LD Residential - Management, Storage and Administration of Medicine Policy

Solihull Adult Care & Support

Solihull
METROPOLITAN
BOROUGH COUNCIL

Version Control Log

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1.0	26/03/2019		Initial document
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CONTENTS

1. Introduction

1.1. This policy applies to all the residential learning disability services provided by Solihull Metropolitan Borough Council (SMBC) where medicines are handled and administered by all staff. This policy has been produced to safeguard both individuals being supported and staff. Its purpose is to promote a quality service without contravening the philosophy of an 'ordinary life'.

2. Statement

2.1. This document states the overarching framework in relation to the handling of medicines, including, obtaining medicines, administration, storage and disposal. It is based on current legislation, NHS, Care Quality Commission (CQC) and professional body guidance, Epilepsies: diagnosis and management (Clinical Guidance (CG137) Last updated April 2018.

2.2. Approved Standard Operating Procedures (SOPs) for the Small Homes Service must be produced and implemented within each unit following the guidance and core principals of this document.

3. Scope

3.1. To ensure that all staff working in residential learning disability homes in SMBC, including bank and agency staff, carry out safe handling of medicines.

4. Responsibilities

4.1. All health and social care professionals are responsible for their own actions and must exercise their own professional judgment at all times. However, any decisions that vary from the agreed SMBC procedures or guidelines should be documented in the individuals care and support plan, and include the reason for variance and the subsequent action taken.

4.2. An accountability structure is in place. It starts from the support staff, managers who oversee the local delivery of all relevant policies, to the Head of Provider Services through to the Service Director who has overall responsibility and accountability for SMBC Learning Disability Services (please note titles of posts/positions may change due to organisational restructure).

4.3. **Management Responsibilities**

4.3.1. To ensure that safe and secure systems are in place and maintained for the management of medicines throughout the service, from medicines reconciliation through to administration, disposal or transfer.

4.3.2. To ensure this document reflects current policy and thinking and is reviewed at regular intervals (every 2 years).

4.3.3. To ensure that all staff are aware of this policy, understands content, are compliant with the policy and to ensure that copies are available for reference.

4.3.4. To prepare, review and approve SOP's specific to the units they work in, in line with this policy.

4.3.5. To ensure all staff have awareness and understand the content of the SOP's and work to them at all times.

4.3.6. To ensure that only appropriately trained and competent members of staff (i.e 'authorised persons') are involved in the management of medicines.

4.3.7. To identify the training needs of staff in relation to their duties to this policy and to ensure that suitable training is provided for its implementation.

4.3.8. To ensure the competency of each 'authorised person' is maintained and assessed on at least six-monthly intervals.

4.3.9. To keep a record of all 'authorised persons' (staff trained and deemed competent to administer medicines).

4.3.10. To keep an up-to-date list of specimen signatures and initials of each 'authorised person' in order to facilitate identification of the person who administered each medication. This includes agency and bank staff whose duties include administration and handling of medicines.

4.3.11. To support audits as identified within the learning disability services and/or if requested to do so by the SMBC Care Quality Monitoring Officers (CQMO), SMBC Investigation and Audit Team, or CQC.

4.3.12. To ensure procedures are in place so that individuals have an adequate supply of medication.

4.3.13. To ensure procedures are in place to support safe sharing of accurate and up-to-date information about an individual's medicines, including when they transfer between care settings.

4.3.14. To ensure that procedures are in place so that medicines remain fit for use and do not exceed their expiry date.

4.3.15. To ensure the recommendations in relation to any handling of medicines audit are actioned within identified timescales.

4.3.16. To ensure that any incidents relating to medicines are reported internally and, where required, externally (e.g. to the CQC and Police), and to ensure that they are investigated in a timely manner and any learning is shared.

4.4. Staff Responsibilities

4.4.1. To ensure that they maintain awareness and understanding of the content of this policy, including any amendments or revisions.

4.4.2. To ensure they attend training as identified by their line manager and ensure they maintain their medication competency

4.4.3. To ensure that they have received training as detailed in this policy and verify any further training needs relating to this policy and the SOPs to their line manager.

4.4.4. To work within this policy, adhere to all SOPs specific to the area they are working in and within their own competency.

4.4.5. To report any medication errors or concerns to their line manager and complete a SMBC Incident Report form if appropriate.

4.4.6. To ensure medication is administered at an appropriate time and manner.

4.4.7. To inform the appropriate manager if medication supplies are running low.

4.4.8. To inform the appropriate manager if medication in the home is approaching or has exceeded its expiry date.

5. Training and Competencies

5.1. Throughout this document an ‘authorised person’ is defined as either a line manager who has attended SMBC approved medication training, or a member of support staff who has also attended SMBC approved medication training but in addition has successfully completed the in-house competency framework including Standard Operating Procedures. See the separate SMBC in-house training/competency documents (Appendices 1-5):

5.2. All staff have the responsibility to ensure that their training is current and up to date.

5.3. Training for specific delegated tasks (i.e. Midazolam or insulin) will need to be attended by all staff supporting individuals requiring these tasks.

Appendix 1 - This form is used to record three separate sessions where the candidate observes an 'authorised person' administer medication.

Appendix 2 - This form is used to record the candidate being supervised administering medication over 3 separate sessions.

Appendix 3 - This form is used to record the final assessment which demonstrates that the candidate has been deemed competent to administer medication.

Appendix 4 - This is the record sheet documenting dates of assessment and reassessment.

Appendix 5 - This provides questions for the final assessment.

5.4. An 'authorised person' may be a permanent member of the team at the service or agency or bank staff who can demonstrate competency across all areas.

5.5. During their induction period, all staff that will administer and handle medicines as part of their duties must be registered on a medication training course from a SMBC approved provider. Refresher training must then be completed every two years as a minimum.

5.6. SMBC staff must be competent to be able to administer medication from all types of packaging, including, Multi meds system (MMS), cardboard boxes and liquid medicine bottles. The type of system assessed must be stated on assessment form - Appendix 4. They will have their training and competency reviewed and documented on a six-monthly basis.

5.7. If an assessment of competency is conducted using the MMS system, then a further observation / assessment of competency should be conducted if the staff member then works in a different area using an alternative system. They will not be required to complete the full process but must show awareness and understanding of the alternative when administering medication.

5.8. Once assessed as competent it will be the expectation that all 'authorised persons' will support the administration of medication within other homes/services as required to meet operational needs.

6. Equality Statement

6.1. All public bodies have a statutory duty under the Equality Act 2010 to measure how their policies and functions impact on people with Protected Characteristics under the Act

6.2. SMBC endeavours to challenge discrimination, promote equality and respect human rights, and aims to design and implement services policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

6.3. All staff are expected to deliver services and provide care in a manner which respects the individuality of each service user and their carers, and to treat users of SMBC services and their carers fairly and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.

6.4. When administering medication, staff should take into consideration any religious or cultural views of the individual. For example, medication containing gelatine, alcohol or pork products may not be suitable for certain religious/cultural groups. This should be recorded in the individual's support plan and hospital passport. Also, during religious festivals, special timings for medication may need to be considered.

6.5. Advice must be sought from the pharmacist or prescriber regarding these issues.

7. Documentation

7.1. SOPs should be available for all stages of the medicines management process, including obtaining, handling, storage, administration and disposal processes that take place within the service. Template SOPs have been produced by a Learning Disabilities Procedures Working Group and are available from the Learning Disabilities (LD) managers (a selection of template SOPs are included as appendices to this policy).

7.2. SOPs should be reviewed at least every two years or sooner if there is any change in the processes that occur, change in SMBC or professional body guidelines (e.g. Nursing and Midwifery Council (NMC)), or changes to legislation.

7.3. Staff involved in handling medicines should sign to confirm that they have read and understand the content of this Policy and the service's SOPs and that they agree to comply with them.

7.4. A register must be maintained within the service of all staff trained and authorised to administer medicines.

7.5. There must be adequate documentation in place to facilitate an audit trail for all medicines received into the service, administered to individuals and returned to the pharmacy for disposal or transferred elsewhere.

7.6. Documentation for ordering prescriptions, including all record books (e.g. CD Register), must be locked away when not in use.

7.7. A Medicines Administration Record (MAR) chart must be used for each individual.

Records retention:

- MAR charts and attached prescriptions must be retained for 2 years.
- CD record books must be retained for 7 years from the date of the last entry.
- Care records should be retained for 8 years.
- Incident reports should be retained for 10 years.

8. Consent to examination, support/care or treatment

8.1. Before beginning an examination, providing support/care or treatment, staff must ensure that they obtain the informed consent of the person they are examining, supporting, caring for or treating. For informed consent to be valid, the person must:

- **Be competent to take the particular decision** - it is presumed that adults have capacity to consent unless it is shown otherwise. The Mental Capacity Act 2005 provides a test for assessing whether a person lacks capacity to take a particular decision at a particular time and the steps to be taken if the person lacks capacity.

- **Have received sufficient information to make it** - this will include information about the benefits and risks, including side effects, of the proposed course of action, the implications of not receiving the examination, care or treatment and alternatives.

- **Not be acting under duress** - there is a need to balance ensuring that all the person's concerns are fully identified and addressed with not persisting in discussions to such an extent that the person feels harassed. Staff must also be aware of the possibility of undue influence from family and friends.

- If there is anything that may hinder individuals ability to give informed consent

to administration of medicines (e.g. health problems or impaired hearing or vision), this must be recorded and brought to the attention of the Line Manager as soon as possible. A healthcare professional may be required to undertake a formal assessment of the individual's mental capacity in line with the Mental Capacity Act 2005.

- If the individual is found to lack capacity to consent, decisions must be made in the best interests of that person. The Mental Capacity Act 2005 provides structured and specific tests for capacity and a list of issues to be taken into account when determining what is in the person's best interests. Any assessment of an individual's mental capacity will be documented in their support/care plan.

9. Supporting people to take their medicines administration

9.1. Medicines reconciliation (on moving into/out of the service)

9.1.1. A full review of the current medication requirements of a new individual are to be established during the assessment process prior to moving into the service.

9.1.2. All medication to be checked against current MAR chart and prescriptions. (See SOP MM16) Further checks can be made with GP or Social Worker if required.

9.1.3. At least one month's supply of medication to be requested ready for admission/transfer, to include MAR chart.

9.1.4. When the individual moves into the home the RCM must ensure that:

9.1.5. Medicines reconciliation is carried out by coordinating the accurate listing of all of the individual's medicines using a minimum of two reliable sources e.g. the individual and/or their family/carer, the physical medicines accompanying them, pharmacy, their GP, a recent prescription or hospital discharge summary, and any other health or social care practitioners involved in managing medicines for the individual.

9.1.6. Sufficient, reliable and up-to-date information is obtained for the individual, including full demographic information (full name, date of birth, address and weight), details of any allergies/sensitivities, their GP and pharmacy, details of any recent changes to the individual's medical/medication history, details of any preference

9.1.7. Contact is made with the GP on the first working day to register the new individual. Once they are registered with a local GP, prescriptions can be obtained as described in section (Ordering Prescriptions.)

9.1.8. When an individual is moving out, a prescription is requested from the GP for one month's supply (or a minimum of one week's supply) of medication for them to take to their new home.

9.2. Obtaining medicines

9.2.1. The supply of medicines to residential services comes under the remit of the Medicines Act 1968. Medicines prescribed and dispensed for individuals (including dressings and nutritional supplements) are the property of the named person and are never to be used by others.

9.3. Ordering prescriptions

9.3.1. All individuals must be registered with a local GP practice.

9.3.2. Repeat prescriptions will normally allow for 28 days' worth to be supplied at a time and should be ordered in a timescale adequate to ensure continuity of supply.

9.3.3. Medication may only be ordered by an 'authorised person' and they must take into account any supplies of medication left over from previous cycles - if non - MMS medicines are still prescribed, within their expiry date and fit for use, they should be carried forward to the next cycle and may only be re-ordered if the remaining quantity will not sufficiently cover the whole of the next month's cycle.

9.3.4. Prescriptions should be written with full and precise instructions avoiding the use of ambiguous phrases such as 'take as directed'. Any ambiguous directions must be queried and, where appropriate, amended by the GP.

9.3.5. Prescriptions produced by the GP practice must be retrieved, checked for accuracy and completeness, and photocopied before they are sent to the pharmacy for dispensing. This should be carried out sufficiently in advance of the individual needing the medication to ensure that there is enough time to address any discrepancies or queries with the GP practice. Arrangements should not be made for the pharmacy to collect the prescriptions directly from the GP practice.

9.3.6. Photocopies of prescriptions should be filed in the MAR chart folder before sending the original prescription to the pharmacy to be dispensed. New medication should be added to the current medication record on the individual's file.

9.4. Obtaining Medicines from the Pharmacy

9.4.1. The service should have an arrangement with a community pharmacy to dispense medicines against a valid prescription for each individual in appropriate containers and to provide professional advice.

9.4.2. The pharmacy may agree to supply medicines in a MMS. The MMS service is not part of a pharmacy's NHS contract; this will be a good will gesture.

9.4.3. Where medicines are dispensed in the MMS system, Patient Information Leaflets (PILs) should be obtained from the pharmacy and kept in a file for reference.

9.4.4. Prescriptions should be taken to the pharmacy in a timescale adequate to ensure continuity of supply and to allow time for any discrepancies to be resolved.

9.4.5. A prescription for immediate treatment may be sent electronically (e.g. via fax or email) to the pharmacy, with the pharmacist's permission, in circumstances where a staff member is unable to get the prescription to the pharmacy in a timescale adequate for the clinical needs of the individual. The service should then ensure the original prescription is given to the pharmacy when the medication is collected or delivered.

9.4.6. The community pharmacy should be asked to supply printed MAR charts whenever possible.

9.4.7. A regular day for collection of repeat medication should be agreed so the service can ensure an 'authorised person' is available to receive and check in the medication.

9.4.8. Where staff collect and carry medicines, the transport arrangements must be secure and prompt. They must be in the possession of the staff member at all times, locked in the car boot and brought directly back to the service.

9.5. Following Hospital Discharge

9.5.1. When an individual is discharged from hospital, staff should ask the hospital to write the discharge (to take out (TTO) medicine on a Hospital HPFP10NC prescription form so that it may be taken to the service user's community pharmacy for dispensing and so a printed MAR chart can be provided.

9.5.2. Where discharge is at short notice or outside of normal working hours, the medicines will need to be supplied by the hospital. The discharge medication

list must be checked against the discharge medication instructions on the pharmacy label and kept with the MAR chart. The individual's MAR chart should be accurately completed/amended as necessary by an 'authorised person' at RCM or deputy level. It should also be checked and countersigned by a second person who is also an 'authorised person'.

9.6. **Emergency/out of hour's prescriptions**

9.6.1. If an individual requires new medication outside normal working hours and it is in the individual's best interest to start the new medication straight away, an out of hours service prescriber may issue an FP10 prescription form, to be dispensed at any community pharmacy. If the prescription from an out of hours service prescriber does not need supplying immediately it should be obtained at the earliest opportunity in normal working hours from the service's regular community pharmacy.

9.6.2. If the supplying pharmacy is unable to supply a MAR chart then an 'authorised person' must add this new item to the MAR chart and sign and date the entry. Another 'authorised person' must check, countersign and date the entry at the earliest opportunity.

9.6.3. In all cases where this occurs, all appropriate staff must be made aware of the additional items to ensure correct and timely administration.

9.7. **Receipt of medicines**

9.7.1. On receipt of medication from the pharmacy the person in charge at the time must be informed and the medicines must be locked away as soon as they are received. Medicines must never be left unattended while waiting to be locked away.

9.7.2. The medication remains the responsibility of the staff member who collected it until the person in charge has taken receipt.

9.7.3. An 'authorised person' must check and record the receipt of all medicines received as soon as possible and always on the same day. The check should involve checking the photocopied prescription against the physical medication that has been received as well as the MAR chart where present. Checks should include checking the medicine's full name, strength and form, directions for use, quantity, and fitness for use (e.g. expiry date). Wherever possible, a second 'authorised person' should perform the same checks independently and this second check should be documented (two signatures).

9.7.4. Where medicines received for an individual differ from those requested on the repeat form, the service must contact the supplying pharmacy as soon as

possible. Any incorrect medication must be kept secure and separated from the other medicines until it can be returned to the pharmacy.

9.7.5. The 'authorised person' will then ensure the medication and MAR charts are stored appropriately (checking if any storage requirements have changed) in a locked area or cupboard until required. Please note that medicines must never be stored on the floor.

