjunction with the Royal Pharmaceutical Society - Handling Medicines in Social Care, which takes precedence over this document, and any specific requirements of the Registration Authority. These publications can be found by following the link below:
  - [The handling of medicines in social care](#)

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## **Common Policy**

### **Roles, Responsibilities and arrangements for supervision**

- Management and supervisors are responsible for:
  - The training and assessment of Care workers in the skills and techniques of medications management consistent with their roles;
  - Instruction of the Care workers in the specific requirements in respect of medications management;
  - Ensuring that Care workers are at all times provided with administration systems and resources to support their role;
  - Supervision and auditing of individual Care workers and systems in order to ensure compliance with this policy, as well as with legal requirements and best practice, and to ensure that at all time care workers are meeting the needs of Service Users;
  - Regular audit of medications records in order to confirm that the standards of practice and record keeping in respect of medications are as specified to the Care worker. Shortcomings will be reported into the organisation's quality assurance system, and in addition the Care worker(s) involved will be formally supervised and remedial action taken.
- Care workers are:
  - Permitted to assist the Service User in taking prescribed medication, within the limit of the Care worker's training and experience;
  - Care workers will be instructed, through induction and continued training in the skills, requirements, and level of competence which are required in order to carry out their role. In particular, Care workers who are not a Registered Nurse must have completed a Medications Administration course approved by the Registration Authority before administering medicines, and must also have completed a Medications Management course approved by the

Registration Authority if they manage the system through which other Care workers and themselves administer medications.

### **Medications management in a (Service User)'s own home:**

- General:
  - Wherever possible, Service Users will manage their medications and self-administer them. If an assessment determines that this is not possible, potential Care Plans may include:
    - A Care worker with appropriate training encouraging the Service User to self-medicate, confirming that the medication has been taken or refused, recording this result, including the time, and taking the action described elsewhere in this policy in the event of a refusal;
    - A Care worker trained and certified as a competent may administer the medication, taking responsibility for correct administration according to this policy and procedure.
  
- Doses can be left out for the Service User to take at a later time. This should be used as a last resort and other options should be discussed before deciding on this action, such as an additional visit for medication prompt. If no other suitable option can be found, then it should be agreed with the Service User, included in the Care Plan, and risk assessed to protect both the Service User and Carers.
  
- Refusal of medication:
  - Identify any special medication administration preferences of the Service User by reading the medication Care Plan.
  - If a Service User refuses to take their prescribed medication then the reasons for refusal should, if possible, be identified with the Service User, and a second attempt made to offer the medication having addressed the Service User's concerns and requirements.
  - A Service User **MUST NEVER BE FORCED TO TAKE MEDICATION**; this act would constitute abuse.
  - When a Service User refuses medication advice should be obtained from the prescribing GP in order to minimise medication risks.
  - Medication refusal and consequent action taken by the Care worker must be documented on the medication Care Plan and the medication administration

record, and the information communicated in the on-site attendance documentation to the incoming person responsible for medication.

**THE REMAINDER OF THIS POLICY DOCUMENT WILL ONLY APPLY IN THE EVENT THAT THE CARE WORKER BECOME INVOLVED IN EITHER SUPERVISING OR ADMINISTERING MEDICATIONS, AND SHOULD BE APPLIED APPROPRIATELY. IT IS RECOMMENDED THAT IN SERVICES WHICH MAY BECOME INVOLVED IN MEDICATIONS SUPERVISION AND/OR ADMINISTRATION, ALL CARE WORKERS ARE REQUIRED TO READ AND UNDERSTAND THIS POLICY, TO AVOID THE POSSIBILITY THAT A SERVICE USER CEASES TO SELF ADMINISTER BUT THEIR CARE WORKER IS NOT APPROPRIATELY TRAINED TO DEAL WITH THAT EVENT.**

### **General**

- Medicines are managed and administered safely to Service Users that need them at a time they need them and by staff who have been trained and assessed as competent to do so.
- Service Users' rights to choice, independence, privacy and dignity are promoted by staff in the medication processes and procedures in the Care service and Service Users' values and beliefs are respected by staff who are involved with the management and administration of their medication.
- All the legal requirements for the management and administration of Service Users' medication will be adhered to at all times and designated staff will be responsible for the sharing of information regarding medication with individual Service Users and, where appropriate, with their advocates.
- Medication will be used to prevent and manage disease and alleviate discomfort.
- Service Users will be fully involved with the management and administration of their medication.
  - They will be fully involved by the staff about their individual medication and its purpose and will have the medication patient leaflet information provided by the dispensing pharmacist shared with them in a method which promotes their understanding.
- Before medication is administered to any Service User, **FORMAL CONSENT** must be obtained. Where a Service User is unable to give valid consent due to mental

incapacity, best interest meetings will take place where it is agreed that it is in the best interest of the person, including their medical interests, that medication is administered then **FORMAL AUTHORISATION** for medication administration will be obtained.

