Lincolnshire Care Home Safe Administration of Medicines Procedure

Lincolnshire Care Homes
Medicines Management
WORKING IN PARTNERSHIP WITH HEALTH AND SOCIAL CARE

CareinLincs Workforce Development
Lincolnshire Care Association
Lincolnshire County Council
NHS Lincolnshire Integrated Care Board
United Lincolnshire Hospitals NHS Trust

Contents

Checklist: Mandatory – Essential – Optional Procedures

The table below breaks down each procedure in to one of three categories:

Mandatory – it must be used as it is written (there are only a few of these)
Essential – it is needed, but can be adapted to local circumstances.
Optional – if you need them, use them.

Each procedure has been cross referenced to the medication policy and this is also shown below. Before implementation, please ***tick*** next to each procedure if it is relevant to your organisation.

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Welcome to the Procedures that support the Lincolnshire Care Home Safe Administration of Medication Policy. In this document, there will be opportunities to make the procedures bespoke to your Care Home. Where you see a highlighted yellow background e.g. (xxxxx) you are required to add your own specific details e.g. Home Name, local process, contact names or contact details.

The named person with overall responsibility for the Safe Administration of Medications within (*care home*) is: (*Name & Date)*

The named person responsible for the safe storage, recording and use of all types of Medication, including Controlled Drugs is: *(Name & Date)*

The named person responsible for all medication training and competency is: (*Name & Date)*

The named person responsible for all reporting & escalation of medication errors and adverse reactions is: (*Name & Date*)

The named person responsible for all medication audits (including Controlled Drug's) is: (*Name & Date)*

Procedure 1
Ordering and Supply

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PROCEDURE 1: **ORDERING AND SUPPLY**

1.1 Ordering & supply of regular repeat prescribed medications

1.2 Medication that has been changed or added during ordering cycle

1.3 Dropped medicines

1.4 Stock medicines

INTRODUCTION

The exact procedures for the ordering and supply of medication may vary in line with the agreement between the home and the medication supplier.
All the stages of the process, as set out in the NICE guidelines, should be followed.

For individuals who manage their own medication

REMEMBER
Support individuals to check that they receive exactly what they need, so that they do not run out. Do not forget PRN medicines.

Prompt individuals to check their supply of PRN medication in line with their person-centred care plan

Support residents to order and check repeat prescriptions in line with their person-centred care plan

Service users may use the [Care Home] pharmacy provider or one which they choose

PROCEDURE 1.1: ORDERING AND SUPPLY OF REGULAR REPEAT PRESCRIBED MEDICATION

For individuals who have their medicines administered
Including items in a [monitored dosage system] (Biodose, blister pack etc.)

Check each individual's stock during week [2] of the monthly medication cycle.

Check what needs to be ordered for the next month and complete the repeat prescription slip, or digital proxy ordering.

Check if any expiry dates are beyond the end of the next cycle.

Check the MAR sheet to confirm that medication being ordered is still current.

Remember, you need enough to complete the next cycle. Check if any expiry dates are beyond the end of the next cycle.

Make a copy of the repeat prescription slip and [take or send] the original to the surgery in a way which meets GDPR requirements. Retain a copy for your reference. If you order via proxy ordering, save or print a copy for your reference for auditing.

Prescriptions are normally sent to the pharmacy from the surgery.

Inform the pharmacy if there are any changes to the medicines between ordering and dispensing.

REMEMBER

If this procedure is not relevant, or possible, undertake a risk assessment and design the most appropriate procedure for obtaining medicines in a timely manner.

This process will be streamlined once the care provider is connected to the NHS Digital network. The NHS Digital network provides services for the NHS and Social Care – including secure sharing of information between different parts of the NHS, and forms the basis for Electronic Prescription Services, Summary Care Records, and Electronic Referral Services.

PROCEDURE 1.2: MEDICATION THAT HAS BEEN CHANGED OR ADDED DURING THE ORDERING CYCLE

If the prescription for a new medicine is not written out in the home, the prescription should be collected by a designated member of staff from the prescriber.
This must be done in a timely manner to ensure the medication can be started at the appropriate time.

Residents arriving from hospital, or for a short-term stay, may need interim supplies to be ordered as part of the medication reconciliation.

Keep an audit trail of the ordered medicines.