9.8. Security and storage of medicines

9.8.1. Access to medicines must be restricted and controlled. Medicines must be stored in a dedicated locked cabinet/cupboard when not in use, and medicines in use during an administration round must never be left unattended. It is the responsibility of all staff to ensure that medicines are kept out of reach of unauthorised persons including individuals and visitors.

9.9. Keys and Key Holders

9.9.1. The medication cupboard key must be kept secure at all times within the provided locked and security coded key holder and only be assessable to the authorised key holder.

9.9.2. Keys to the medicines cupboard must be kept on a separate ring from any other keys to ensure that the medicines keys are not accessible by unauthorised persons.

9.9.3. Keys should never be left unattended (except when locked in the key cupboard which is only accessed by 'authorised' staff).

9.9.4. A spare set of keys must be available and kept locked away in a secure place. The main set and the spare set of keys must not be kept in the same place within the home. Alternatively, they may be exchanged with another service. All staff who work in the home and the Service Manager must be aware of the storage arrangements for the spare keys.

9.9.5. The allocated key holder is stated on the rota for each shift showing time, name and handover to next key holder, including location & any key code.

9.9.6. Loss of keys must be reported immediately to the relevant manager. If the lost keys are not located within 24 hours, the locks must be changed. An incident form should be completed and consideration given as to whether the police should be informed.

9.10. Storage

9.10.1. There must be adequate space to allow the appropriate and secure storage of all medicines within the service.

9.10.2. The designated medicine cupboard(s) should only be used to store medicines.

9.10.3. Medicines must be stored in line with the manufacturer's storage/temperature recommendations.

9.10.4. The following storage systems to be used:

- Medicines Cupboard(s) - this is for the storage of room temperature medicines (medicines indicated to be stored up to 25-30°C). Internal medicines (e.g. oral medicines, injections, MMS must be clearly segregated from external medicines (e.g. topical preparations).
- Controlled Drugs Cupboard - this should be a designated cupboard, which meets the standards of the Misuse of Drugs (safe custody) Regulations 2001 (for more information see CQC guidance).
- Fridge medicines - either a dedicated, lockable, medicines fridge or a lockable container within the normal domestic fridge to be used to store medicines requiring storage at temperatures between 2°C and 8°C. Medicines are not to be allowed to freeze.

9.11. Temperature monitoring

9.11.1. A digital maximum/minimum thermometer to be used to maintain a record of all areas where medicines are stored. Temperatures read and recorded, and the thermometer reset, at least once per day. Temperatures recorded on a temperature log. Local SOPs should be in place in case the temperature goes outside the recommended range.

9.11.2. Medicines must be kept in the container in which they were supplied from pharmacy. Blisters of tablets/capsules must never be removed and stored outside of their original container. Items such as eye drops and creams should be kept in the outer carton.

9.12. Multi Meds System (MMS)

9.12.1. MMS blister packs may be provided by the pharmacy. Care must be taken to ensure that all MMS medicines are checked on receipt and are identifiable. Any medicines left over in MMS blister packs at the end of the cycle must be returned to the pharmacy for destruction.

9.12.2. PRN medication must not be put into an MMS as this can lead to wastage of medicines.

9.12.3. Certain medicines cannot be put into MMS this may be for a number of reasons including sensitivity to moisture in the air, because they won't physically fit, or because they have other specific storage requirements. These medicines must not be removed from the original container in which the pharmacy supplied them and care must be taken to ensure that the MMS blister packs and non-MMS medicines are administered.

9.13. Medicines administration record (mar) charts

9.13.1. Each individual must have a current MAR chart. The supplying pharmacy should be asked to print the MAR charts wherever possible.

9.13.2. Each MAR chart should be dated, unambiguous, complete, legible, written or printed in indelible ink and updated following any change to the individual's prescribed medication. The supplying pharmacy will print MAR charts wherever possible. Checks must be in place to ensure MAR charts contain:

- the individual's demographics i.e. full name, address or location, date of birth, GP and/or consultant and weight , where appropriate e.g. frail older individuals
- details of any medicines the individual is taking, including the name of the medicine and its strength, form, dose
- directions for use, including the dose (quantity of medicine to be administered), time of administration, how often it is given (the frequency), how it is to be given (route) and duration if the medicine is only prescribed as a course
- any known allergies or reactions to medicines or their ingredients, and the type of reaction experienced (the allergy field must never be left blank)
- any special instructions about how the medicine should be taken (such as before, with or after food, dissolved in water etc.)
- the quantity that has been received and/or carried forward; it is good practice to also include regular stock balance checks
- clear records of any medicines being self-administered, being administered by healthcare professionals (not staff) or being administered outside of the home.

9.13.3. If possible, no more than one MAR chart should be in use at any one time for any individual. On occasions where individuals are taking a large number of

medicines it may be unavoidable to have more than one current MAR chart at any one time, in which case each chart must be clearly marked e.g. ‘1 of 2’, ‘2 of 2’ etc.

9.13.4. A new chart must not be started because the first is not immediately available. If a further MAR chart is supplied mid-cycle then the page numbers are to be changed accordingly with two staff signatures next to the number change.

9.14. Amendments to MAR charts

9.14.1. If there are any changes mid-cycle to the individual’s medication regimen, a new MAR chart should be obtained from the pharmacy or the entry rewritten by the prescriber. In exceptional circumstances where this is not possible in a timescale to meet the clinical needs of the individual, an ‘authorised person’ can cross out the old entry using a diagonal line (records must not be obliterated, Tippex or sticky labels must never be used) .and clearly write in block capitals the new information on a new section of the MAR chart.

9.14.2. All amendments must be signed and dated by the ‘authorised person’ carrying out the amendments, and a brief reason for the amendment stated nearby; a witness must also check, sign and date the amendments. Instructions for mid-cycle amendments to prescriptions that have been received from the prescriber by telephone must be supported in writing (or by fax/email) before the next dose is given. Superseded MAR charts must be cancelled by a diagonal line, signed and dated, and retained in the individual's records.

9.15. Six Rights

When administering medication, staff must consider the six rights of administration:

Right Individual

- Check the individuals name against the care plan, medication and MAR chart.
- In care homes and day services a photograph of the individual must present to assist with confirming the individual’s identity. A photo should be taken upon admission to the care setting, dated and reviewed or updated annually.
- Providers must ensure that medicines prescribed for an individual r are not used by any other person.

Right Medicine

- Check that the medicine is labelled with the individual's name.
- Check the medicine name (e.g. Paracetamol), strength (e.g. 500mg) and form (e.g. tablets); the MAR chart, medication label, packaging and contents all must match.
- Check there have not been any recent changes to the medication.
- Check the dosage instructions before giving medication.
- Check that the medicine is fit for use i.e. in its original packaging as supplied by pharmacy and in date (check the expiry date, taking into account whether or not the medicine has a reduced shelf life after it has been opened).

Right Route

- Check the way in which the medication is to be administered (e.g. orally, topically, nasally etc.) – this should be recorded on the MAR chart.
- Medication must only normally be administered by non-invasive routes.
- Any invasive medicines (e.g. those administered rectally, by injection, by feeding tube etc.) carry a higher level of risk and should only be administered by a healthcare professional or, in exceptional circumstances, by 'authorised persons' who have been specifically trained and deemed competent by a healthcare professional to administer via a specific invasive route e.g. by PEG feeding tube. This must be risk assessed by the Registered Care Manager (RCM).
- When the staff member needs to insert drops to ears, nose or eyes; or administers inhaled medication - the patient information leaflet that comes with the medicine 'How to use' must be followed

Right Dose

- Check that the dose on both the MAR chart and medication label match (dose is the amount of medication to be given to the individual).
- Check that the dose has not already been administered by checking the MAR chart – if the dose has already been signed for on the MAR chart, the service manager, On Call Manager or the pharmacist should be consulted before the medicine is given.
- Check for changes to the dose (any amendments must be clearly signed and dated).

- Record on the MAR chart the actual amount given at each administration where a variable dose is prescribed.
- Check that you have the right measuring device for liquid doses; the smallest marked measuring device available to suit the intended dose should be used in order to ensure accuracy, and oral syringes should be used for small doses of liquid medicines that cannot be accurately measured in a 5ml spoon.
- Doses should be equally spaced throughout the waking hours.

Right Time

- Check that the dose time is clearly specified on the MAR chart and/or the medication label. For example, 'Take one tablet in the morning' clearly identifies when this medication is to be given, however, 'take one tablet daily' leaves this open to interpretation, unless the dose column on the MAR chart is marked as to identify the time.

- Ensure the dose is offered within an hour of the time indicated on the MAR chart. For a medicine that needs to be given or taken at a specific time, where a delay in receiving the dose or omission of the dose may lead to serious patient harm (e.g. insulin injections for diabetes. HIV meds or specific medicines for Parkinson's disease), this needs to be clearly documented on the MAR chart.

  This should also be documented in the individual's medical notes and information passed on as required to the appropriate others.

  Information about time sensitive medicines needs to be shared with other agencies involved.

  See appendix 3 when to refer to Safeguarding (criteria for considering a medication incident/error as a safeguarding concern)

- Ensure a record (administration signature or omittance code) is made on the MAR chart immediately after administration.
- Check for any additional labels, precautions or special instructions such as 'take with or after food' or 'avoid grapefruit juice' and ensure these are adhered to.
- Record on the MAR chart the actual time given where a PRN medicine is administered.
- Before administering a PRN medicine, check the last time of administration against the PRN protocol to ensure the necessary time interval between doses has passed.

Right of the Individual to Refuse

- The individual has the right to refuse to take any medicine, unless they have been assessed and found to lack capacity (see Covert Medication Administration).

- Do not give the medication if one or more of the above rights is incorrect. Seek further guidance, initially from your line manager.

- Medicines that are prescribed and dispensed for one individual remain the property of that individual and must not, under any circumstance, be given to another individual or used for a purpose that is different from that for which they were prescribed. Medicines must never be used for social control or punishment.

- Medicines administration should only be undertaken by an 'authorised person' as described in (Training & Competencies Section). The service must have and maintain a register of 'authorised persons' as described in (Management Accountabilities Section) In line with the Health & Social Care Act 2008 (regulated activities) regulations 2010, there must be a sufficient number of trained and competent 'authorised persons' to ensure medicines can be administered safely at all times, including during periods of staff annual leave and sickness.

- It is the responsibility of the 'authorised person' administering the medication to ensure that medicines are administered as prescribed. If at any stage in the process the 'authorised person' cannot resolve any queries or discrepancies, then the Registered Care Manager, Deputy Manager, or if out of hours On Call Manager should be contacted as soon as possible

- Medication must be administered directly from the container provided by the pharmacist and never be secondary dispensed ('put up' for someone else to administer to the individual at a later time or date).

- Where medicines are transported around the service for administration to be undertaken, it must be done in a secure manner. Medicines must never be left unattended. It is the responsibility of all staff to ensure that medicines are kept out of reach of unauthorised persons including those individuals being supported and visitors.

- When an 'authorised person' is administering medicines, it should be their only task for that period of time. The same 'authorised person' should complete the whole administration process from start to finish for each service user, dealing with just one person at a time, and they must have enough protected time allocated to be able to do it safely without distraction.

- Each medicine administered must be checked against the MAR chart as well as the container/MDS/BDS label using the Six Rights. For procedures specific to each service, the service's medicines administration SOP must be followed.

- The MAR chart must be signed/initialled by the 'authorised person' administering the medicines to the individual after each medicine is administered and before moving on to the next person.

9.16. When assisting with medication administration please bear in mind the following:

- If in doubt, DON'T administer, seek advice: IF IN DOUBT, CHECK IT OUT.
- If things go wrong, telephone Line Manager for advice. Alternatively contact the GP, a community pharmacist or another healthcare professional. Call NHS 111 for urgent, non-emergency medical help.
- Hands should be washed before administering any medication.
- Medication must not be touched unless disposable gloves are worn.
- Any spoons / medicine pots used during the process must be washed after use.
- A glass of water should always be offered with medication that is taken orally.
- Spilled or dropped medication must be recorded on the MAR chart.
- Disposable gloves should be worn when applying topical preparations such as creams.
- Topical preparations such as creams must not be applied to broken skin unless specified by the prescriber.
- Do not advise on or suggest medication other than what is written on the MAR chart.
- Do not administer medication that has been tampered with.
- The date of opening must be recorded on medicines that have a shortened shelf life after they have been opened e.g. eye drops that state 'discard one month after opening'.
- Staff must not assist with any medication that is not written on the MAR chart.

9.17. Non-administration/refusal:

9.17.1. Details of non-administration (e.g. refusal) must also be recorded on the MAR chart. Instead of an administration signature/initial, an omittance code must be put into the signature box and a record made on the back of the MAR chart

and in the service user's care record; this information should also be passed on to the Registered Care Manager, Deputy Manager who will decide what further action is necessary, including notifying a healthcare professional if appropriate.

Any omittance code used must be clearly referenced in the Key on the MAR chart; if there is not a code that adequately describes the reason that the dose has not been given, it is acceptable to create a new code as long as this is clearly referenced (added to the Key). Regular or on-going refusal or non-administration of medication must be communicated to the prescriber as a medication review may be required.

9.17.2. Planned non-administration e.g. due to service user being out of service on a visit or holiday must also be noted on the MAR chart using the appropriate code. See 'Medicines Given Outside the Service' section below.

9.17.3. The date of opening must be written onto the medicine container for any medicines with a reduced shelf life once opened (e.g. eye drops, creams etc.).

9.17.4. Crushing of tablets and opening of capsules to facilitate swallowing is not allowed unless it is authorised by the doctor and/or pharmacist.

9.18. PRN and Variable Dose Medicines

9.18.1. PRN medicines (medicines to be administered 'as required') must be available outside of the normal medicines administration times and must be kept in their original packaging as supplied by pharmacy – they should not be dispensed in MMS packs as this will lead to wastage.

9.18.2. A PRN protocol should be produced for each PRN medicine and put in the individual's Medicines Administration File – it must be easily accessible when administering medicines. PRN protocols should, as a minimum, state the reason/conditions that must be present in order to warrant administration, specify the maximum single dose, the minimum dosage interval (time between doses) and the maximum number of doses that may be given within 24 hours.

9.18.3. PRN protocols for behavioral medication should be drawn up in consultation with a psychiatrist and/or psychologist. All other PRN protocols can be drawn up by the RCM, Deputy and confirmed by the service user's GP.

9.18.4. All PRN medication administered must be recorded on the front and back of the MAR chart and in the individual's notes.

9.18.5. A protocol similar to a PRN protocol should also be used for variable dose medicines to ensure consistent administration in line with the prescriber's

intentions. When administering a variable dose, the protocol should be adhered to and the exact dose given at each administration must be clearly recorded on the MAR chart.

9.18.6. If the MAR chart or prescribed directions are in any way unclear, the corresponding medication must not be administered. The RCM, Deputy or On Call duty manager should be contacted in the first instance as soon as possible. If appropriate the pharmacist or prescriber should be contacted.

9.19. Self- Administration

9.19.1. Individuals able to self-administer medication should be encouraged to do so in order to maintain and promote their independence. An individual risk assessment should be completed and clear evidence of the level and type of support required must be documented within care / support plans.

9.19.2. A lockable storage facility must be provided for all individuals who choose and are assessed as safe to self-administer.

9.19.3. A MAR chart must be in place for all individual's, including those that self-administer, in order to ensure there is an audit trail for all medicines within the residential home. Staff should not sign for administration on the MAR chart on behalf of any individual who self-administers – instead, there should be a clear record on the MAR chart to indicate that the individual is 'self-administering'.

9.19.4. Monthly medication audits must be undertaken to ensure that medication is being taken and not being stockpiled.

9.20. Medicines given outside the service ('TTOs')

9.20.1. Individuals should not be prevented from going on holiday or visits simply because of their need for medication. Arrangements should be made for the medicines to be available and administered in a safe manner.

9.20.2. For planned holidays, a separate supply to cover the period outside of the service should be obtained on prescription from the GP and dispensed by pharmacy.

9.20.3. When medication needs to be administered outside of the service unexpectedly or at short notice, an 'authorised person' may prepare the medicine(s) but must avoid secondary dispensing (removing the medicines from their pharmacy-issued container).