## Training

- Care workers must be trained in the handling and use of medication and have their competence assessed:
  - By supervisor's observation of practice during the first medication handling following initial training completion.
  - By supervisor's of practice at 3 months following initial training completion
  - Reviewed at formal supervisions.
  - By supervisor's observation of practice annually.
- Each staff member will have an individual record of medication training, competence assessment, and practice skills supervision monitoring.
- Training must include:
  - The supply, storage and disposal of medicines
  - Safe administration of medicines
  - Quality assurance and record keeping
  - Accountability, responsibility and confidentiality

## Induction Training

- CERTIFICATION of previous medication training must be supported by a competence assessment of the staff member's knowledge and ability to manage and administer medication before any such staff member is permitted to undertake medication handling.
- Staff must be given time to read and understand all of the provider's policies and procedures related to medication management and administration.
- **Basic medication training** prepares Care Staff:
  - To give medicines via mouth (tablets, capsules and liquids);
  - Drops into the ears, nose and mouth;
  - Medication be inhalers;

- Medicine applied to the skin
- **Further training is needed for:**
  - Any invasive techniques such as giving suppositories, enemas and injections;
  - Medication competence is assessed formally by the Care manager or Provider where qualifications and skills are appropriate. This is carried out by observation of practice against the medication policies and procedures.
- **The following key tasks of Care workers are to be observed:**
  - Checking what medication the Service User takes on the medication administration record and on the medication labels;
  - Checking it is the right person;
  - Asking whether the person wants the medication;
  - Checking that the medication has not already been given;
  - Preparing the correct dose for the time of the day;
  - Giving a suitable drink, with the medication, to the Service User;
  - Signing the medication record entering the relevant date (for example, where specific time is required or for a medication which is taken only when needed e.g. for pain management).
- Care workers are permitted, if trained, to:
  - Give capsules tablets and oral medicines;
  - Apply external creams and lotions;
  - Insert drops to ears nose or eyes;
  - Administer inhaled medication.
- **Timing of medication** administration can be crucial and **adherence to medication prescription instructions must be followed**. This must be clearly indicated in the medication Care Plan and in the medication administration record.
- **Medicines must be given only to the person for whom they are prescribed**, following the prescription instructions.
- **Medicines must be given only from the container in which they are supplied by the pharmacy or GP. DOSES OF MEDICATION MUST NOT BE PUT OUT IN ADVANCE OF ADMINISTRATION**; this can lead to errors and accidents.

### Ongoing and updating

- Health and social care practitioners should be able to access reliable and up to date information about medicines. Resources may include the patient information leaflet supplied with the medicine and the following websites:
  - Medicines and Healthcare Products Regulatory Agency

- NHS Choices
- NICE Evidence
- Patient.co.uk
- Health professionals may also use the:
  - British National Formulary (BNF)
  - British National Formulary for Children (BNFC)
  - Clinical Knowledge Summaries Electronic Medicines Compendium

**Particular staff training issues for services delivered in the Service User's own home:**

- Where care staff only supervise Service Users' self-medication:
  - There may be occasions when the Care service needs to offer support with medication due to Service Users' mental health issues;
  - Training must include:
    - How to support Service User to take responsibility for their own medicines;
    - Action to be taken if a Service User becomes unwell and unable to take full responsibility for medicines;
    - Obtaining Service User formal consent if Care workers give medication;
    - Which medication the Care worker can give, having been trained to do so;
    - By what method the Care worker keeps records;
    - Providing medication storage on an individual Service User basis.
    - Policies and procedures to guide homecare staff in the processes of medication handling in the person's own home including what to do if a person decides not to take their medication.
    - What to do if the Service User's mental or physical health state changes significantly.
    - How to communicate between Care workers and other agencies.
    - How medicines that are no longer in use are disposed of.
- Where Care workers administer medications to Service Users:
  - **Insurance** it is important that those that provide care in a domiciliary setting have adequate insurance for all the tasks including supporting the Service User with their medication;