For new medication, the prescription should be taken to a pharmacy that can dispense it in a timely manner.

PROCEDURE 1.3: DROPPED MEDICINES

Replacements for “dropped medicine” should be ordered in line with Care Home Policy.

To cover shortfall, the additional amount needed should be ordered and given at the end of the current cycle.

This puts a lot of pressure on the doctors and pharmacy if you only order 1 or 2 tablets, it should be encouraged to order the replacements needed as additional tablets to be delivered with the next monthly cycle, so 28 days for next cycle *plus* the additional amount needed that can be taken at the end of the current cycle to complete shortfall.

PROCEDURE 1.4: STOCK MEDICINES

To be confirmed with provider of non-prescribed medication

Stocks of non-prescribed (home remedies/ OTC) medication should be checked at the same time as repeat prescriptions are ordered.

Check stock quantities

Order sufficient stock to cover next cycle but to avoid excess stock

Procedure 2
Receiving Medicines into the Home

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PROCEDURE 2: **RECEIVING MEDICINES INTO THE HOME**

2.1 Medicines reconciliation

2.2 Receiving, storing, and disposing of medicines

2.3 Identify appropriate level of support with medication.

PROCEDURE 2.1: MEDICINES RECONCILIATION

"Medicines reconciliation is the process of accurately listing a person's medicines. This could be when they are admitted into a service or when their treatment changes." – CQC 3.11.22

An essential part of a safe admission process is:

1. Confirm details of any medication that has been prescribed for a new resident.
2. Compare this to what they have brought with them and what they have been taking.

The resident should **always** be at the centre of this process.

Other people who may need to be involved are:

1. Those who have prescribed the medication: GP, Mental Health Team etc.
2. Those who have supported the resident with medication: family members, carers, paid or voluntary care and support staff.

For Planned Admissions:
A patient summary and non-prescribed medication schedule is required from the appropriate care clinician before the resident moves in.

For admissions from the hospital:
Request a copy of the Electronic Discharge (EDD) or discharge letter from the hospital and the prescription chart showing the last time the medication was given.

For unplanned admissions from the community:
Request medication details from the appropriate urgent care practitioner.

Relatives and/or previous care and support professionals should be asked for details of any other medication that the resident has been taking, if appropriate.

REMEMBER

The list of medicines that have been prescribed should be included in the resident's care plan.

This procedure relates to residents who are self-administering or receiving any level of support.

As part of the care planning process, a designated, competent member of staff should record on the [care home to complete where this is recorded]

Current GP details, and if appropriate, the GP that they will be registering with.

Details of other relevant contacts e.g. regular pharmacist.

Known allergies and reactions to medicines and the type of reaction experienced.

The level of support the resident needs to carry on taking the medicine.

If the resident does not have the mental capacity to give consent to this support, the reasons why it is in their best interest.

What information has been given to the residents/ families/ carers.

Date of next scheduled medication review.

The same member of staff should have a conversation with the resident to confirm:

Has the resident brought all of the correct medication and nothing else with them?

Has the resident been taking all of the medication as prescribed?

When was the last dose of each medication taken?
Pay particular attention to PRN medication taken less than once a week.

Has the resident brought any other medication with them?

REMEMBER

Residents arriving from hospital or short-term stay may need interim supplies to be ordered as part of the medication reconciliation.

PROCEDURE 2.2: RECEIVING, STORING AND DISPOSING OF MEDICINES

When a new supply of medicines is delivered, a competent member of staff should check and record what and how much is delivered. Sufficient protected time should be allowed for this process.

Receiving individually prescribed medication

Check the seals on the bags/ boxes to ensure they are intact.

If the seals are broken reject the delivery. Take out any controlled drugs and items which require special and separate storage like refrigerated items. Store delivery intact in secure area, especially CDs until a suitably competent person is available to record receipt.

Resident by resident, physically check the items received are as ordered and correctly described on MAR chart i.e. count medication in boxes. Medication with a short shelf life should be clearly labelled (use by/opened on).

Resolve any discrepancies with supplying pharmacy before first dose is due.

Record date and initial quantities received on MAR sheet.
[care home to add where to put MAR sheet]

Storing Medicines

- Store medicines securely in line with resident's care plan, risk assessments and [*local procedures*]. Medication should be transferred to correct storage within [*care home add time*] of delivery.
- When storing medicines that require a temperature control record - daily records of the temperature are taken and recorded in [Care Home] medication fridge record documentation.
- Individual medicines may require specific storage and risk assessments in line with Home Policy.