9.20.4. For each medicine required during the period of leave, the pharmacy-labelled container must be provided. If a MMS is in place (where each individual pot is

printed with the individual's name and medicine details), then the required number of individual pots may be provided. For all other medicines, the whole pharmacy-labelled container must be provided; this includes MMS r packs and PRN medicines in their original pack. A second 'authorised person' must check the preparation of the medicines as a witness.

9.20.5. Each service must keep a To Take Out ('TTO') Medication Record Book/Form. Each time medicines need to leave the premises for administration during a period of leave, a record must be made to include the following:

- Name of Individual
- Reason for taking medication out
- Date medication is going out
- Medication name, strength and form
- Dose and times to be administered
- Quantity of medicine being taken out
- Person responsible for taking medication out
- 'Authorised person' signature
- 'Authorised person' witness signature

And on return:

- Quantity of medicine received back onto the premises

9.20.6. The named person taking responsibility for giving the medication outside the service could include a staff member trained in the needs of the individual, a, family member, friend or advocate.

9.20.7. The 'authorised person' must explain to the named person when and how the medicine(s) should be administered (allowing opportunity for the named person to ask any questions). Clear directions should be given (preferably a photocopy of the MAR chart) as well as contact details for who to contact if there are any queries or issues.

9.20.8. The named person must sign the TTO Medication Record Book/Form for receipt of the medicine(s) and to confirm that they understand when and how to administer each medicine, are responsible for their safekeeping, agree to keep them secure until needed, and will ensure the medicine(s) are looked after and stored in a responsible way to prevent theft, exposure to extremes of temperature or damp and kept out of reach of children.

9.20.9. Upon return, the containers (including any that are empty) should be returned to an 'authorised person' who will check them and make a record in the TTO Medication Record Book/Form. The named person should be asked if any doses have not been given, and to provide the reason for any non-administration – this must be recorded on the MAR chart as well as in the TTO Medication Record Book/Form and the individual's medical file.

9.20.10. During an Individual's leave, the MAR chart should be marked accordingly.

9.20.11. If there are any concerns about sending whole supplies of medicines outside of the home during periods of leave, a separate smaller supply should be obtained via the GP and pharmacist and held for such occasions.

9.21. Covert medication administration

9.21.1. Covertly giving medication means hiding it (e.g. in food or drink) so that the individual is not aware in any way that they are taking it. This practice will only be used in exceptional circumstances, never routinely.

9.21.2. Staff should never administer medicines to an individual without their knowledge (covert administration) if the individual has the capacity to make decisions about treatment and care.

9.21.3. Covert administration must be agreed by a Best Interest decision (a decision that the need for the medication is greater than the need for the individual to consent to taking it). A Best Interest decision should involve the GP (or other healthcare professionals trained to assess mental capacity), someone representing the service, someone acting in the best interests of the individual (e.g. a family member or advocate) and a pharmacist to ensure the medication will remain stable and effective when administered in food or drink.

9.21.4. The decision to covertly administer medication to an individual must be clearly documented in the care and support plan, detailing why the decision has been made, with copy notes from the Best Interest Meeting, which must detail all rights and benefits. This must also be recorded on the individual hospital passport. The decision to covertly administer must then be reviewed regularly (minimum annually).

9.21.5. There must be individual guidelines in place to detail how to best administer each medicine to the individual.

9.21.6. Nutritional effects must never be compromised; generally medication should be administered at the end of the meal in a small portion of food or liquid - not the whole meal.

9.21.7. For further information, see the policies, procedures and guidelines on consent and the Mental Capacity Act 2005.

9.22. Homely or 'Household remedies

9.22.1. Warfarin is an oral anticoagulant. Individuals on warfarin must have regular blood tests to ensure their dose of warfarin is safe and effective; these may result in the dosage being adjusted on a regular basis.

9.22.2. Individuals on warfarin will have either a 'yellow oral anticoagulant booklet' or a printed sheet from the GP where test results and the prescribed daily dose of warfarin are detailed. Doses of warfarin may vary on a day-to-day basis and are subject to change regularly, therefore 'authorised persons' administering warfarin must always refer to the most recent instructions from the GP in the yellow book or printed sheet before each administration. Warfarin must also never be supplied in MMS.

9.22.3. Side effects, including any form of bleeding (nose, vomit, urine, faeces), severe bruising and headaches must be reported to the GP.

9.22.4. A clear and detailed SOP must be in place to support local warfarin administration and must include:

- Take tablets at the same time each day (this will usually be in the evening)
- Instructions for if the individual misses a dose
- Administer from original packaging (not MMS
- Staff training and assessment must include the colour codes of the tablets
- Always check the INR report when giving medication (GPs and pharmacists should check INR is at a safe level before issuing the prescription)
- Process to ensure blood tests are taken at the correct time, that INR results are received and that the correct dosage is written on the MAR chart.
- Process to follow up results if not arrived within 3 days by contacting the GP or anticoagulant service
- Attach written dosage instructions from the lab to the MAR chart
- Details of all changes to be written in the care and support plan

9.23. Adverse drug reactions

9.23.1. Any adverse drug reaction or suspected adverse drug reaction must be reported to the prescriber and/or supplying pharmacist for that individual before further administration.

9.23.2. For serious reactions, medical advice should be sought immediately and a manager informed. The reaction must be recorded in the individual's medical notes and hospital passport.

9.24. Disposal of unwanted/expired medicines

9.24.1. There must be an audit trail for all medicines leaving the service premises. If medicines are no longer wanted (e.g. if they have been discontinued by the prescriber, if they are no longer fit for use or if they have expired) an entry should be made in the 'Medicines Returns Book'. This should include:

- The entry date
- Individual's name
- Name, strength and form of medicine
- Quantity
- Date dispensed
- Signature of person making the entry
- If applicable, an entry should also be made on the MAR chart
- Reason for return
- Witness signature
- Where returned to (Pharmacy name & address)

9.24.2. The unwanted medicines should be stored securely and safely, separate from the medicines still being used, until they can be returned to the pharmacy for safe destruction. The pharmacist, dispensing technician, or delivery driver should sign and date the 'Medicines Returns Book' to acknowledge receipt and complete the audit trail.

9.24.3. Unwanted medicines must not be put in waste bins or down drains/toilets.

9.24.4. Medication which is spat out or dropped should be put in a clearly labelled container, stored safely and appropriately and returned to the community pharmacy.

9.24.5. Medication returned to the pharmacy must be recorded on the MAR chart following SOP MM11.

9.25. Controlled drugs (CDS)

9.25.1. CDs must be stored in a lockable metal cabinet meeting the requirements of the Misuse of Drugs (Safe Custody) Regulations.

9.25.2. Only 'authorised staff' should hold the keys and have access to the CD cabinet.

9.25.3. All services must have a CD cabinet and CD register (also known as 'CD record book') for the receipt, administration and return of CDs. All entries must be legible, made in indelible ink, signed by the 'authorised person' making the entry and countersigned by a witness.

9.25.4. The administration of CDs should be witnessed by another 'authorised person' and countersigned on the MAR chart as well as in the CD register.

9.25.5. The CD register must include a running balance for each individual CD with a separate record page being maintained for each individual. The balance must be checked at each administration and also on a weekly basis.

9.25.6. When receiving CDs from the pharmacy, the CD section on the back of the prescription must be signed by the staff member collecting the CDs. The name of the pharmacy should be written into the CD register to ensure there is a clear audit trail.

9.25.7. There must be a clear audit trial following the return/disposal of expired or unwanted CD's (see SOP MM 18). The collecting driver should sign the Controlled Drugs book to confirm collection.

9.26. Medication errors and incidents

9.26.1. All medication omissions, administration, dispensing or prescribing errors, including near misses, are considered incidents.

9.26.2. All incidents should be reported to the RCM or Deputy manager immediately after they are discovered. If no senior staff are available then the on-call duty manager is informed, the RCM or Deputy manager should be informed when they are next on duty.

9.26.3. Medication errors can be an indication of safeguarding issues (see section below).

9.26.4. An SMBC incident form should be completed for each incident. This helps ensure actions are taken to minimise the recurrence and to share learning.

9.26.5. It is the responsibility of the RCM / Deputy to inform Safeguarding Teams of the error and actions taken for safeguarding consideration.

9.26.6. On finding an **omission** the following actions must be taken as soon as possible:

- Find out if the medication has actually been omitted or just not signed on the MAR chart i.e. check MMS or packaging as appropriate and check with the person who was responsible for administering omitted medication
- If medication has been omitted, seek advice from the GP or pharmacist and ascertain if the medication can be given at a later time, or if any further action is needed
- Monitor/observe the individual if directed to do so
- Record omission in the individual's medical notes and on the MAR chart
- The manager should inform the individual's family/carer if appropriate (see 'duty of candour' section below)
- Follow the SMBC incident procedure ensuring complete and accurate details with actions taken are documented clearly.

9.26.7. On finding **any other error** the following action must be taken as soon as possible:

- Advice should be sought immediately from a prescriber/duty doctor/out of hours healthcare professional and, if appropriate, a pharmacist
- Any necessary corrective measures, observation or monitoring requirements requested must be carried out
- The error and any immediate action taken must be clearly recorded in the individual's medical notes and reported back to the manager and doctor in an agreed timescale
- The manager should inform the individual's family/carer if appropriate (see 'duty of candour' section below)
- The error must be reported following the SMBC incident procedure.

The Registered Care Manager must re-affirm that any 'authorised person' who made the error is competent to continue administering medication. This person will need to be suspended from administering medication until they have been fully reassessed and deemed competent. This may involve further training and re-assessment.

9.26.8. **Duty of candour:** This is the duty to be open and honest with the individual and/or their family/carer when something that goes wrong with their treatment or care or causes, or has the potential to cause, harm or distress to them. For any incident that results or has the potential to result in harm or distress to the individual r, the service has a duty of candour to them.

The individual or their family/carer (as appropriate) must be contacted and informed of the incident, offered an apology, informed that the incident will be fully investigated and offered support.

9.26.9. **Pharmacy errors:** If any dispensing error or defect regarding a medicine, label or container is identified (e.g. a labelling error, wrong medicine found inside a differently labelled box etc.) the item(s) should be segregated from current stock and clearly marked 'Do not use'. The error should be reported to the supplying pharmacy and arrangements made to rectify the error in an appropriate timescale to ensure continuity of medication. An SMBC incident form should be completed.

9.26.10. **Prescriber errors:** Where the error has been a prescribing error, the prescriber should be notified and arrangements made to rectify the error in an appropriate timescale to ensure continuity of medication. An SMBC incident form should be completed.

9.26.11. If medication is discovered to be missing from the service, the RCM or Deputy manager or 'on call' duty manager should immediately be informed. An investigation should be carried out and appropriate action taken which may involve contacting the police if necessary, and arranging for a replacement supply of medication. An SMBC incident form must be completed and senior management advised.

9.27. Safeguarding consideration and external reporting

9.27.1. Criteria for considering a medication incident/error as a safeguarding concern:

- The victim is caused significant and/or permanent harm or death.
- Errors in the administration of prescribed medication that leads to a medical intervention and/or A&E attendance.
- The incident/error was a deliberate act.
- The incident is part of a pattern or culture e.g. the same drug, carer or agency is involved, or the duration / frequency is particularly concerning.
- There is a risk of repeated or increasingly serious acts involving this or other vulnerable adults.
- The incident results in significant and/or permanent harm or death.

- Controlled drugs are involved, resulting in significant and/or permanent harm or death.
- Incidents where someone is given medication that has not been prescribed or bought specifically for them that results in significant and/or permanent harm or death.
- Incidents which involve a large number of people.
- Incidents that involve drugs liable for misuse/abuse; if unsure, consult a community pharmacist. Some common examples include:
- The 'Z' drugs – zaleplon, zolpidem and zopiclone (hypnotics indicated for insomnia)
- Sedating antipsychotics e.g. haloperidol, chlorpromazine
- Stronger opiate based painkillers like dihydrocodeine
- Benzodiazepines e.g. diazepam, temazepam etc.

The Care Quality Commission must be notified of all incidents that:

- Result in physical or mental impairment that is not likely to be temporary
- Require treatment by a healthcare professional in order to prevent death or injury/impairment
- Cause prolonged pain or prolonged psychological harm
- Shorten the life expectancy of the person
- Involve abuse or allegations of abuse in relation to the service user
- Have been reported to, or are being investigated by, the Police.

9.28. Drug withdrawals and hazard warnings

9.28.1. The RCM must action any information received concerning a hazard warning and/or drug withdrawal immediately. The supplying pharmacy should be contacted for advice and to discuss.

9.28.2. A signed and dated record must be made noting the action taken (even if no action is necessary). Where necessary a new supply of the affected medication must be obtained in an appropriate timescale for the needs of the service user.

9.28.3. The doctor must be contacted as soon as possible if the service user has been given faulty medicines or where it is necessary to change to an alternative medicine

9.29. **Medication reviews**

9.29.1. Arrangements must be in place for all individual's on regular medication to have regular medication reviews.

9.29.2. Arrangements (including frequency) for medication reviews should be agreed in advance and documented in the individual's care plan. The interval between medication reviews should be no more than 1 year. Medication reviews should involve the prescriber, the individual and/or their family/carer as well as, where possible, any other healthcare professional involved in the individual's medication (e.g. pharmacist) and a member of residential home staff.

9.29.3. Whilst regular reviews may be planned in advance, staff and 'authorised persons' who support the individual on a regular basis are well placed to identify if they may require a medication review sooner. Any recommendations for a medication review should be escalated via the RCM.

9.30. **Service self-assessment**

9.30.1. All Managers' must carry out at least six-monthly assessments of all staff to check that staff are complying with the SOPs in place.

9.30.2. All areas where medicines are stored should be regularly checked by the Registered Care Manager, Deputy Manager (at least weekly) for tidiness, cleanliness and appropriate stock management.

9.30.3. Expiry dates should be checked routinely and medicines rotated appropriately. This should be undertaken on at least a monthly basis by an 'authorised person' and documented.

9.30.4. All records relating to medicines including MAR charts, receipts and returned medicines books, and daily records of temperatures should be checked by medicine competent staff within the monthly audit to ensure appropriate recording and use.

9.30.5. RCM's / Deputy Managers must undertake at least a six-monthly audit of each service.

9.31. **Sharing information about an individuals medicines**

9.31.1. All information relating to individual's medicines, especially anything that may identify them or anything of a sensitive nature such as information relating to their health should be treated confidentially and respectfully.

9.31.2. It is sometimes important to share confidential information outside of the residential setting, particularly when it is needed for the safe and effective care of an individual e.g. if the individual has been admitted into hospital or if they are being transferred to another care provider.

9.31.3. When sharing information about an individual's medicines, the most up-to-date source of information should be used; this will usually be the MAR chart and the physical medicines, but it may also be a hospital discharge summary or recent prescription.

9.31.4. When an individual's complete list of medicines needs to be shared outside of the residential setting, a photocopy of the most the MAR chart, latest prescription and/or hospital discharge summary (whichever is most recent) should be sent. Staff must avoid handwriting or transcribing lists of medicines wherever possible due to the potential for errors.

9.31.5. If it is not possible to photocopy the MAR chart or if details of only certain medicines need to be shared, the medicine name, strength, form and directions that have been printed by pharmacy on the MAR chart or medicine label should be used.

9.31.6. Before sharing information:

- the information must be checked for accuracy, completeness and validity; wherever possible this should be checked by two members of staff.
- the identity of the requestor/recipient and confirmation that they have a legitimate need to access the information must be obtained.
- a secure method of transfer must be agreed to ensure the information is protected as far as possible from accidental disclosure or theft. Sharing information over the telephone must be avoided due to the potential for mishearing.

9.31.7. Care must be taken to ensure that only information that is legitimately required for the benefit and care of the individual is shared.

9.31.8. Whenever information about an individual's medicines is transferred to an external organisation, details of the transfer must be documented locally and communicated to colleagues e.g. at handover.

9.31.9. An individual's right to object to the sharing of confidential information about them must be respected.

9.31.10. Information that does not need to be shared for the direct safe and effective

care of the individual may only be shared after it has been fully anonymised i.e. after any information that could potentially identify the individual has been fully removed.

9.32. **Ensuring records are accurate and up-to-date**

9.32.1. It is essential to ensure that all current information in use for an individual is accurate and kept up-to-date.

9.32.2. Any changes to an individual's situation (including but not limited to medication changes, drug reactions, new or changed medical conditions, allergies, transfers of care or medication errors) must be documented in a timely manner in the individual's medical record/care plan, communicated in writing to colleagues (e.g. handover document or communication book) and, where applicable, updated on the MAR chart.