- Homecare workers who work alone must be appropriately trained and regularly assessed for their competence in the safe handling of Service Users' medication;
- The Care provider must have clear plans on the individualised support for Service Users in their own homes who use medication. This must be detailed in their Care Plan and actively reviewed and monitored by the designated Care staff, who will have the appropriate skills and knowledge to do so safely and effectively;
- Communications between Care workers, supervisors, and prescribers must be effective in order to ensure that the Care staff are kept up to date with Service User medication changes and associated support needs.
- **Important points for domiciliary care staff:**
  - The role of the Care worker in the Community is to enhance the independence of the client;
  - They must have received appropriate and accredited training, and been assessed as competent, before assisting the client in the administration of medicines;
  - To follow and adhere to any written policy and procedure when administering/supporting the client with their medication;
  - It is important to assess beforehand and document the amount of help and support the client with their medications. In all cases this should be agreed with the client;
  - Care staff should be confident with which medications they may administer after being trained to do so;
  - Clearly and unambiguously understand the way that the Care worker keeps records;
  - What the Care worker MUST NOT DO e.g. OFFER ADVICE ON TREATMENT OF MINOR AILMENTS. They should see advice and guidance from their line manager should this issue arise or if they are asked to do so;
  - Care Workers must not apply antiseptic cream ointment to broken skin lesions.
- **It is not appropriate for a Care worker to influence:**
  - How a person chooses to obtain medicines;
  - How and where the person chooses to keep medicines in the Agency;
  - How medicines that are no longer in use are disposed of;

- The choice of over the counter medicines the person/parent of the child Service User may wish to buy;

## **Confidentiality**

- All medication records for the Service User must be treated as confidential, and permission obtained from the Service User (or their advocate where appropriate) for the sharing of medication records, when this is needed to contribute to their health and wellbeing.
- Where Service Users wish to be given their medication in private this must be accommodated to support their personal dignity and promote their autonomy.

## **Self - administration**

- All service users that have the ability and mental capacity to self- medicate should be given the opportunity and support to do so.
- In order to protect the safety of the Service User and others it is essential to assess the Service User's ability to manage their medications independently and safely. This assessment should include:
  - Whether the Service User wishes to self-medicate;
  - Identify that the Service User knows the medication they are taking, what it is for, and how and when to take it;
  - Understand how important it is, not to leave the medicines lying around where someone else may take it accidentally.
- A full assessment of their ability and mental capacity to self-medicate must be carried out and documented.
- In a Service User's own home, the assumption is that the GP supports self-medication. However, if there is any doubt then self-medication by the Service User should be authorised by the prescribing GP, following a risk assessment.
- The assessment and documentation will be stored in the individual Service User Care Plan, and a copy held with the Service User's medication record when Service Users are self-medicating. This will help to remind staff of the need to monitor any associated risks.
- The assessment will be reviewed if there is a change in the Service User's mental or physical health state, and on a routine basis timed according to self-medication Care Plan instructions (as the timing of the review will depend on individual needs and risks).

- The Agency will have an individual medication record for Service Users who self-medicate and their medication supply will be checked in and out, as for other Service Users.
- Any Service Users who share their home with other people and self-medicate will have a locked facility in their room for the safe storage of medicines. Where the Service User is taking controlled drugs they are also kept in their personal locked storage area together with other medications.
- Consent must be obtained from the Service User to enable designated Care staff to monitor the medication supply being used by the Service User and to monitor the Service User's continuing ability to manage their medication safely.
- A full audit of the medications used in self-medication will need to support the tracking of the medication from the point of ordering, receipt into the Agency, the date given to the self-medicating Service User, the usage of the medication by the Service User and the destruction or disposal of any medications that are not required.
- When Care staff have to prompt self-medicating Service Users to take their medication this should be documented and closely monitored by all staff involved in medication management and administration. If this situation is recurring a review of the risk assessment for self-medication for the individual should be carried out and appropriate action taken and documented in the Service User's Care Plan and medication records.

### **Cultural requirements and medication**

- Vegetarians, Vegans and people from certain religious groups will not want to take gelatin capsules, because they are made from animal products.
- Some people may prefer to have medications given to them by people of the same gender.
- Some religious festivals include fasting and some people prefer not to have medicines given at certain times.
- Followers of the Jewish and Islamic faiths may be concerned about medicines containing substances which are unclean according to the tenets of their faith.

### **Obtaining medication supplies**

- Where possible and ideally the client or their family/friends should be responsible for ordering their repeat medicines. In situations where this is not possible, the Care Worker (following advice from their line manager) may assist the client to do this and

record this in any care Plan. The Service User must be capable of Directing the Care Worker and any assistance given should be recorded in the medication record;

- The Service User is ultimately responsible for specifying the medicine to be ordered and the dosage and quantity to be requested;
- The Service User must inform the care worker which surgery/GP they use and the procedure for ordering repeat prescriptions as different surgeries have different;
- The Service User must always retain the right to choose which Pharmacy dispenses their medicines;
- The preferred option for collection of medicines from the Pharmacy should include family/friends or checking whether the pharmacy has a delivery service. If these are not possible, a risk assessment for the Care Worker should be carried out by their line manager, and if it is felt appropriate, the Care Worker may then be asked to collect medicines on behalf of the Service User. This must be clearly noted in the Care Plan;
- Prescriptions received from GP practices should be checked against the requested medications before submitting the prescriptions to the pharmacy;
- Any unexpected medication changes should be checked with the GP before use;
- A formal process for the arrangements with the dispensing pharmacist should be organised and documented in order to specify the internal medication training and competence assessment programme, and to be available for staff reference.

### **Administration of medication**

- Medication must be given safely to maximise the benefits to Service Users' health and wellbeing.
- Medication must be managed and administered by procedures and processes which promote Service User independence, choice, privacy and dignity.
- Medication management and administration procedures and processes must take account of Service Users' cultural and religious values and beliefs
- Service Users must be given an opportunity to self-medicate and be given the range of support and Care needed to enable them to self-medicate when they have been assessed and proved to be able to self-medicate.
- Where Service Users have consented to their medication to be administered by staff, they should be assured that the staff responsible have been trained and assessed as competent to do so.
- All Care staff, including those who are not directly concerned with the administration of medicines, should be trained in the understanding of medications, the main types

of medications in use, their administration procedures, and how to look for and report possible adverse reactions, including changes which may require review of the Service User's medication prescription.

- Only staff who have had certificated medication management and administration training and who have been assessed by the manager as competent should be involved in the administration of medication.
- Medication must be checked, administered and signed for on the medication record by one person who is accountable for all stages of medication with respect to individual Service Users.
- MEDICATION MUST NOT BE TAKEN FROM ITS ORIGINAL CONTAINER AND GIVEN TO ANOTHER MEMBER OF STAFF TO GIVE THE MEDICATION TO THE Service User as the person checking the right dose for the right person must also witness the person taking the medication, and must be sure that the medication has been taken properly by the Service User.
- Carers must not administer insulin injections
- Staff administering medicines must be provided with protected time sufficient to carry out the task accurately.

### **Storage of medication**

- Medications must be stored in a safe place.

### **Record keeping**

Record what you do when you do it. As medicines are given they should be recorded immediately and signed for by the person responsible immediately following administration, and before moving on to the next Service User.

- Record any medications not taken, with reason why.
- Correct mistakes with a single line through the text, accompanied by a signature, date and time. Never use correction fluid.
- Record medicines given by other professionals, such as a visiting health professional.
- Records will be clear, complete, legible, written in black ink dated and signed to say who has made the record.
- The intention of the medication records is to allow a full stock quantity reconciliation to be carried out without warning at any time. Therefore records must include:
  - Receipt;