9.32.3. Any information that is no longer relevant, accurate or required must either be updated or, if no longer required, removed for archiving or secure confidential disposal. The Registered Care manager must be consulted prior to disposing of any confidential information in order to ensure any statutory/mandatory retention periods are adhered to.

9.33. **Death of an individual**

9.33.1. In the event of death, all medication (including prescribed, homely and topical preparations) must be retained for at least one month after the date of death, or until otherwise told it can be returned for disposal. The medication may be required for evidence by the Coroner as part of any on-going investigation.

10. Related Documents

- This document must be followed in conjunction with the following Policies:
- SMBC Reporting of Incidents
- Hand Hygiene Policy
- Safe Handling and Disposal Of Sharps Policy

11. Reference and further reading

- NICE Managing Medicines in Care Homes 2014 *(last updated Dec 2017)*
- CQC Regulations *(www.cqc.org.uk)*
- HSCIC Guide to Confidentiality 2013 *(NHS Digital's online resources)*
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2010
- Records Management Code of Practice for Health and Social Care 2016

- Epilepsies: diagnosis and management (Clinical Guidance (CG137) Last updated April 2018.

Prior to 2019 review:

- BNF online
- NMC - Standards for Medicines Management 2008
- Medicines.org.uk
- MAR in care homes and domiciliary care
- Safe management of CDs in Care Homes
- The handling of medicines in Social Care
- Training care workers to safely Admin Medication in Care Homes
- CQC Essential Standards of Quality & Safety, Outcome 9.
- Management of Medicines, regulation 13 of the Health and Social Care Act 2008
- Hand Hygiene Policy
- Safe Handling and Disposal of Sharps Policy

12. Commonly used abbreviations

- MMS Multi-Meds System
- CD - Controlled Drug
- CQC - Care Quality Commission
- GP - General Practitioner
- LD - Learning Disabilities
- MAR - Medication Administration Record
- NMC - Nursing and Midwifery Council
- PIL - Patient Information Leaflet
- PRN - When required
- RPSGB - Royal Pharmaceutical Society of Great Britain
- SOP - Standard Operating Procedure
- RCM - Registered Care Manager

13. Appendices

- Appendix 1 - Administration of Medication/Performing Allied Procedures by Support Staff - Training (Observation) Checklist

- Appendix 2 - Administration of Medication /Performing Allied Procedures by Support Staff - Practical (Supervision) Checklists

- Appendix 3 - Administration of Medication by Support Staff - Assessment Form

- Appendix 4 - Administration of Medication/Performing Of Allied Procedures - Competency Card

- Appendix 5 - Questions For Medication Assessment Appendix 6 - Standard Operating Procedures

- Templates -

Candidate Name:

ADMINISTRATION OF MEDICATION/PERFORMING ALLIED PROCEDURES BY SUPPORT STAFF - TRAINING (OBSERVATION) CHECKLIST

1. Encourage and facilitate understanding of the importance of safety when administering the following medications/procedures:
   - Oral medication (including medicines from tablet bottles and boxes, MMS, liquid medication,
   - Inhaled medication
   - Ear/Eye/Nose drops and sprays
   - Topical medications
2. Encourage and develop skills in the administration of medicines and when carrying out the above procedures.
3. **Discuss the "what to do if…" situations**.
4. Repeat the practical session at least three different occasions ensuring that this covers all medicine procedures as required.

Procedure MMS or Other (please state)

Date	Time of procedure/administration	Supervised by
Comments:		

Is the individual ready to go onto the practice of administering medication/carrying out procedures? **Yes/No** (delete as appropriate)

If No give details:

Candidate Signature	
Assessor Signature	
Date	

Candidate Name:

ADMINISTRATION OF MEDICATION/PERFORMING ALLIED PROCEDURES BY SUPPORT STAFF - PRACTICAL (SUPERVISION) CHECKLIST

1. Encourage and facilitate understanding of the importance of safety when administering the following medications/procedures:
   - Oral medication (including medicines from tablet bottles and boxes, MMS and liquid medications.
   - Inhaled medication
   - Ear/Eye/Nose drops and sprays
   - Topical medications
2. As supervisor of the support staff member you must provide constant supervision as they carry out the administration of medicines and allied procedures.
3. Step in immediately if an error is about to be made, offering constructive criticism.
4. Observe carefully the administration by staff member (using the administration of medicines SOP as a checklist).
5. **Discuss the "what to do if…" situations**.
6. Repeat the practical session at least three different occasions ensuring that this covers all medicine procedures as required.

Procedure MDS or BDS **(please state)**

Date	Time of procedure/administration	Supervised by
Comments:		

Is the individual ready to go onto the practice of administering medication/carrying out procedures? **Yes/No** (delete as appropriate)

If No give details	

Candidate Signature	
Assessors Signature	
Date	

ADMINISTRATION OF MEDICATION BY SUPPORT STAFF ---WORKERS

ASSESSMENT FORM

Service			
Candidate		**Assessor**	
Date		**Six Month Review Date**	

Stages achieved	✓	**Date**
1. Observation		
2. Administration under supervision		
3. Assessment of competency		
Category (activity)		
a) Oral medical including MMS tablet bottles & boxes		
b) Liquid medication requiring measuring		
c) Topical skin preparations		
d) Eye drops/ointment		
e) Ear drops		
f) Nasal drops		
g) Blood sugar testing (in line with individual's care plan) in line with the **Infection Prevention & Control Policy**		
h) PRN/Home remedies		
i) Inhaled medication		

Successful/Unsuccessful **Delete as appropriate**

Candidate Signature	
Assessor Signature	
Date	

Guidelines for "Administration of Medicines and Assessment Procedures for Care Staff" are to be given to each person undertaking and successfully completing the assessment.

This document is to be kept as a teaching record and proof of training and assessment and must not be destroyed. Please maintain a copy for audit purposes. .

Appendix 4

IMPORTANT

If at any time you have any concerns or queries, or you make an error in the administration of medication/performing of an allied procedure, contact the nearest manager or the on call Duty Manager for advice.

ADMINISTRATION OF MEDICATION/PERFORMING OF ALLIED PROCEDURES COMPETENCY CARD

Name

Post _____

Location/ _____

s _____

Registered Manager _____

This is to certify that an authorised person has assessed the above named person to administer medication in line with the service's standard operating procedures. In addition, the named person has been assessed in the administration of the following medications and procedures.

Category		Date of initial Assessment
A	Oral Medication using MMS	
B	Liquid Medication	
C	Topical Skin Preparations	
D	Eye drops/Ointment	
E	Ear Drops	
F	Nasal Drops/Spray	
G	Bathing Solutions	
H	Blood Sugar Testing	
I	PRN / Home Remedies	
J	Administration From Boxes	
K	Inhalers	
L	Soluble Powders /Sachets	

Date	Category for amendments Identifying letter/s	Signature of Registered Care Manager, Deputy Manager	Date of next Assessment

Date	Category for amendments Identifying letter/s	Signature of Registered Care Manager, Deputy, Manager	Date of next Assessment

Appendix 5

ON FIRST ASSESSMENT OF COMPETENCY, THE ASSESSOR MUST ASK ALL QUESTIONS LISTED ON SIX MONTHLY RE ASSESSMENT

A MINIMUM OF 10 QUESTIONS FROM THE 15 MUST BE ASKED AND ANSWERED APPROPRIATELY.

QUESTIONS FOR MEDICATION ASSESSMENT

Many answers can be found within the SOPs.

1. When administrating medication, what things do you have to ensure correspond between the MAR chart and the medication to be administered?

- Name of Individual.
- Name of Medication (e.g. Paracetamol).
- Strength of Medication (e.g. 500mg).
- Form of Medication (e.g. tablets).
- Date and time (frequency).
- Directions.
- Dosage.
- Route of administration.
- Any special instructions.

2. What measures should you take before, during and after administering any medication?

- Ensure infection control procedures are followed to maintain hygiene standards (wash hands, no-touch technique etc.)
- When staff members are administering medicines it should be their only task for that time.
- MMS and other items are stored in identified sections within cupboards.
- Identity of the Individual must be confirmed – check the photo on the MAR as well as asking them by name.
- Ensure medicines are kept secure during administration and returned to a locked cupboard at the end of the administration round.
- If at any stage of the process you are interrupted you must take appropriate steps to secure the medicines.

3. At what temperature should the medication cupboard and fridge be to store medication safely? Why do we need to monitor this?

- The temperature in the medication cupboards should be between 15 – 25°C (although some room temperature medicines may be stored up to 30°C).
- The temperature in the fridge should be between 2 – 8°c.
- If not at suitable temperature medication may be altered and effectiveness reduced.

4. How would you apply?

a) Creams

- Explain to the individual what you are about to do.
- The amount to apply would depend on the type of cream and application instructions.
- Check where the cream is to be applied according to body map.
- Follow hygiene procedures and use gloves.
- Sign MAR chart to confirm application.

b) Eye Drops

- Check the MAR chart to confirm which eye(s) the drops should be put into.
- Explain to the individual what you are going to do.
- Follow hygiene procedures, wash hands and use gloves.
- If the individual has an eye infection and both eyes require drops, a separate bottle should be used for each eye (and labelled accordingly)
- Shake before use (if prompted by the labelling instructions)
- Ask the individual what the best position is for them to be comfortable and still – this could be lying down on their own bed or sitting with head leaning back. Staff to discuss the choice they make in Support / Care Plan.
- Gently pull the lower eyelid down, hold the dropper above the eye and squeeze one drop inside the lower eyelid.
- Ask the individual to blink a few times.
- Do not make contact with the eye, eyelashes or anything else with the dropper tip.
- Sign MAR Chart.

c) Nasal Sprays

- Explain to the individual what you are going to do.
- Follow hygiene procedures, wash hands use gloves.
- Check the patient information leaflet provided with the medicine if unsure of technique.
- Shake before use (if prompted by the labelling instructions)
- Gently insert the tip of the spray bottle just inside one nostril.
- Gently close the other nostril with a finger (either you or the individual can do this).

- Angle the spray straight up (i.e. not towards the side of the nose).
- Ask the individual to breathe in as you administer the spray.
- Repeat in the other nostril if required.
- Sign MAR chart.

5. What would you do if?

a) You dropped a tablet while administering?

- Wear gloves to pick the medication up.
- Place tablets/capsules into a labelled container.
- Place into locked medication cupboard and complete back of MAR chart and returns book.
- Re-dispense medication (if MMS re-dispense from the end)
- Re-order medication as appropriate.

d) Found a tablet on the floor

- Wear gloves to pick the medication up.
- Place tablets/capsules into a labelled container.
- Place into locked medication cupboard and complete returns book.
- Complete any relevant documentation (e.g. communication book).
- Observe all for any signs of missed dose.

6. What would you do if?

a) You noticed medication had not been signed for?

- Check medication to see if administered.
- If medication not administered report to manager or on call.
- Speak to individual responsible if possible, if not then leave message for them.
- Document in the individual's medical notes.
- Complete Incident form, if medication error has occurred.

b) You found tablets in the MMS Tray from the day before?

- Record in relevant Individual's medical notes.
- Inform manager or on call manager.
- Document on back of MAR chart.
- Observe individual for signs of missed dose.
- Complete an incident form.

7. What would you do if an individual refused to take their medication? Refer to SOP MR10

- Try again in a few minutes up to a maximum of 3 times, remembering to lock in the medicines in the cupboard in between attempts.
- If still refusing following this, ask another member of staff to try.
- If still refusing after an hour; the medication (including any liquids) must be put in a suitable labelled container and disposed of as described in SOP MM12 for returning medication.
- If medication cannot be administered contact RCM or Deputy manager or on-call for advice to establish if the individual may be put at risk by missing the dose.
- Contact GP for further advice if needed.
- Record all information within the individual's medical notes. notes.

8. What would you do if you gave an individual the wrong medication and what would your concerns be?

- Do not induce vomiting.
- Do not attempt to retrieve any tablets from the person's mouth.
- Call GP for advice. NHS 111or local pharmacist may also be used for advice.
- Have details of all medication both individual's are prescribed.
- Follow advice given by GP etc. and observe the individual for side effects.
- Inform call the on-call manager of the situation and all action taken.
- Dispense the individual's medication from the end of MMS and administer if advised by a healthcare professional that it is safe to do so.
- Concerns are overdose, contraindications and allergies.
- Complete all relevant documentation/incident form.
- Re-order medication as required.

9. What would you do if an individual vomited shortly after receiving their medication?

- Do not re-administer any further medication.
- Clear up any vomit and dispose of safely.
- Call GP for advice. NHS111or local pharmacist may also be used for advice.
- Have details of all medication administered/ prescribed.
- Follow advice given by GP etc. and observe the individual for side effects.
- Inform call the on-call manager of the situation and action taken.
- Record in the individual's medical notes.

10. What is the process for administering PRN medication as per SOP MR07?

- Follow the individual's PRN protocol.
- Check the MAR chart to see when the PRN medicine was last administered.
- Contact on call manager, if needed.
- Administer PRN medicine as per protocol or as advised if appropriate.

- Sign front and back of MAR chart, making a record of the time given.
- Record all information in the individual's medical notes.

11. What is the process for returning unwanted medication to the pharmacy as per SOP MR11?

- Identify any unwanted medication, this may be any that has been discontinued expired, unsuitable for use or refused.
- Check that the MAR chart has been amended and signed by two authorised persons if any medication has changed been discontinued.
- Complete the returns book.
- Store medication to be returned in designated locked cupboard (segregated from current stock).
- Inform Pharmacy that the medication needs to be collected.
- Check that the driver signs the returns book when they collect the medication.
- Record on MAR chart amount of medication returned

12. Where would you store liquid antibiotics?

- Check the pharmacy label/packaging to find out the storage instructions.

13. List 5 common side effects of medication (Any from list below)

- Vomiting.
- Nausea.
- Dry mouth.
- Dizziness.
- Headache.
- Diarrhoea.
- Constipation.
- Blurred vision.
- Drowsiness.

14. Why do you need to know about side effects?

Because side effects may have an undesirable effect on the individual's behaviour and/or clinical condition so that may affect their health, care and/or wellbeing.

15. How would you find out the side effects of a specific medicine?

- Check the corresponding patient information leaflet (PIL)
- Look in the most current BNF or online BNF
- Call Pharmacist
- Call NHS 111
- Call GP

This is a standard list of questions. Questions to do with any procedures outside of this list (e.g. nebulisers) may be asked by the assessor and documented with the assessment.

Date…… Name of Candidate……

Signature…….....

Name of Assessor…….. Signature……

14. Standard Operating Procedures (SOP) (MM01 - MM18)

LEARNING DISABILITIES STANDARD OPERATING PROCEDURES – Residential Homes		
SOP No.	**Procedure Title**	**Appendices**
MM01	Obtaining prescription for repeat supply of medication from GP and Ordering repeat medication from the pharmacy	Appendix 1 - Process for Ordering Medication Appendix 2 - Good practice for Care Homes-Expiry Dates
MM02	Obtaining prescription for reviewed medication by Psychiatrist	Appendix 3 - Record of Medical Appointments
MM03	Obtaining prescription for new medicines from GP for illness and Ordering new medication from the pharmacy	Appendix 3 - Record of Medical Appointments
MM04	Accepting delivery (or collection) of medication at the Service (including new and regular medication)	No Appendix
MM05	Checking and recording of medication at the service	No Appendix
MM06	Administration of medication	No Appendix
MM07	Administration of PRN medication	No Appendix
MM08	Planned take out, home leave and holiday medication	Appendix 4 - Home Leave Medication Handover Form
MM09	Medication for unplanned takeout, home leave - less than 4 weeks notice	Appendix 5 - .TTO Medication Record Form
MM10	Medication that has been spat out, refused or spilt	No Appendix
MM11	Returning unwanted medication to the pharmacy	No Appendix
MM12	Temperature monitoring and recording in areas where meds stored	Appendix 6 - Temperature Monitoring and Recording
MM13	Monthly Audit	Appendix 7 - Monthly Medication Audit Checklist
MM14	Maintaining Security of Medication in the service	No Appendix
MM15	Maintaining Security of Medication away from the service	No Appendix
MM16	Medicines Reconciliation on Admission	No Appendix
MM17	Self Administration of medication	Appendix 8 - Risk Assessment
MM18	Receiving, storing, Administering – checking controlled drugs	Appendix 9 - Controlled Drugs (Number of pages 1- 5)

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE -

Obtaining a prescription for repeat supply of medication and obtaining the medication from the pharmacy	
SOP NUMBER: MM01	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system for requesting prescription for the repeat supply of medication from the GP and obtaining a supply from the pharmacy.