- Dispensing;
- Destruction or disposal for whatever;
- Transfer to another person or facility.
- The medication administration record for an individual Service User will include the name of the Service User, date of birth, weight, name of the drug, the dose, the to be given, and any special requirements, e.g. with food only.
- For self-medicating Service Users the date and the name of the Care staff who gave the Service User their supply of medication must be recorded in their medication administration record, as well as in the Care Plan, and must be accounted for by their signature.
- Where records are held on computer these must comply with data protection regulations, must be tamper-proof, and must give clear indications of who has made the record entry.
- ALL STAFF INVOLVED IN MEDICATION MANAGEMENT AND ADMINISTRATION ARE RESPONSIBLE FOR ACCURATE RECORD KEEPING.
- Medication administration records must record:
  - The medications are prescribed for the person;
  - Where, when and the quantity of any medications received;
  - The dose of the medication;
  - Any special administration requirements;
  - The name and designation of the person making the record;
  - Copies of emails, texts, faxes and transcriptions of phone messages must be kept and stored with the mediations Care Plan.
- **Disposal of medication records must record:**
  - Preferably family and friends should assist the client to return unwanted medication to a Community Pharmacy for safe disposal. Where this is not possible then a Care Worker can with the permission of the client remove any unwanted medicine from the client's home and return to the pharmacy for safe disposal and as long as the provider has a waste licence and a formal process/procedure for the care worker to do so safely;
  - It is good practice to use a medicine disposal form and ask the pharmacy to sign for any returned medication and a copy kept.
- **Hand-over.** Staff must ensure at shift handover that all information regarding all changes to medications administration during that shift is communicated to the incoming staff, and they have received and understood the message.

## **External medication application**

- Medication applied to the Service User's skin should be applied by a staff member wearing disposable gloves. Creams and lotions must be applied according to the prescription instructions.
- Instructions for creams and lotions must be clear.
- Before Care staff members apply creams and lotions they must be trained and assessed for their knowledge and competence related to the application of external medication.
- Clear information must be available to inform Care staff as to what the Service User's cream is for how much to apply, where precisely to apply the cream, the frequency of application and for how long the application is to continue.
- There must be a Care Plan for the application of the cream and a daily account of its application.

### **Controlled Drugs**

- Anyone collecting controlled drugs from a pharmacy will need to produce personal identification and sign for receipt of the medication.
- All controlled drugs must be accounted for on the Service User's medication administration record for receipt, times of administration and destruction or disposal.

### **Adverse drug reaction**

- If a Service User becomes unwell after taking a new medication then the prescribing GP should be notified immediately, or it may be necessary to contact the emergency ambulance service if the reaction is severe.
- An incident report must be completed and submitted to the Registered Manager for review.

### **Inappropriate use of medication**

- MEDICATION MUST NOT BE USED AS A FORM OF RESTRAINT TO SEDATE PEOPLE FOR THE CONVENIENCE OF THE CARE SERVICE STAFF. THIS IS ABUSE.
- Medication must only be administered to the person who has been prescribed that medication.

- Partly used medication dispensed for an individual, and no longer required, must not be used for any other person.
- Where several Service User have the same medication, the medication must only be administered from the container marked with the Service User's name. This must be clearly accounted for in the drug stock audit.
- An incident report must be completed and submitted to the registered manager for review.
- Administration of medicines inappropriately, whether by design or accident, is potentially abuse and must be reported immediately to the registered manager, and the formal safeguarding process initiated.

### **Medication errors**

- Any medication error must be immediately reported to the GP of the Service User affected by the medication error and any advice given acted upon to protect the safety of the Service User. If a GP cannot be contacted immediately then NHS Direct and the local pharmacy should be contacted for advice.
- The incident and all action taken must be documented in the Service User's Care Plan, medication record, and an appropriate incident form completed by the person responsible.
- The Service User and their personal advocate must be fully informed by the service manager of the incident and the actions taken in order to minimise the risk to the Service User.
- An incident report should be made to the regulatory authorities regarding the incident and actions taken by the service management following the medication incident to investigate causal factors and future medication error prevention strategies to be acted upon.
- All staff involved in medication error incidents should have an immediate formal supervision by their line manager to offer support and to support investigation of the incident.
- All medications errors should be documented on an incident report, reported to the manager and investigated to prevent further errors occurring.
- Any mistake with medication management or administration should be treated as an incident or error and recorded as such, and brought to the attention of the person in charge of the Service at the time, and to the attention of the service manager.
- Examples of medication errors:
  - Medication given to the wrong person;

- The wrong dose is given, i.e.e too much or too little;
- Medication is not given.
- All staff should be encouraged to promptly report medication errors
- All medication errors should be investigated, with any necessary changes to training and procedures being made immediately.
- All actions taken should be recorded.
- All serious incidents should be reported to the professional regulatory body.