APPLICABLE TO

All Staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Allow sufficient time to ensure that any discrepancies can be resolved and that the individual has sufficient supply of medication.
- Check this medication is to be repeated.
- Check individual's name on repeat prescription.
- Check medication name, strength, amount to be administered and times to administer.
- Take prescription to identified pharmacy.
- To ensure the medication will be put into MMS or other appropriate system

:

THE PROCESS STAGES

1	Check stock levels before completing the order chart.
2	Complete the repeat order sheet in a timescale adequate to ensure continuity of supply and to ensure that any changes or discrepancies can be resolved.
3	Take order sheet to the GP surgery for the prescription to be made up. (Some prescriptions may also need to be obtained via a psychiatrist, hospital or non-medical prescriber – see SOP MM02 & MM03).
4	Collect prescription 48 hours later; make arrangement/reminder for member of staff to collect.
5	Check the prescription against the current MAR charts to ensure mistakes or discrepancies (i.e. changes) can be addressed in good time. Resolve any discrepancies by corresponding with the GP surgery.
6	Photocopy the prescription and keep for record purposes.
7	Put photocopy of prescription in MAR chart folder in the appropriate Individual's section.
8	Take the original prescription and the order sheet to the pharmacy.
9	Alert the pharmacy that the medicines are required in an MMS system and confirm with them when the drug order will be delivered or can be collected.
10	Keep a copy for cross reference purposes when the scripts arrive from the surgery.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

:

PROCESS FOR ORDERING MEDICATION **APPENDIX 1**

When ordering medication the following is needed:

- Repeat green prescription sheets
- Current MAR charts

This is done on week 2 of the medication cycle. The medication is then ordered via repeat prescription forms which are checked against the current MAR to identify if any medicines have changed or are not needed i.e. can be carried over. They are then requested from the GP and then checked again before going to pharmacy for dispensing.

1. Check medication cupboards for existing stock and note what is required for reordering

2. Check creams and PRN for expiry dates. If due to expire, then tick to reorder (Creams- once opened, use within 28 days, PRN if in boxes – check expiry date) Creams do not necessarily require disposal after 28 days, see attached shelf life guidance.

3. For liquids, check if existing stocks are sufficient for the 28-day period (e.g. if 10mls of lactulose prescribed once daily, times this by 28 days which = 280mls).

4. Once checked, tick medications required on the repeat prescriptions, mark the re-order box on the MAR chart and sign.

5. Take the repeat prescriptions to GP surgery and arrange for collection 48 hours later.

6. Collect within 48hrs.

7. Photocopies of prescriptions should be taken and filed suitably.

8. Prescriptions without full directions (i.e. "take as directed") must be clarified with the GP before sending them to pharmacy.

9. If some medication is not required for this period, however needs to remain on the MAR chart, then the pharmacy will need to be contacted.

10. If a medication has been stopped or discontinued, then the pharmacy will need to be contacted to have the item removed from the MAR chart for the next period.

GOOD PRACTICE GUIDANCE FOR CARE HOMES: EXPIRY DATES APPENDIX 2

EXPIRY DATES

The expiry date is the point in time when a pharmaceutical product is no longer within an acceptable condition to be considered effective. Depending upon the product, the expiry date may be set as a fixed time;

- after manufacture,
- after dispensing,
- after opening of the manufacturer's container.

The shelf life of products is determined by either the breakdown of the active drug or by risk of contamination. Not all medicines deteriorate at the same rate.

Any product whose appearance suggests that it may be unfit for use should be discarded irrespective of expiry date. If there is any doubt contact pharmacy for advice.

STORAGE GUIDELINES

Keep all medicines in the original container in which they were dispensed.
All medicines requiring room temperature storage should be stored in a cool, dry place (not a kitchen or bathroom) should be kept below 25°C. Medicines requiring refrigerated storage should be kept below 2°C and 8°C. Temperatures should be monitored daily and action must be taken if the temperature falls outside these limits.
The expiry date of products can change once opened e.g. eye drops or dipyridamole capsules; always refer to the dispensing label or packaging for further information.
For medicines that have a shorter expiry date once opened:

- Record the date opened on the packaging/label
- Ensure a robust date checking process is in place so that medicines are not used once they have expired
- Once opened, store as recommended by the manufacturer; as this may be different to the unopened medicine.

MONITORED DOSAGE SYSTEMS (MDS) MMS

Not all medicines are suitable for inclusion in MDS, for example:

- medicines that may be harmful when handled e.g. cytotoxic products like methotrexate;
- medicines that are sensitive to moisture e.g. effervescent tablets;
- light sensitive medicines
- medicines that should only be dispensed in glass bottles e.g. glyceryl trinitrate tablets (GTN)
- medicines that should only be taken when required (PRN);
- medicines for which the dose may vary depending upon test results e.g. warfarin.

If the expiry date is not specified and the MDS is still in use after the 28-day cycle, contact pharmacy for guidance on suitability of continues use.

WHEN REQUIRED (PRN) MEDICINES

Wherever possible PRN medicines:

- should be supplied by the pharmacy in their original packs (not MDS) to give the longest shelf life
- should be carried forward each month, following expiry date guidance, provided that the service user is regularly reviewed by the prescriber to ensure that the medicine is still required
- should be stock rotated and date checked to ensure that the oldest medicines are used first
- must not be discarded/returned and re-ordered each month as this is unnecessary and wasteful

Ask your pharmacy to label medicines that have been decanted from a bulk container and are likely to be administered beyond the monthly medicine cycle with an appropriate expiry date.

Good Practice Guidance for Care homes: Expiry Dates

TABLE OF SUGGESTED LIVES FOR MEDICATION: Remember to check the manufacturer's guidance on the packaging before referring to the information below.

PREPARATION	UNOPENED	AFTER OPENING	COMMENTS
TABLETS / CAPSULES – IN ORIGINAL BLISTER STRIP / CONTAINER WITH PRINTED EXPIRY DATE:	Manufacturer's expiry date.	**Manufacturer's expiry date or sooner once opened if specified by manufacturer. Follow guidance in Patient Information Leaflet.**	➢ **Where the expiry date is shorter once opened, write the date of opening on the dispensing label / container.** ➢ PRN ('when required') medicines should be supplied by pharmacy in the manufacturer's original pack (not MDS) to reduce waste / facilitate carrying forward of any excess. ➢ Record the quantity of each medicine carried forward from a previous supply on the MAR e.g. 'C/F 12'. ➢ If a medicine has been carried forward for a number of months, discuss with the GP whether it is still needed.
TABLETS / CAPSULES – NOT IN ORIGINAL PACK (E.G. AMBER BOTTLES) WITHOUT A**N** EXPIRY DATE.	Follow guidance from dispensing pharmacy	**Follow guidance from dispensing Pharmacy.**	
TABLETS / CAPSULES – SUPPLIED IN A MONITORED DOSAGE SYSTEM (MDS) BLISTER PACK	Follow guidance from dispensing pharmacy	**Follow guidance from dispensing Pharmacy**	➢ Check what is left in each MDS pack at the end of each cycle and ensure endorsements on the MARs reflect any omitted doses. ➢ If an expiry date is not specified and the MDS is still in use after the 28 day cycle, contact pharmacy for guidance.
ORAL LIQUIDS – DISPENSED IN ORIGINAL CONTAINER	Manufacturer's expiry date	**Manufacturer's expiry date or sooner once opened if specified by manufacturer. Follow guidance in Patient Information Leaflet.**	➢ **Where the expiry date is shorter once opened, write the date of opening on the dispensing label / container.** ➢ Estimate the remaining volume of each liquid carried forward and record on the relevant section of MAR chart. ➢ Where possible request that the GP prescribes approximately 28 days' supply to minimise what needs to be carried forward. ➢ If an expiry date is not specified and the liquid is still in use after the 28 day cycle, contact pharmacy for guidance.
ORAL LIQUIDS – RE-DISPENSED INTO AN AMBER BOTTLE	Follow guidance from dispensing pharmacy	**Follow guidance from dispensing Pharmacy**	
ORAL SACHETS / GRANULES	Manufacturer's expiry date.	**After reconstitution, follow guidance from manufacturer, Patient information leaflet or dispensing Pharmacy**	➢ **Where the expiry date is shorter once reconstituted, write the date of opening on the dispensing label / container.** ➢ Carry forward to the next month if the medicine is still prescribed.
CREAMS / OINTMENTS / EXTERNAL (TOPICAL) LIQUIDS (E.G. LOTIONS/SHAMPOOS/BATH OILS)	Manufacturer's expiry date.	**Manufacturer's expiry date or sooner once opened if specified by manufacturer. Follow guidance in Patient Information Leaflet.**	➢ **Where the expiry date is shorter once opened, write the date of opening on the dispensing label / container.** ➢ Some products may show the expiry date symbol  ➢ Check that the label is still legible; if not, request a new supply. ➢ Any product whose appearance suggests that it may be unfit for use should be discarded irrespective of expiry date. If there is any doubt contact your pharmacy for advice.
EYE DROPS / EYE OINTMENTS **EAR DROPS / EAR SPRAYS** **NOSE DROPS / NASAL SPRAYS**	Manufacturer's expiry date.	**As specified by manufacturer. Follow guidance in Patient Information Leaflet.**	**Write the date of opening** on the dispensing label / container.
INHALERS & GLYCERYL TRINITRATE (GTN) SPRAYS	Manufacturer's expiry date.	**Manufacturer's expiry date or sooner once opened if specified by manufacturer. Follow guidance in Patient Information Leaflet.**	➢ **Where the expiry date is shorter once dispensed, the dispensing Pharmacy** ➢ **will have specified the new expiry date on the dispensing label / container.** ➢ If inhalers / sprays are used on a PRN basis, keep for on-going use; do not routinely re-order each month.
INSULIN	Manufacturer's expiry date (in a fridge at 2°C and 8°C).	**As specified by manufacturer. Follow guidance in Patient Information Leaflet.**	➢ Reduced expiry date when stored at room temperature. **Write the date of first** ➢ **storing at room temperature/first use** on the dispensing label / container. ➢ One pen/cartridge will often be sufficient for a month (a box of 5 will rarely be ➢ needed every month); calculate your stock requirements for the next cycle based on the services required.

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Obtaining prescription for reviewed medication by psychiatrist	
SOP NUMBER: MM02	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system for obtaining prescriptions for acute and long term psychiatric conditions.

APPLICABLE TO

All staff suitably trained and authorised to administer medication.

SAFETY MEASURES

- Confirm Individual's identity.
- Individual's allergies.
- Individual's medication history.

THE PROCESS STAGES

1	Determine whether this is a routine 3 monthly review or an urgent appointment.
2	Support the individual to and during the appointment. their care plan.
3	Ensure all relevant information is shared with psychiatrist.
4	Gain necessary information from psychiatrist to ensure appropriate care. See Appendix 2 / SOP 3.
5	• If any changes to the medication regime are required that are **not urgent**, the psychiatrist will provide a letter of the alterations. Copy the letter to keep in the home and ensure that the GP receives the original letter and request a prescription for the changed medication. • If any **urgent** changes are required the psychiatrist will provide a prescription.
6	Photocopy prescription.
7	Take prescription back to the home and complete medical notes (see Appendix 2 / SOP 3 for information to be recorded).
8	Take the prescription to the pharmacy (or fax / e mail the prescription to the pharmacy as arranged with the pharmacy).
9	Alert the pharmacy that the medicines are required in an MMS and confirm with them when the drug order will be delivered or can be collected.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

Record of Medical Appointments **APPENDIX 3**

NAME:

This section of the individual's notes is for recording any health appointments.
Staff will need to record: who an appointment has been made with, why and when for. Staff are to take this sheet to the appointment for healthcare professionals to make comments on as needed.

When staff return from appointments, they will need to record all information set at the appointment and action needed, in the individual's medical notes / health file if not completed at the appointment.

Please note you may also be required to complete other existing health or support plan evaluation sheets or behavioural recording charts.

Date:

Why the appointment has been made and date of appointment:

Sign:

Date:

At the Appointment:

Investigations and treatment carried out at appointment (e.g. BP, temperature, pulse reading or results from previous tests):

Diagnosis:

Medication prescribed: **Yes** **No**

Length of Course:

Further Action:

Name and Signature:

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Obtaining prescription for new medicines from medical practitioners and obtaining a supply from a pharmacy	
SOP NUMBER: MM03	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system for obtaining new prescriptions for acute and long term conditions and for obtaining a supply from a pharmacy.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines

SAFETY MEASURES

- Confirm individual's identity.
- Individual's allergies.
- Individual's medication history.

THE PROCESS STAGES

1	Determine the urgency of an appointment; seek advice from manager or on call manager if necessary.
2	Make an appointment with relevant healthcare professional.
3	Support the individual to and during appointment. their care plan.
4	Gain necessary information from medical practitioner to ensure appropriate care (see Appendix 2).
5	Photocopy prescription.
6	Take prescription back to the home and complete medical notes (see Appendix 2 for information to be recorded).
7	Take the prescription to the pharmacy (or fax the prescription to the pharmacy as arranged with the pharmacy).
8	Alert the pharmacy that the medicines are required in an MMS and confirm with them when the drug order will be delivered or can be collected.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Accepting delivery (or collection) of medication at the service (including new and regular medication)	
SOP NUMBER: MM04	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of receiving regular medication at the service.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Check the medication delivered is for the correct house.
- That the bag / box has not been tampered with.
- The medication is received with enough time to get it checked and booked in.
- The medication is locked away in a safe place until an authorised person is available to book it in.

THE PROCESS STAGES

1	Check for any CDs or fridge items which must be stored immediately on receipt in their dedicated storage locations.
2	Sign the receipt tag and hand back to the driver. Retain the second half *(add detail for individual service).*
3	Record receipt in record book or message book.
4	Lock the medication in appropriate cupboard *(add detail for individual service).*
5	Inform the person booking the medicines in that they have arrived.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Checking and recording medication at the service	
SOP NUMBER: MM05	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To ensure medication ordered by the home has been supplied by the pharmacy.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Check the seal on the bag or tamper-proof container supplied by the pharmacy is not broken.
- If there are any concerns in regard to the service users' MAR charts or medication supplied refer to the manager or supplying pharmacy.
- Reminder card for medicines that are not in an MMS
- Check for PRN / variable dose medicines that a care/ support plan is in place giving further information about the dosage to give and when.

THE PROCESS STAGES

1	Cut and remove the seal on the pharmacy bag or tamper-proof container.
2	Locate all the medication, creams etc. and MAR charts within the bag/container for the first service user.
3	Check the new MAR chart against the current MAR chart that the following details are correct: • Name. • Address. • Date of birth. • Allergy status. • GP. • Medication prescribed – name, strength, form, route, frequency, directions
4	Starting with the first medication on the MAR chart check that the label corresponds to the MAR chart (including any special instructions).
5	Check the number of tablets/capsules or volume corresponds to the amount stated as supplied on the MAR chart.
6	In pen write in the corresponding box on the MAR chart the amount supplied.
7	In pen, 2 members of staff are to initial in the corresponding box on the MAR chart to indicate amount of received is correct.
8	For non MMS system items supplied (Epilim, creams, injections etc.) check that a reminder card has been provided and labelled with the correct directions.
9	For each medicine prescribed follow steps **4** and **8.**
10	Repeat steps **2** to **9** for each individual service user.
11	After checking in is completed, lock all medication in medication cupboard ensuring that the correct storage conditions are maintained.
12	If the MAR chart has a reordering form attached to it, remove and file in designated place.
13	Place each individual's new MAR chart within their own section of the medication administration folder.
14	Ensure that Patient Information Leaflets (PIL's) for each individual's medication is held in the Home and filed suitably as a reference source. These are available via the dispensing pharmacy.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Administration of medication	
SOP NUMBER: MM06	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of administering regular and 'PRN' medication at the service.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Ensure medicines are kept secure during administration rounds.
- MMS and other items are stored in identified sections.
- Only staff, who have received the approved medication training, are to administer medication.
- Staff to receive regular assessments at appropriate intervals.
- When staff are administering medicines it should be their only task for that time.
- The medication is returned to a locked cupboard at the end of the administration round.
- Check that medication is in-date.
- Ensure infection control procedures are followed to maintain hygiene standards.
- If at any stage of the process you are interrupted, take appropriate steps to secure the medicines.
- After an interruption start the procedure from the beginning again.

THE PROCESS STAGES

1	Before you start, collect all equipment you may need (medicine pots, oral syringes, measuring devices, water, pen, tissues), prepare area and wash hands.
2	Collect the current MAR chart folder.
3	Check which Individual's need medication at that time and what medication they Need (check the MAR chart). REMEMBER any additional medicines needed that are not in the MMS System e.g. liquids, topical medicines, eye drops, PRN medicines (see MM07) etc.
4	Collect the appropriate packs/tray for the time of day (**CHECK THE COLOUR CODE),** and any other medicines.
	ENSURE ONLY ONE INDIVIDUAL'S MEDICINES ARE ADMINISTERED AT ANY ONE TIME.
5	Select the individual MAR chart(s), PRN care plans/protocols and any other support records e.g. anticoagulant yellow book, MMS and any other medication.
6	Check the pharmacy label on the medicines against the MAR chart for: • Name of Individual. • Date. • Medicine name, strength and form. • Administration time. • Dosage. • Route of administration. • Any special instructions. Check the container to assess that the medicine is currently in date by checking the medicine expiry date or an expiry after opening (whichever is sooner). **If any problems are identified e.g. previous missed dose/signature see appropriate procedure.**
7	Prepare the medicine for administering. **Ensure the medicine is for that day (e.g. week 1 today is Monday).** (If medication is missing check MAR chart and follow procedure for missing medication).
8	Pop tablets/capsules into medicine pots (the MMS System medication is already prepared in pots)
9	When measuring liquids use a medicine pot or oral syringe (if using a pot, place it on a flat surface). Check measured liquid at eye level.
10	Secure medicines supplies before taking prepared medicines to the appropriate service user.
11	Address Individual's by name, explain it is time for their medicines and administer the medication as indicated in the care plan.

12	Ensure the medication is swallowed. If dropped or discarded follow SOP MM10.
13	**Complete the MAR chart on return from each Individual,** signing for which doses have been given or entering appropriate omittance code if not. If necessary, make a note on the back of the chart. If a variable dose is given, then add the exact dose that was given.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Administration of 'PRN' Medication	
SOP NUMBER: MM07	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of administering 'PRN' medication.

APPLICABLE TO

All staff suitably trained and authorised to administer medication

SAFETY MEASURES

- Check the 'PRN' protocol has been followed.
- If there is not a qualified Registered Manager, or Deputy Manager on duty contact on call manager for authorisation to administer 'PRN' medication. For Paracetamol PRN on call does not need to be contacted.
- Check medication is not out of date.
- Check it is the right medication/dose for the right service user.
- *As per the previous SOP MM06…*
- *Only staff, who have received the approved medication training, are to administer medication.*
- *Staff to receive regular assessments at appropriate intervals.*
- *When staff are administering medicines it should be their only task for that time.*
- *The medication is returned to a locked cupboard/trolley at the end of the administration.*
- *Ensure infection control procedures are followed to maintain hygiene standards.*
- *If at any stage of the process you are interrupted, take appropriate steps to secure the medicines.*
- *After an interruption start the procedure from the beginning again.*

THE PROCESS STAGES

1	Follow Individuals 'PRN' protocol to determine the need for PRN medication.
2	Check the MAR chart to see when the last 'PRN' medication was given (you must give this information to the on-call manager when you contact them).
3	Contact the on-call manager and give them the information stated in the 'PRN' protocol to determine if applicable to give 'PRN'.
4	If authorised / applicable to give PRN medication, follow procedure MMO6 for administration.
5	Ensure the exact time of administration is recorded on the MAR chart.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Planned Take out, Home leave and Holiday medication	
SOP NUMBER: MM08	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of taking medication away from the home.

APPLICABLE TO

.All staff suitably trained and authorised to administer medicines.

SAFETY MEASURES

- Identify how long the individual will be away from their home and then what medication needs to be administered during that period.
- Give pharmacist enough time to place medication in separate containers for planned home leave and holidays.
- Home leave, take out and holiday medication must be signed in as monthly medication.
- Security and suitable storage (taking account of refrigerated medicines) of medication must be paramount away from the home.
- Maintain standards of personal hygiene.
- Home leave - staff member to discuss with person to administer, the process and obtain signature to say understood (see Appendix 3).

THE PROCESS STAGES

1	Obtain a prescription for the required length of time from the GP.
2	Attach a letter to prescription for pharmacist identifying which medication would need to be blistered or put into MMS packs separately for home leave, holiday or take out.
3	Sign medication arriving in separate MMS packs with the monthly medication.
4	When the medication is due to go out, sign this medication out in the TTO form (Appendix SOP 5). If leave is with family then Appendix SOP 4 to be completed.
5	In the TTO book, the following columns are needed: • Reason code. • Date medicine is going out. • Name of Individual. • Medication name. • Dose and times to be administered. • Amount of medicine being taken out. • Person responsible for taking medication out. • Who medication handed to. • Signature of person responsible for taking medication out. • Person dispensing signature. • Person witnessing signature. • Amount of medicine due to be returned. • Amount of medicine returned. • Signature of person checking the return and making record on MAR chart.
6	When staff are taking medication out for day trips, appropriate Utensils / food/fluids / pots/oral syringes to administer medication to be taken out. See MM06 for administering of medication.
7	On return home complete the MAR chart and the TTO form. Appendix SOP 5.
8	When on holiday supported by staff, staff will complete MAR chart as per MM06.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

This form must be used with the TTO book

APPENDIX 4

Family Home leave medication handover form

Record discussions with family/carer regarding: the medication, concerns or any other issues on this form. Tick as appropriate and sign at end.

Date	Name of service user	Medication and dose to be taken out given and instruction on times to administer	Store out of the reach of children or vulnerable persons	1 Store at suitable temperatures (See note below)	Equipment given for measuring of liquids	Family/ Carer sign	Staff sign	Comments

Note: i.e. not next to a direct heat source e.g. a radiator or window sill in full sun; in a fridge if appropriate for the medicine e.g. Eye Drops or Antibiotics

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Medication for unplanned take out, home leave – Less than 4 weeks notice	
SOP NUMBER: MM09	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system for preparing medication to be administered away from the home.

APPLICABLE TO

.All staff suitably trained and authorised to administer medication.

SAFETY MEASURES

- Identify how long the individual will be away from their home and then what medication needs to be administered during that period.
- Only send or take out medication in original containers as supplied by pharmacy. The MMS will have individual supplies of medication in suitably labelled containers that can be taken.
- Only staff, who have received the approved medication training, are to prepare the medication.
- Security and suitable storage (taking account of refrigerated medicines) of medication must be paramount away from the home.
- Maintain standards of personal hygiene.
- Home leave – discuss with person to administer the process and they must sign to say they understood (see Appendix 3).
- The prepared medication is checked by a second person at the time of preparation.

THE PROCESS STAGES

1	Identify medication needing to be administered outside the home.
2	Collect MAR chart folder, required medication to cover the period of leave (DO NOT remove from the pharmacy-issued container – the original pharmacy labelled container must be sent. When using MMS then the cartons / pots are already appropriately labelled for sending individually in TTO form (Appendix SOP 5).
3	When the medication is due to go out, sign this medication out in the TTO form (Appendix SOP 5). If leave is with family then Appendix SOP 4 to be completed.
4	In the TTO book, the following columns are needed: • Reason code. • Date medicine is going out. • Name of Individual. • Medication name. • Dose and times to be administered. • Amount of medicine being taken out. • Person responsible for taking medication out. • Who medication handed to. • Signature of person responsible for taking medication out. • Person dispensing signature. • Person witnessing signature. • Amount of medicine due to be returned. • Amount of medicine returned. • Signature of person checking the return and making record on MAR chart.
5	When staff are taking medication out for day trips, appropriate utensils/food/fluids/pots/oral syringes to administer medication to be taken out. See MM06 for administering of medication.
6	On return home complete the MAR chart and the TTO form. Appendix SOP 5.
7	When on holiday supported by staff, staff will complete MAR chart as per MM06.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

Home leave medication handover form

APPENDIX 5

This form must be used with the TTO book

Record discussions with family/carer regarding: the medication, concerns or any other issues on this form. Tick as appropriate and sign at end.

Date	Name of service user	Medication and dose to be taken out given and instruction on times to administer	Store out of the reach of children or vulnerable persons	2 Store at suitable temperatures (See note below)	Equipment given for measuring of liquids	Family/ Carer sign	Staff sign	Comments

Note: i.e**.** not next to a direct heat source e.g. a radiator or window sill in full sun; in a fridge if appropriate for the medicine e.g. Eye Drops or Antibiotics

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Medication which has been spat out, refused or spilt	
SOP NUMBER: MM10	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To ensure that medication that has been spat out or refused are, disposed of safely and replaced if appropriate.

To ensure that every effort to administer the dose is made.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Suitable containers for solid and liquid medicines must be available.
- Wear gloves to pick the medication up.
- Place tablets/capsules into a labelled container if appropriate.
- Place into locked medication cupboard in segregated area marked returns, and complete returns book.
- Spat out or spilt liquid medication must be cleared away using a suitable absorbent cloth and thrown away.
- Complete incident form with details of medication spat out or refused.
- Only re-administer solid form if spat out straight away onto a clean surface.

THE PROCESS STAGES

1	**SPAT OUT** • Solid form medication that is immediately spat out onto a clean surface should be re-administered straight away if possible. • Solid form medication that is either spat out later, or onto an unclean surface or medication which is unidentifiable or has started to breakdown must not be used and disposed of appropriately. • Liquid medication should be cleared away using a suitable absorbent cloth e.g. kitchen towel, and thrown away. **REFUSED** • Medication which has been refused should be offered again in a few minutes and should be locked in the medicines cupboard in-between times. • If still refusing, ask another member of staff to try. • If still refusing after an hour, then the medication (including liquids) must be put in a suitable labelled container and disposed of as described in procedure MM12 for returning medication.
2	Complete appropriate referenced omittance code on the MAR chart and details on the back of MAR chart.
3	If medication cannot be administered contact house leader/assistant house leader or on call for advice, as to whether the individual may be put at risk by missing the dose, whether to try to administer later or to contact a healthcare professional such as the GP (if the service user is put at risk by missing a dose an incident form must be completed). **IF THIS IS AN ON-GOING ISSUE, REVIEW WITH GP, PSYCHIATRIST, OR PSYCHOLOGIST AS APPROPRIATE**.
4	Complete information in Individual's medical notes.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Returning of Unwanted Medication To The Pharmacy	
SOP NUMBER: MM11	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To return unwanted or unused medication to the pharmacy.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- Segregate from other medication and clearly marked “returns”.
- Unwanted medication is kept secure in a locked area.
- Unwanted medication is returned to pharmacy as soon as possible.
- The audit trail is completed.

THE PROCESS STAGES

1	Identify any unwanted medication, these may be – a) Discontinued b) Expired c) Unsuitable for use d) Refused.
a	If DISCONTINUED • Cross in black pen 2 diagonal lines across the box which states the

	medication/ directions • Write ‘Discontinued’ between the 2 diagonal lines • 2 signatures required within the same box • Write the amount to be returned in the section marked ‘Returned’ on the MAR chart • 2 signatures required in sections marked ‘By’ and ‘Signed’ If the discontinued medication is housed in MMS system with other medication that has not been discontinued. Contact the pharmacy to arrange collection and repackaging of medication that has not been discontinued
b	If EXPIRED (PRN) • Write the amount to be returned in the section marked ‘Returned’ on the MAR chart • 2 signatures required in sections marked ‘By’ and ‘Signed’
c	If UN SUITABLE FOR USE • Same as b
d	If REFUSED • Same as b
2	Complete returns book stating: • Name of medication • Name of Individual • Amount returned • Reason for returns • 2 signatures
3	Store medication to be returned in designated locked cupboard segregated from current stocks of medication.
4	Inform pharmacy that the medication needs to be collected.
5	Check that the driver signs the returns book when he collects the medication and takes the top copy.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation: **Deputy manager/ Assistant manager**		
Authorised by:		
Print Name:	**Signature:**	**Date:**

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Temperature monitoring and recording in areas where medication is **Stored**	
SOP NUMBER: MM12	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of temperature monitoring and recording in areas where medication is stored.

APPLICABLE TO

All staff suitably trained and authorised to administer medication.

SAFETY MEASURES

- Two minimum/maximum thermometers showing current temperature must be used in every cupboard storing medication.
- Record minimum/maximum & current temperatures daily four times per day to demonstrate temperatures at different times of the day.
- The temperature in the medication cupboards should be between 15 - 25^{o}c.
- The temperature in the fridge should be between 2 - 8^{o}c.
- If there are more than 2 readings out of range, it must be investigated as to why.

THE PROCESS STAGES

1	Record on the record sheet (see Appendix 4) the current, minimum and maximum temperatures in every medication cupboard (and fridge if appropriate) 4 times each day according to the thermometer manufacturer's instructions.
2	Reset the minimum/maximum function of the thermometer according to the manufacturer's instructions after the temperatures have been recorded.
3	If the temperatures are exceeding recommended levels, then the following action must be completed: • If reason obvious as to why temperature would be too high or too low and this can be safely corrected or adjusted, then do so. For example if it is very hot ensure air con services/fans are on to lower the temperature in the room. • Affected medicines should be quarantined whilst still keeping within the recommended storage temperature range • Contact pharmacy and inform of out of range reading and follow advice on suitability to administer. • Pharmacy may advise for the GP to be contacted for further advice, and they may require all medication to be replaced. In this instance, obtain a prescription from the GP ASAP and take the pharmacy for replacement medication. • In all cases a comment must be written on the temperature record sheet containing as much detail as possible e.g. any known causes for temperature deviation, fridge breakdown, air conditioning failure etc. and any action taken/outcomes, and also advice given by the pharmacist and / or GP. • Temperature records must be stored/archived in a dedicated folder for future audit/inspection purposes
4	Place any medication not suitable to administer in the returns box and lock away. The returns book must be completed and pharmacy informed.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

APPENDIX 6

Insulin Fridge

Temperature Monitoring & Recording

Solihull Metropolitan Borough Council

Date	Time	Temperature	Staff Sign	Actions
	08.00			
	12.00			
	17.00			
	21.00			
	08.00			
	12.00			
	17.00			
	21.00			
	08.00			
	12.00			
	17.00			
	21.00			
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	17.00			
	21.00			
	08.00			
	12.00			
	17.00			
	21.00			
	08.00			
	12.00			
	17.00			
	21.00			

If the temperatures exceed recommended levels (Less than 2°C or greater 8°C), then the following action MUST be completed.

- Record in the actions column what you have done to rectify (i.e. 'increase the temperature dial, checked again after 1 hour').
- Contact pharmacy to inform and follow advice on suitability to administer & monitor medication for change of appearance and insure all advice given is recorded.
- If the reason is obvious as to why temperature would be up/down and you are able to move medication safely or adjust, then do so following advice.
- If the temperature issue persists escalate to the Register Manager.

Insulin Fridge Temperature Recording Sheet.200718 v1.0

Medication Cupboard One temperature monitoring & recording

Solihull Metropolitan Borough Council

- Record the current, minimum and maximum temperatures each medication administration time according to the thermometer manufacturer's instructions.
- Variances of 1°C between thermometers within the same cupboard are acceptable larger variance must be investigated to establish the reason (make sure the probe is not next to something cold, change the batteries etc.)

The thermometer max/min temperatures MUST be reset after each temperature recording

Date	Time	Temperature			Thermometer Reset (Tick to Confirm)	Staff Sign	Actions
		Min	Max	Current			
	08.00						
	17.00						
	08.00						
	17.00						
	08.00						
	17.00						
	08.00						
	17.00						
	08.00						
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	08.00						
	17.00						
	08.00						
	17.00						
	08.00						
	17.00						

If the temperatures exceed recommended levels (Less than 15°C or greater 25 °C), then the following action MUST be completed

- Contact pharmacy to inform and follow advice on suitability to administer & monitor medication for change of appearance.
- If the reason is obvious as to why temperature would be up/down and you are able to move object safely or adjust, then do so following advice.

Medication Cupboard Two temperature monitoring & recording

- Record the current, minimum and maximum temperatures each medication administration time according to the thermometer manufacturer's instructions.
- Variances of 1°C between thermometers within the same cupboard are acceptable larger variance must be investigated to establish the reason (make sure the probe is not next to something cold, change the batteries etc.)