### **Nutritional supplements**

- There must be a Care Plan for any nutritional supplements used the Service User. These must be supported by an assessment of need and a monitoring and review record to document when the supplements are given, by whom and the measured quantity taken by the Service User accurately recorded and accounted for.
- The medication record must be signed when the supplement. A daily record of nutritional supplements taken or refused by the Service User must be recorded in the Care Plan daily. Refusal to accept nutritional supplements must be treated as other medication refusal and reported to the prescribing professionals and recorded as refused on the medication record by the accountable staff member.
- A regular review of the use of nutritional supplements should be requested by the Care service and this will be made by the prescribing GP or dietician.
- All medications given must be recorded at the time they are given and also when a person refuses their medication.
- If a person cannot swallow then their medication advice must be obtained from a health Care professional and alternative liquid medication could be prescribed.  
MEDICATION MUST NOT BE CRUSHED OR CAPSULES SPLIT TO GIVE TO Service users as this may affect the way medicines work and can be potentially harmful to the Service User.

### **Homely remedies**

- Relatives who buy homely remedies for Service Users should be encouraged to contact the GP or pharmacist for their advice regarding proposed homely remedy medication.
- Advice regarding the use of homely remedies must be obtained from a doctor, pharmacist, or nurse.

## **Advice from a pharmacist**

- All services should have an arrangement with a local Pharmacy or dispensing GP to provide advice to staff concerning medication management and administration.
- Medication supply from a community pharmacist should be of appropriate quality and suitably labelled for its intended purpose.
- Dispensing service should be:
  - Accurate;
  - Accessible;
  - Prompt;
  - Reliable;

## **Monitored dosage system and compliance aid**

- MDS do improve some procedures including:
  - The system of organising repeat prescriptions for Service Users;
  - A visual check whether medicines have been prepared and given to the Service User.
- Medication NOT to be packaged in a monitored dosage system:
  - Medicines that are sensitive to moisture, e.g. effervescent tablet;
  - Light-sensitive medicines, e.g. Chlorpromazine;
  - Medicines that should only be dispensed in glass bottles, e.g. glyceryl trinitrate (GTN);
  - Medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate;
  - Medicines that should be taken when required, e.g. painkillers;
  - Medicines whose dose may vary depending on test results, e.g. warfarin.
- Liquid medicines, creams, eye drops, inhalers must be supplied in traditional containers. Therefore, any Care agency that uses MDS will have two different systems operating.
- Some Care providers who have been unable to get medicines in MDS have allowed Care workers to re-package medicines in compliance aids. This is also known as “secondary dispensing”.
- Repackaging of medicines by Care workers should NOT take place. The risk of making a mistake is too great.

## **Ordering, storage and administration of “when required” (PRN) medication**

Medication with a “When required” (PRN) dose is usually prescribed to treat short term or intermittent medical conditions, i.e. it is **not** to be taken regularly. Therefore, it should be approached differently to regular repeat medication.

### **Recording PRN Medication in Care Plans**

- The details of the medication, i.e. name of drug and strength.
- Signs and symptoms - specific to the individual
- The precise reason for dispensing, for instance “in the event of lower back pain”
- Why has it been prescribed and how to give it?
- How long for? If advised by the prescriber.
- When the medication should be given, e.g. before, with or after food.
- The maximum daily amount or the time to leave between doses **must** be recorded.  
E.g. Paracetamol - 2 tabs every 4-6hrs when necessary (**Max 4 doses in 24 hours**)

### **Ordering PRN Medication**

PRN Medication by its nature should not need to be included in the monthly repeat medication, this will help to minimise waste.

- PRN medication should always be supplied in an original box rather than a monitored dosage system (MDS). This allows for check on the expiry date and reduces waste.
- PRN medication that is still in use and i date should be carried over from one month to the next and **not** disposed of.
- A record of the quantity carried over must be recorded on the new MAR chart so there is an accurate record of the quantity in stock.

### **Storing PRN Medication**

Please follow the policy for storage of medicines.

### **Administration of PRN Medication**

Staff administering medication should have the appropriate training and follow the procedures set out in medication policy. However, when administering PRN medication the following points need to be considered:-

- PRN medication should not be offered or given only at the times listed on the MAR chart or at specific medication rounds. As it is for occasional use the person should be offered the medication at the times they are experiencing the signs and symptoms either by telling a member of staff or by staff identifying the residents' need as **outlined in the Care Plan.**
- The exact time the medication was given and the amount given (e.g. 1 or 2 tablets if prescribed as 1-2 tablets prn,) should be recorded on the MAR.
- A record does not have to be made at each medical round to show the person has been offered the medication. However, the Care Plan should demonstrate that staff know what the medication is for and have made an assessment on whether the person requires the medication.
- The Care Plan should show the needs of the person e.g. If signs of pain are expressed in a non-verbal way.