The thermometer max/min temperatures MUST be reset after each temperature recording

Date	Time	Temperature			Thermometer Reset (Tick to Confirm)	Staff Sign	Actions
		Min	Max	Current			
	08.00						
	17.00						
	08.00						
	17.00						
	08.00						
	17.00						
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	17.00						
	08.00						
	17.00						

If the temperatures exceed recommended levels (Less than 15°C or greater 25 °C), then the following action MUST be completed

- Contact pharmacy to inform and follow advice on suitability to administer & monitor medication for change of appearance.

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Monthly Audit	
SOP NUMBER: MM13	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of auditing the medication and MAR charts monthly to ensure correct administration.

APPLICABLE TO

All staff suitably trained and authorised to administer medication.

SAFETY MEASURES

- Allow for appropriate time and space before commencing audit.
- Use identified audit checklist.
- Individual's medication is audited individually.

THE PROCESS STAGES

1	Collect the appropriate audit checklist (see Appendix 5 / SOP 7) and medication and MAR charts for the previous month.
2	Record any discrepancies on the audit form and report to manager.
3	

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

Appendix 7

Monthly Medication Audit Checklist

To be carried out in the 1st week of monthly cycle for the previous months 4 week cycle.
Add details of any discrepancies and actions taken in the comments box.
To be alternated between all staff who administer medication.

STAFF NAME(s):	
SIGNATURE(s):	
START & END DATE OF CYCLE BEING AUDITED:	

Audit Criteria	YES	NO	Comments
STORAGE AND ORGANISATION OF MEDICINES (all areas)			
1) All medicines storage areas (rooms, cupboards, trolleys, fridges etc.) are locked and the keys are stored securely out of the reach of unauthorised persons.			
2) Medicines storage areas (rooms, cupboards, trolleys, fridges etc.) are clean and tidy.			
3) The fridge temperature is recorded daily and is between 2°C and 8°C.			
4) All medicines are stored appropriately according to pharmacy dispensing labels or manufacturers guidance.			
5) All liquids, eye drops, topical preparations (i.e. creams) and any other medicines with reduced expiry dates once opened specify the date they were opened.			
6) Medicines outside of MDS blister packs are all in date. All MDS blister packs are dated within the last 2 months.			
MARS & ADMINISTRATION (audit a random selection of service users)			**Number audited:**
7) There is a cover sheet containing a photograph, name, date-of-birth and allergy status in front of each service user's MAR(s).			
8) Receipt details are completed fully for each medicine on each MAR (including date, signature and quantity received and / or			
9) Any medicine entries on the MARs that have been handwritten by home staff are signed, dated and countersigned by a witness (two			
10) Any handwritten amendments made to existing entries on the MARs are signed by two people, dated and have the reason for the change clearly recorded next to it.			

11) Administration directions are followed e.g. if the printed instructions are 'twice daily', signatures show that the medicine is being administered twice a day.			
12) Full directions are specified on the MARs. Anything prescribed "as directed" or "when required" is accompanied by a protocol stating the max single & daily doses, frequency and symptom indicators specific to the individual service user.			
Audit Criteria	**YES**	**NO**	**Comments**
13) Where a variable dose is prescribed (e.g. "take 1 or 2 tablets") the actual quantity given is recorded at each administration. A protocol is in place to state the amounts to be given with regard to symptom indicators specific to the individual service user.			
14) All administered medicines (including medicated externals such as steroid creams) are consistently signed for on the MAR, or appropriate (referenced) codes for non-administration are			
15) There is an explanation (i.e. "discontinued" or "self-administering") on all MAR entries where there are no administration signatures or receipt information.			
16) The quantities of all medicines outside of MDS blister packs match up with what has been recorded on the MAR.			
17) All medicines in MDS blister packs have been given; any remaining tablets (omissions) have been appropriately coded on the MAR and recorded on the back of the MARS.			
18) Where homely remedies are used, the administration is recorded on the MAR as well as on a central stock control record.			
RECORD KEEPING AND RESOURCES (all areas)			
19) An up-to-date sample signature list of all staff who administer medicines is kept at the front of the MAR folder. This list must be			
20) Staff have access to www.BNF.org, and / or patient information leaflets (PILs) for all medicines on the MARs are available.			
21) Photocopies of the most recent prescriptions for all of the medicines on the MARs are available for reference in the MARS			
22) Returned / destroyed medicines are accounted for in the pharmacy's returns book and the reasons are documented in that book. The reasons are legible and clear.			

23) The reasons for destroying / returning medicines to the pharmacy DO NOT indicate that everything is returned at the end of the month i.e. 'end of cycle' (***everything that is still in date & relevant should be carried forward, not returned***).			
24) The stock level of all controlled drugs (CDs) within the home is checked on at least a weekly basis. The checks are recorded in the			
25) The quantities of CDs held matches the levels recorded in the CD record book.			
26) Receipt of each CD is recorded in the CD record book and specifies the date, source (i.e. "from Joe Bloggs Pharmacy" including full postal address and telephone number), quantity received, staff signature, witness signature and remaining balance.			
27) The use of CDs is recorded in the CD record book and specifies the date of use, quantity used, staff signature, witness signature and remaining balance.			
28) The return / destruction of CDs is recorded in the CD record book and specifies the date, quantity, destination of return / disposal method, staff signature, witness signature and remaining			

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Maintaining security of medication in service	
SOP NUMBER: MM14	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of maintaining security of medication in service.

APPLICABLE TO

All st6aff suitably trained and authorised to administer medicines.

SAFETY MEASURES

- Medication cupboards/trolley/areas are locked at all times.
- The keys for medication cupboards/trolley/areas only are on an identified person at all times or placed in a coded locked box.
- The keys are kept on a separate key ring to the other household keys.
- A message to be left in the communication book when any medication has arrived at the home. Including documenting its status regarding the checking process.
- New medication arrives in a sealed bag or tamper evident container and is locked away in a separate cupboard, until an authorised person is available to book it in.
- Any medication arriving which requires storing in the fridge or CD cupboard is done so immediately and a message left in the communication book regarding its checking in status.

THE PROCESS STAGES

1.	When new medication arrives on the service, See MM04.
2.	Staff administering medication per shift are identified on the rota.
3.	If identified staff member leaves the building during their shift, they will secure the keys appropriately.
4.	All medication is locked away at all times.
5.	Staff hand over the keys at the end of each shift.
6.	Spare keys located at designated areas. A list of the designated areas to be located in MARs folder.
7.	Staff sign a signature list with their full name and initials to be kept at the front of MAR charts. This listed is updated annually or as changes occur.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Maintaining security of medication away from the service	
SOP NUMBER: MM15	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system of maintaining security of medication away from the service.

APPLICABLE TO

.All staff suitably trained and authorised to administer medication.

SAFETY MEASURES

- For planned trips away from the service, the medication will be in separate blister packs.
- All medication taken out of the service is signed out by an authorised person and witness.
- For day trips and holidays, all medication taken out of the service is under the responsibility of the staff member administering the medication.
- When going on holidays, the medication is stored in a locked container.
- If going abroad, the staff members will have access to the safe in their rooms in which to store medication.
- For day trips, the medication is kept in the person's bag.

THE PROCESS STAGES

1.	**DAYS OUT** • The identified person who will be administering the medication should keep the medication in a suitable bag. • That person is responsible for ensuring the bag is kept safe.
2.	**HOLIDAYS** • Before the holiday staff must find out if a suitable lockable space is available to store the medication; if not a suitable lockable container must be taken with them e.g. lockable suitcase. • The keys to the lockable space or container should be kept secure either on the person or locked in another secure area.
3.	**HOME LEAVE** • At home the individual's family or carer is responsible for ensuring that the medication is kept safe. • The family or carer should be informed that they are responsible for the safety of the medication and advised of the safety considerations listed below.
4.	**OTHER MEDICATION SAFETY CONSIDERATIONS FOR ALL TYPES OF LEAVE** • Store out of the reach of children or vulnerable persons. • Suitable store temperatures i.e. not next to a direct heat source e.g. a radiator or window sill in full sun; in a fridge if appropriate for the medicine e.g. chloramphenicol eye drops. See Appendix SOP 4.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Medicines Reconciliation on Admission of a new Individual to the service	
SOP NUMBER: MM 16	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO: All SMBC Residential Homes	

OBJECTIVES

To Ensure a safe system for checking and sourcing required medication of a new individual on admission to the residential homes.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- A full assessment of all medication required by any potential new individual will be conducted.
- All medication being taken will be checked against current MAR chart and prescriptions.
- Checks to be made with individuals current GP and Social Worker should further clarification be required.
- At least one month's supply of medication to be requested ready for admission including MAR chart.
- On Admission to the home all medication for a new individual will be checked and signed in by two "authorised" persons.
- New individual to be registered with local GP as appropriate.

4 THE PROCESS STAGES

1	• On admission all medication and any other sources of information relating to what the individual user takes (e.g. repeat prescription, hospital discharge summary, previous MAR chart) will be checked against current prescriptions and MAR chart.
2	• All medication will be checked and signed into the home by two "authorised" persons.
3	• An appointment will be made to register with a local GP within the first week.
4	• All medicines will be placed in appropriate storage areas as per policy.
5	• Information will be documented and communicated to all staff relating to new individual's medication.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Self-administration of medication	
SOP NUMBER: MM 17	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To ensure a safe process in enabling individual's to self-administer prescribed medication at the home.
Individuals have the right to choose to manage their own medicines if they so wish.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines.

SAFETY MEASURES

- An individual risk assessment will be available for all individual's who are able to self-administer medication.
- The levels and type of support required relating to the administration and care of their medication will be clearly stated within Care and Support Plans. This will be reviewed on a monthly basis or as required.
- Individual's who choose to self-administer medication will be provided with a lockable storage facility to safely store their medication.
- Thermometer to be housed in the lockable storage facility and daily readings recorded as per policy.
- A MAR chart will be provided and signed by the individual following administration.
- All Medicines ordered by the home will be signed in as per policy and a record maintained of any handovers of medication to an individual.

- Only staff who have received the Approved Medication training are to support self-administration of medication with individual's
- Staff to receive regular assessments at appropriate intervals as per policy.
- When staff are supporting individual's with self-administering medicines it should be their only task for that time
- Ensure infection control procedures are followed to maintain hygiene standards

THE PROCESS STAGES

1	• Before you start, check individual's Care / Support Plan and Risk Assessment that relate to self-administration.
2	• Give the appropriate support / instruction as detailed in the Care / Support Plan and Risk Assessment to the individual to enable the correct medication to be administered.
3	• Ensure that a glass of water is available.
4	• Ensure that a Current MAR chart is available.
5	• Provide appropriate support to ensure medications are taken and placed back in the individual's lockable storage facility following administration.
6	• Ensure individual signs the MAR chart following administration (staff must not sign for individuals who self-administer, but the MAR chart must be marked accordingly

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

Residential Services.

Medicines Administration and storage including Self Administration by Service Users.

Impact/severity				
	High	Amber	Amber	Amber
	Med	Green	Amber	Amber
	Low	Green	Green	Green
		Low	Med	High
		Likelihood		

Number	Issue 1											
			Initial risk			Control Measures; **(existing controls / precautions) should be considered.**	Net Risk				
Hazard	**Risk Description / Hazardous Event**	**Persons at Risk**	Likelihood	Impact / Severity	Risk Level	Preventative & Protective Measures; **(IP)** = measures in place; **(TP)** = measures to be put in place / date of completion.	Likelihood	Impact / Severity	Risk Level	**Owner**
Administration and storage of Medicines.	Incorrect Medicines administered. Incorrect Route Incorrect Time Non Prescribed medicines administered. Medicines stored inappropriately. Staff administering not suitably trained Poor storage – medicines accessible to other SU and staff. Inappropriate storage could affect Capacities of Individual to self administer medication. Controlled Drugs Poor Recording – People who self administer	Service Users	MED	HIGH	AMBER	A Policy for the Administration and Storage of Medicines is in place and reviewed regularly. The policy covers: Administration Process. External preparations Controlled Drugs Covert medicines requirements. Correct Storage process including Controlled Drugs and MMS systems. What to do in case of error Training of Staff Medication Administration Records are available. Individual's have care assessments / plans in place which show level of support required to administer and store their medicines. This document will also include information relating to Capacity and Consent.	LOW	MEDIUM	GREEN	
						Individual Guidelines and Risk Assessments are also in place.				

						Appropriate storage facilities are available – lockable cupboards, Controlled Drug cupboards. Regular Audits relating to Medicines, safe keeping and storage are regularly conducted. There will be an individual Risk Assessment in place for each individual who self administers medication.				

Hazard	Risk Description / Hazardous Event	Persons at Risk	Likelihood	Impact / Severity	Risk Level	Preventative & Protective Measures; **(IP)** = measures in place; **(TP)** = measures to be put in place / date of completion.	Likelihood	Impact / Severity	Risk Level	Owner

RISK ASSESSMENT ACTION PLAN

This action plan identifies the control measures to be implemented in order to reduce the lowest acceptable risk level.
Note any Net Risk identified, as a red-risk – immediate action must be taken.
Other categories of Net risk (amber & green) should be completed within the time period (from the report date) specified providing it is reasonably practicable.

Risk Section number	Existing Risk Level	Further actions / Control measures (as identified from the risk assessment)	Responsible Person/s	Target Completion Date	Managers Comments	Completion Date	Managers Signature

ASSESSED BY (PRINT) **SIGNED_____DATE ASSESSED**	**MANAGER (PRINT)** **SIGNED_____ DATE ASSESSED_____**

I have read and understood the ……Risk Assessment and acknowledge this by my signature below.

Print Name	Signature	Date	Amendment – Date	Amendment - Date

LEARNING DISABILTIES SERVICE MEDICINES MANAGEMENT STANDARD OPERATING PROCEDURE (SOP)

Receiving, storing, administering, checking & recording and returning unwanted controlled drugs (CDs) to the pharmacy	
SOP NUMBER: MM 18	
DATE EFFECTIVE FROM:	**REVIEW DATE:**
LOCATION APPLICABLE TO:	

OBJECTIVES

To provide a safe system for receiving, administering, checking & recording and returning unwanted Controlled Drugs to the pharmacy.

APPLICABLE TO

All staff suitably trained and authorised to administer medicines. .

SAFETY MEASURES

- All CD's will be stored in a cupboard that meets the requirements of the Misuse of Drugs (Safe Custody) Regulations.
- An Individual CD record book should be kept securely on each site/premises; only one should be in use at any one time and not be used for any other purpose
- Check the medication delivered is for the correct house and that the bag/ box has not been tampered with.
- All CD medication should be checked and booked in immediately on receipt to the service by 2 authorised people
- If there are any concerns in relation to an individual's' MAR charts or controlled drug supplied these should be referred to the supplying pharmacy and line manager.
- All CD's will be kept secure during administration rounds
- Only staff who have received approved medication training are to administer medication
- Two staff are to prepare and witness the administration of CD's
- When staff are administering medication it will be their only task at that time.
- All Medication will be returned to the CD cupboard following administration.

  Refer to Appendix SOP 9
- Unwanted CD's are returned to the pharmacy as soon as is possible.
- All medication will be audited on a monthly basis and any discrepancies / concerns identified and actioned appropriately.

THE PROCESS STAGES

RECEIVING

1	When collecting a prescription for controlled drugs the GP surgery will require a signature before they release the prescription. The prescription should be locked securely while awaiting collection by the pharmacy. The prescription should be collected by the pharmacy without delay.
2	On receipt of CDs, check the Index to see if the individual already has a dedicated page for each CD received. Go to the corresponding page and record on a single line across all columns: ○ The date ○ The quantity (write quantity in words) received ○ The name and address of the supplying pharmacy ○ Receivers signature ○ Witness signature ○ Remaining balance On the receipt of a new CD or when starting a new record book page state at the top of the page: ○ The drug name ○ The strength and formulation ○ Enter the new CD, individual and page number in the index.
3	All entries must be: ○ In chronological order and made on the day of the transaction ○ The entries made in ink and be clearly written and legible ○ Entries must NOT be crossed out, obliterated or overwritten ○ Mistakes MUST be bracketed and noted as an error by exclamation on the next line or referenced in the margin or footnote ○ A new line should be written indicating the correct balance ○ The corrections must be witnessed and countersigned by a second person and dated

ADMINISTERING	
1	When administering CD's to an individual r, the MAR **must** be taken to the CD Cupboard
2	Refer to the index page at the front of the CD register to establish on which page the administration should be recorded
3	In black indelible ink, enter the date, time, individual's name (if applicable), dose administered and any wastage e.g. 10mg vial 5mg given and 5mg wastage.
4	The process must be carried out by **TWO** members of staff who are authorised to administer CD's
5	The two staff **must** independently check and sign that the CD is correct for the Individual.