#### **Other areas to be considered**

- If a PRN medicine is administered on a regular basis a referral to the prescriber should be considered for review of the resident's medication. This action must clearly be recorded in the resident's Care Plan.
- Should the PRN medication not have the expected effects the prescriber should be contacted. This action must be clearly recorded in the residents' Care Plan.
- Paracetamol: If body weight is <39kgs consider giving 1 or 2 tablets up to four times a day, in order to stay within safe toxicity limits of a maximum dose of 100mg/kg body weight per 24 hours.

#### **Return of unused/unwanted PRN Medication**

Please refer to the policy for control of medicines for homes.

### **MEDICATION FOLLOWING SERVICE COMMENCEMENT**

#### **Medication Assessment**

- Pre-commencement assessments of medication taken by the Service User should be made to include medication name, dose, time of taking, reason for taking and Service User understanding regarding their medication.

- On commencement, the Service User's formal consent will be sought, and recorded, in order to allow the designated Care staff to support the Service User with the management of their medication supply.
  - Medication assessments and associated Care Plans will be carried out by staff who have been trained and assessed as competent for the management and administration of Service Users' medication.
  - All Service Users will have a format, documented assessment for self-medication.
  - All Service Users will have a format, documented assessment of their individual needs and specialist requirements in relation to their medications.
  - The assessment will include any potential side effects or known allergies associated with medication for the individual Service User.
  - On commencement day all medications will be recorded on the Service User's medication assessment.
  - Following the assessment the information will be used to formulate a medication Care Plan which will stipulate medication names, doses, times of administration, route of medication, and any special requirements the Service User has in relation to individual medications and their safe management.
  - Any changes made by the GP will be noted and appropriate changes made in the records and in the medication supply. This will be discussed with the Service User where appropriate, and with their consent any medication no longer required by the Service User will be returned to the pharmacy.
  - Service User will be advised that they should seek the advice of an independent advocate if they have concerns regarding their medication.
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  - On commencement day all medications will be recorded on the Service User's medication assessment.
  - Following the assessment the information will be used to formulate a medication Care Plan which will stipulate medication, doses, time of administration, route of medication, and any special requirements the Service User has in relation to individual medications and their safe management.
  - Any changes made by the GP will be noted and appropriate changes made in the records and in the medication supply. This will be discussed with the Service User where appropriate, and with their consent any medication no longer required by the Service User will be returned to the pharmacy.

- Service User will be advised that they should seek the advice of an independent advocate if they have concerns regarding their medication.

### **Medication Review**

- Medication review can be made by the prescribing GP, community pharmacist, or prescribing specialist community nurse.
- Medication review should take place:
  - As soon as possible following commencement;
  - When medication side effects are noted;
  - Where the Service User's health state changes;
  - When there are any recommendations by the Department of Health regarding particular medications taken by the Service User;
  - When the Service User is discharged from hospital and there been changes in their medication.

### **Medication on temporary transfer or absence**

- The supplying pharmacist will be able to advise the Care service and be able to offer support by providing a special container for medication at the time when the Service User is likely to be on leave.
- If a Service User is likely to be out of their home for one or more medication administration time then the Service User should be given the correct medication, clearly named and with clear written instructions stipulating the medication dose and time to be taken:
  - These medications should be entered onto the medication record as given to the Service User but not administered by the staff;
  - A risk assessment of the Service User's ability to manage the medication should be documented in the Care Plan by the staff responsible for the medication arrangements at the time the Service User leaves the building;
  - Where a Service User is unable to self-medicate the staff member escort will be trained and competent in the administration of medication, will take responsibility for the medication, and will complete the medication records on to the Agency.
- Ensure that any person responsible for administering or assisting with self-administration of medicines while off the premises is aware of:

- What medicines the Service User needs to take;
  - Clear directions on how, when and how much of each medicine to take;
  - What time the last dose of each was taken;
  - Contact numbers for queries, such as The Agency, pharmacy, or GP.
- On return to The Agency the senior designated staff should check with the Service User to ensure that their medication has been taken correctly and record the answer on the medication administration record.