CHECKING AND RECORDING

1	CD record books must be securely stored within the home for two years from the date of the last entry.
2	It is the Registered Care / Deputy Managers responsibility to ensure that CD entries are completed correctly, that balances are correct and that regular stock balance checks are
3	SCHEDULE 2 The balance of CD drugs must be checked by two staff at the handover of each shift and recorded in CD book as follows: • compare the quantity of each CD held in stock against the corresponding balance in the CD record book • Document and countersign on a new line on the appropriate page in the CD record book e.g. '[DD/MM/YY]...Balance checked and correct... [sig] / [sig]... [Balance]'. • Both staff to sign the CD book as witnesses to the check SCHEDULE 3 The balance of CD drugs must be checked by two staff at least weekly and recorded in CD book as follows: • compare the quantity of each CD held in stock against the corresponding balance in the CD record book • Document and countersign on a new line on the appropriate page in the CD record book e.g. '[DD/MM/YY]...Balance checked and correct... [sig] / [sig]... [Balance]'. • Both staff to sign the CD book as witnesses to the check

4	When CD balances are inaccurate: • The Manager must be **immediately** informed and an investigation must be carried out. • If the inaccuracy cannot be resolved immediately (e.g. by recounting the stock or checking the CD book entry for errors) a thorough investigation must be carried out • The incident must be formally reported without delay via incident form. • In cases where the discrepancy cannot be explained or rectified, it is appropriate that the manager inform CQC, the Area Team CD accountable officer and the Police.

RETURNING

1	Identify any unwanted medication – these may be discontinued, expired, unsuitable for use or refused
2	Complete entry on MAR chart
3	Check that the MAR chart has been amended and signed if medication changed.
4	In the CD book record the activity on a single line (across all columns) the date, the quantity, the destination (name & address) or disposal method, the signature of the staff member completing the record, a witness signature and the remaining balance.
5	Store controlled drug to be returned in the locked controlled drug cupboard
6	Inform pharmacy that the medication needs to be collected.
7	Check that the driver signs the CD book when he collects the medication.

Prepared by:		
Print Name:	**Signature:**	**Date:**
Designation:		
Authorised by:		
Print Name:	**Signature:**	**Date:**
Designation:		

COMMON CONTROLLED DRUGS (CDs) AND THE LEGAL REQUIREMENTS FOR CARE HOMES

The misuse of Drug Regulations 2001 define the classes of person who are authorised to supply and possess CD's whilst acting in their professional capacities and lay down the conditions under which these activities may be carried out. In the regulations drugs are divided into five schedules each specifying the requirements governing all CD handling activities. The following table describes typical CD's that may be used in the Care Home setting and the legal requirements. Recommendations for best practice are also included.

SCHEDULE 2

Drug Name	Brand Name(s)	Legal Requirements	Good Practice
Morphine	MST, Zomorph, Filnarine, Morphgesic, MXL, Sevredol, Cyclimorph, Oramorph Concentrated oral soln 100mg/5ml and oramorph oral soln 10mg/5ml*	Store in a CD cupboard Record in a CD record book	***** Oramorph (10mg/5ml oral solution)** is not a controlled drug, however CD storage and CD records are a good practice recommendation
Diamorphine	-		
Pethidine	-		
Methadone	Physeptone, Synastone		
Methylphenidate	Ritalin, Concerta XL, Equasym XL		
Fentanyl	Durogesic, Abstral,Effentora, Recivit,Actiq, PecFent		
Hydromorphone	Palladone		
Oxycodone	Dolocodan, Longtec, Oxynorm, Oxyccontin, Targinac		

SCHEDULE 3

Drug Name	Brand Name(s)	Legal Requirements	Good Practice
Buprenorphine	Subutex, Temgesic, BuTrans, Transtec, Hapoctasin	Buprenorphine and temazepam must be stored in a CD cabinet (for all others it is good practice recommendation).	Controlled drugs in this schedule do not need to be recorded in a CD register, but this is a good practice recommendation
Midazolam	Buccolam (oromucosal), Hypnovel		
Temazepam	-		
Tramadol	Zydol, Zamadol		
Pentazocine	-		
Phenobarbitone	Fortral		

SCHEDULE 4 - PART 1

Drug Name	Brand Name(s)	Legal Requirements	Good Practice
Diazepam	Valium, Diazemuls, Stesolid	No additional legal requirements for care homes	No additional good practice requirements for care homes
Lorazepam	Ativan		
Cannabis extract	Sativex		
Zopiclone	Zimovane		
Zaleplon	Sonata		
Zolpidem	Stilnoct		

NB: This is not an exhaustive list; if unsure of a controlled drug's legal status of storing recording and prescription requirements and validity, ask your supplying Pharmacy.

CD STORAGE RISK ASSESSMENT ADVICE

A CD cabinet must…	A CD cabinet is not…
• Be made of steel • Have a specified locking mechanism that is protected against cutting or manipulation from outside • Be securely fixed to a wall or floor • Not have on it any indication that controlled drugs are kept inside it	• A cupboard within a cupboard • A locked metal cashbox fixed to the shelf of a wooden cupboard • A safe used to store personal items of value

As soon as a Controlled Drug (CD) that requires CD storage is prescribed for a service user and enters a nursing or residential home, the home is acting outside of the law if the drug is not stored in line with the Misuse of Drugs Act 2001.

If your home does not have a CD cabinet, it is strongly advised that a risk assessment is completed which documents what processes are in place to mitigate the risks should a service user be prescribed a CD.

A risk assessment should include a step-by-step guide illustrating exactly what staff should do in the event of a CD being prescribed; including (but not limited to):

- Recording the receipt of the CD in a CD record book.
- Placing the CD into a locked cabinet with limited access as a temporary storage measure.
- Contacting a CD cabinet supplier to arrange the swift purchase and fitting of a CD cabinet. It is recommended that the contact details of at least two suppliers of suitable CD cabinets (or, at the very least, website addresses from where cabinets may be purchased) are documented on the assessment to speed up the process.

N.B. It is important to emphasise on the risk assessment that the processes must happen as quickly as possible to reduce the length of time that the CD is stored unlawfully.

The CD cabinet should comply with the Misuse of Drugs (Safe Custody) Regulations 2001. Approved cabinets can be found by entering 'controlled drug cabinet' into the search bar on the following sites:

www.drugs-cabinets.co.uk www.bristolmaid.com www.medisave.co.uk

Suppliers of medical equipment sell CD cabinets and their catalogues state when the product meets the requirements of the Misuse of Drugs (Safe Custody) Regulations 2001.

CD RECORD BOOKS & RECORDING

It is advised that a CD record book is kept, regardless of whether CDs are present or not. A record book is a reasonably inexpensive purchase and it is essential that recording is initiated as soon as a CD is received. Commonly used and approved CD record books are available at **www.medipost.co.uk** (many other books would be suitable, as long as they can accommodate the information stated below). Your supplying pharmacy may also be able to advise on how to obtain a CD record book.

It is recommended that the book used for CD recording:

- Is bound (so that the spine cannot be easily accessed to remove the pages, like a hardback book).
- Has numbered pages (so that torn out pages can be easily identified and to aid the locating of specific pages referenced in the index).
- Has columns on each page to allow for recording of the date and if applicable the time of administration, dose given, signature of administrator, witness signature and remaining balance.

THINGS TO REMEMBER:

- ✓ All entries or corrections must be made in chronological order and must be written in indelible ink.
- ✓ A separate CD record book should be kept securely on each site/premises; only one should be in use at any one time.
- ✓ On receipt of a new CD or when starting a new record book page, state the drug name, strength and formulation on top of the new page. Enter the new drug and page number in the index.
- ✓ On receipt of a CD; record the entry on a single line (across all columns) the date, quantity received (it is good practice to write the quantity in words), supplier, receiver's signature, witness signature and remaining balance.
- ✓ When administering CD's to a service user, the MAR **must** be taken to the CD cupboard and the following procedure should be followed:
- Refer to the index page at the front of the CD register to establish on which page the administration should be recorded
- In black indelible ink, enter the date, time, service user name (if applicable), dose administered and any wastage e.g. 10mg vial 5mg given and 5mg wastage.
- The process must be carried out by **TWO** members of staff who are authorised to administer CD's i.e. suitably trained and competent, who **must** independently check and sign that the CD is correct for the service user.
- ✓ When starting a new page, transfer the balance from the previous page onto the new page ensuring the drug name, strength, and form and witness signature is completed.
- ✓ When a CD is to leave the premises or be destroyed; record the activity on a single line (across all columns) the date, the quantity, the destination (name & address) or disposal method, the signature of the staff member completing the record, a witness signature and the remaining balance.
  For CD destruction in Nursing Homes the controlled drugs must be denatured in the presence of a registered nurse and an Accountable Officer before being issued to a contracted waste disposal company. CQC state 'To be eligible to carry out the role of accountable officer, a person must be a senior manager of their organisation. They should not routinely supply or handle controlled drugs themselves as part of their duties as an employee or Officer'
- ✓ Once an entry has been made in the CD record book, it **must not** be crossed out or overwritten; mistakes should be bracketed and noted as an error by explanation on the next line or referenced in the margin or footnoted. A new line should be written indicating the correct balance. The correction must be witnessed and countersigned by a second person. All entries in the CD record book must be clearly written and legible.
- ✓ CD record books must be securely stored within the home for two years from the date of the last entry.

Auditing and Discrepancies

It is the Home Manager's responsibility to ensure that CD entries are completed correctly, that balances are correct and that regular stock balance checks are undertaken by means of weekly self-auditing at the Home.

A check, comparing the quantity of each CD held in stock against the corresponding balance in the CD record book should be witnessed by another member of staff before being documented and countersigned on a new line on the appropriate page in the CD record book e.g. '[DD/MM/YY]...Balance checked and correct...[sig] / [sig]...[balance]'.

Where CD balances are found to be inaccurate, the Home Manager must be **immediately** informed and an investigation must be carried out. If the inaccuracy cannot be resolved immediately (e.g. by recounting the stock or checking the CD book entry for errors) a thorough investigation must be carried out and the incident must be formally reported without delay. In cases where the discrepancy cannot be explained or rectified, it is appropriate to inform CQC, the Area Team CD accountable officer and the Police.

Audits will also be carried out by the Community Services Pharmacy Team to ensure compliance. Areas of non-compliance will generate an action plan which will be escalated to the Home Manager, copies will also be sent to the Solihull Care Contracts Team at SMBC. A copy may also be shared (upon request) with the Care Quality Commission.

Prepared by the Community Services Pharmacy Team, Heart of England NHS Foundation Trust Version 6.0 Sept 2015
Information sourced via HoEFT CD factsheets & PrescQIPP NHS Care Homes - Controlled drugs good practice guide (Dec 2014)

There are differences between some of the various brands of transdermal opioids available. The list is not exhaustive and care home staff should refer to the patient information leaflets or speak to their pharmacy for further advice.

Examples of transdermal buprenorphine preparations

Brand Name	Strength	Duration	Administration
BuTrans	5, 10, and 20 mcg/hr	The patch should be worn **continuously for 7 days**.	Patch may be applied to the upper outer arm, upper chest, upper back or side of chest, but not on any parts of skin that have large scars. It is recommended that no more than two patches are applied at the same time, regardless of the patch strength. A new patch should not be applied to the same skin site for the subsequent 3 - 4 weeks.
Transtec	35, 52.5 and 70 mcg/hr	The patch should be worn continuously and **replaced after 4 days (96 hours) at the latest**. For convenience of use, the transdermal patch can be changed twice a week at regular intervals, e.g. always on Monday morning and Thursday evening.	The patch may be applied to the upper back or below the collar bone on the chest, but not on any parts of skin that have large scars. A new patch should be applied to a different skin site. At least one week should elapse before a new transdermal patch is applied to the same area of skin.
Hapoctasin	35, 52.5 and 70 mcg/hr	Hapoctasin should be worn **continuously for up to 3 days (72 hours)**	Preferable sites on the upper body are: upper back or below the collar-bone on the chest. After removal of the previous transdermal patch a new Hapoctasin transdermal patch should be applied to a different skin site. At least one week should elapse before a new transdermal patch is applied to the same area of skin.

Examples of transdermal fentanyl preparations

Brand Name	Strength	Duration	Administration
Durogesic DTrans	12, 25, 50, 75 and 100 mcg/hr	The patch should be worn continuously for 3 days (72 hours)	The patch may be applied to the upper outer arm, upper chest, upper back or side of chest, but not on any parts of skin that have large scars. A new patch should be applied to a different skin site. Several days should elapse before a new patch is applied to the same area of skin.
Matrifen			The patch may be applied on a flat surface of the upper torso or upper arm. A new transdermal patch should always be applied to a different site from the previous one. The same application site may be re-used only after an interval of at least 7 days.
Fentalis	25, 50, 75 and 100mcg/hr		The patch may be applied on a flat surface of the upper torso or upper arm. A new transdermal patch should always be applied to a different site from the previous one. The same application site may be re-used only after an interval of at least 7 days.

Key points regarding transdermal opioid preparations

- Patches are usually prescribed by brand as there is some variation between different brands of product.
- The patch should be applied to an area of skin which is clean, dry and non–hairy (hair may be clipped but not shaved).
- Do not apply the patch to irritated, recently irradiated or shaven skin, or on Lymphoedematous areas.

Prepared by the Community Services Pharmacy Team, Heart of England NHS Foundation Trust Version 6.0 Sept 2015
Information sourced via HoEFT CD factsheets & PrescQIPP NHS Care Homes - Controlled drugs good practice guide (Dec 2014)

- Refer to the patient information leaflet (PIL) for information as to where the patch may be applied.
- Creams, ointments and talc should not be used on the area of skin that the patch is to be applied to.
- To apply the patch, remove it from the pack, press it firmly in place using the palm of the hand for at least 30 seconds.
- If more than one patch is applied they should be applied at the same time and placed far enough apart to not overlap.
- The site of application should be rotated in accordance with the manufacturer guidance.
- Service users with fever should be observed for signs of toxicity (heat increases the absorption of the drug from the patch).
- Do not apply the patch immediately after the service user has had a hot shower or bath.
- Heat sources such as hot water bottles and electric blankets should not be used.
- The patch should be checked each day to ensure that it is still in place.
- Generally a patch that has been cut, divided or damaged in any way should not be used, in this case check with a pharmacist before using the patch.

Example of a MAR for transdermal opioid preparations

Month		Week	Week 3						Week 4							
		Date	26	27	28	29	30	31	1	2	3	4	5	6	7	8
BuTrans 10mcg/hr patch Apply ONE patch once weekly		8.00am	EJ	/	/	/	/	/	/		/	/	/	/	/	/
		12 noon														
		4.00pm														
		8.00pm														
Checked by AB		Qty: 4	Upper left arm													

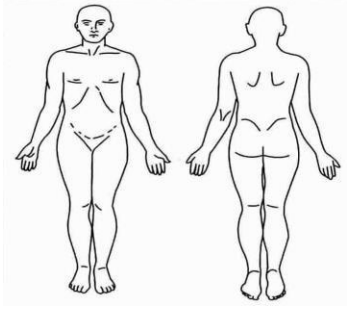
A record of the site application should be made; this can be on the MAR chart as shown or on a patch application record chart

The dates between patch changes should be crossed out

The day the patch should be changed can be highlighted on the MAR chart

At the end of the cycle the new MAR chart should be annotated based on the information from the previous MAR chart. Therefore using the example above, the new MAR chart should be annotated to indicate the patch is next due to be changed on the 9th.

A patch application record should be used to record the removal of an old patch to include the following.



Old patch removal date		Time	
Removed by			
New patch applied date		Time	
Applied by			
Witnessed by			

An amendable version of 'Patch application record print version' can be found at:

http://www.prescqipp.info/resources/viewcategory/303-care-homes-controlled-drugs-good-practice-guide

Prepared by the Community Services Pharmacy Team, Heart of England NHS Foundation Trust Version 6.0 Sept 2015
Information sourced via HoEFT CD factsheets & PrescQIPP NHS Care Homes - Controlled drugs good practice guide (Dec 2014)

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