### **Medication on permanent transfer**

- On permanent transfer to another care facility a copy of the current assessment, most recent review and the current medication administration chart must be transferred together with the Service User.
- Record the transfer of information in the Service User's documentation.
- Original copies of all documents relating to medications for the Service User must be retained in accordance with normal practice for storage and retention.

### **Sharing of information on medications**

- Medications information regarding a Service User is confidential and must only be shared with persons or organisation who may have need to temporarily administer medicines to the Service User, or is responsible for reviewing the medications, such as a hospital.
- The Service User must be informed of the proposed information sharing and authorise it.

### **Disposal of medication**

- Medicines must be disposed of as soon as they cease to be currently prescribed, or the person for whom they are prescribed is no longer present.
- Where the Service User has left the service or dies, see the " Medication on discharge" or "Medication on death" sections of this policy.
- Where medications for existing Service Users require disposal:
  - A complete written record of all medicines to be disposed of should be made;

- Services providing Care in Service Users' own homes are to return medication to the dispensing service which must have an appropriate arrangement for medication disposal in order to meet current regulatory requirements for waste management;
- All unused medications will be returned to the pharmacy, covered by a written record of the returns on a Disposal of meds form, with signatures against each item.

### **Verbal telephoned, video link or online medication instructions**

- Changes of drug doses are sometimes ordered by GP s over the telephone. This must be by exception only. There must be a formal procedure for this and all staff must be made aware of the process by internal training and supervision.
- The prescriber must establish the capacity and consent of the Service User, and the training and capacity of the staff before prescribing when not present.
- Records of telephone medication messages should include:
  - Who took the call;
  - The time of the call;
  - The name of the person who called;
  - Record of changes made.
- Before ending the call:
  - Read back the information that has been written down to reduce the chance of misunderstandings;
  - Spell out the name of the medicine(s);
  - Request written confirmation by letter or secure email or by issue of a new prescription, without delay, and before the next administration of the medicine.
- Staff must change the Service User's medications records immediately on receipt of a "not present" prescription.
- Staff must record the time and date of the change, and ensure that a second administration of that medicine does not take place before written confirmation is received.

### **PROCEDURE FOR MEDICATION ADMINISTRATION**

#### **Remember the 5 x R's:**

- 1. Right Medication**
- 2. Right Dose**

### **3. Right Way**

### **4. Right Person**

### **5. Right Time**

- Check you are giving the medication to the right person. Ask them for their name, check recent photograph, and cross reference name and , if appropriate, their room number on the medication record. Make sure that you know the person by name. If in any doubt check with another member of the Care team or contact the administration office who will know the Service User well.
- Select all of the correct medication for the time of day for the individual Service User. ALWAYS CHECK THE MEDICATION RECORD. DO NOT RELY ON MEMORY OR ADMINISTER ONLY WHAT IS IN FRONT OF YOU.
- Ask the person if they are experiencing the condition for which the medication has been prescribed.
- Give the medication with a tumbler of water(or milk if required by the prescription) and encourage the person to sit in an upright position whilst swallowing the medication.
- If the tablets or capsules are in a monitored dosage pack, open the appropriate section and empty the tablets/capsules into a medicine pot and hand it directly to the Service User.
- Transfer the medication from the bottle or pack into a medication pot and give this directly to the Service User.
- Liquid medication must be measured into a clearly graduated and marked medication pot or by using an appropriate sized syringe which clearly identifies individual millimeter markings.
- Medication must not be handed but transferred to the medication pot in a non-handling clean method.
- Some medications may be harmful if handled by the Care worker and disposable plastic gloves must be available and worn where there is an identified risk. This may also apply where the Service User is unable to handle medication and they require extra support, although the handling of drugs should be avoided and medication spoons used to aid administration where difficulties are identified.
- Medication doses affected by the latest blood results should have a copy of the latest results kept with the medication administration record.
- Ask if they want to take their medication before removing them from the pack. If they refuse, try again a little later. Refusal must be documented and the GP or pharmacist

telephoned for advice. NEVER FORCE ANYONE TO TAKE MEDICATION AND IT MUST BE HIDDEN IN FOOD OR DRINK.

- Medicines to be taken when required (PRN) should be offered to people experiencing pain, and the time and dosage noted in the medication administration record.