Medicines to be stored as follows:

	[Home to complete]
Medicines supplied in MDS and original packs	
Homely Remedies and Over the Counter lines. (They can be stored together just stored separately from other medication e.g. their regular prescribed medication)	
Self-Administered medication	
Controlled Drugs	
Other medicines with the potential for abuse or misuse e.g. opioid painkillers, anti-anxiety medication, sedatives, and stimulants. e.g. Diazepam, lorazepam, tramadol, zopiclone	
Medicines which need to be stored in the fridge	
Skin creams and other topical preparations	
Oral nutritional supplements and thickeners	
Appliances and devices including sharps	

Controlled Drugs (CD)

REMEMBER

Controlled Drugs relate to drugs that are included in schedule 2 and 3 of the Misuse of Drugs Act 1971, Misuse of Drugs Regulations 2001, and associated regulations.

Adult residential homes must comply with the law in relation to controlled drugs.

For further information/ clarification on whether a specific drug is a controlled drug, contact your local pharmacy or an online resource. e.g., www.gov.uk/government/publications/controlled-drugs-list--2

It is important that staff know which medicines are CDs to ensure they adhere to safe keeping and recording requirements. Please note the importance of using when approved by the Lincolnshire ICB a regular CD medication items used chart that can laminate and used to support which CD are being used.

Keys are currently stored: Staff to monitor the storage conditions:	

Checking of incoming CDs must be witnessed by a second member of staff.

The CDs must be put into the CD cupboard immediately whilst a second member of staff is found.

The CD Register must be completed with the relevant details including the quantity received and the total quantity in stock.
Check against the prescription in the presence of, and checked by, a second member of staff.

If there is a discrepancy, the Duty Manager [Name] **must** be informed immediately.

Any discrepancy on receipt of a CD from a pharmacy must also be reported via www.cdreporting.co.uk

If the Controlled Drug is collected from the pharmacy or dispensing doctor by a member of care home staff, it is good practice for the member of staff to be asked to sign for the CD (there is space on the back of the prescription and there may be other documents to sign); they may be asked for proof of identity.

Following collection of the CD, the member of staff must return to the care home without delay.

Controlled drugs must be **recorded immediately** on receipt, by a designated member of staff (where practicable with a witness).

- The seal should be broken
- CDs checked for accuracy (name, form, strength, quantity , fit for use & not damaged and expiry date)
- Delivery sheet dated and signed.
  The delivery driver should also sign the delivery sheet

Check the medicine against the label (where practicable, this check should be conducted with a witness). Check:

- Drug name
- Quantity (i.e. tablets, capsules, ampules, or patches)
  It is not expected that liquids are measured
- Formulation
- Strength
- Expiry date
- Fit for Use (i.e. Not damaged)

CDs must be checked against any paperwork received, or relevant documentation e.g. copy of prescription

Receipt of CDs must be recorded in the care homes CD Register and the entry witnessed by a second, suitably trained and competent, member of staff.

Once checked and recorded, the CD must be locked away.

It is important for staff to know which medicines are Controlled Drugs, so that they adhere to safe keeping and recording requirements.

List of most commonly encountered drugs currently controlled under the misuse of drugs legislation - GOV.UK (www.gov.uk)

REMEMBER

If there is a discrepancy, inform [care home to complete] immediately.

Others to be informed are as follows:

- [Care home to complete]
- [Care home to complete]
- [Care home to complete]
- [Care home to complete]

Local NHS England controlled drugs accountable officer for Lincolnshire is:

Bhavisha Pattani
Email: b.pattani@nhs.net
england.centralmidlands-cd@nhs.net
Telephone: 07730 381109 / 07730 381119

Stock Medication
(Excluding OTC & Homely Remedies)

Check medicines received against order.

Check stock records.

Store in a way that ensures medication with the earliest expiry date is used first i.e. longest expiry date is placed at the back of the shelf.

PROCEDURE 2.3: IDENTIFY THE APPROPRIATE LEVEL OF SUPPORT WITH MEDICATION

REMEMBER

There **must** be a conversation with **all** residents regarding their personal choices in supporting the safe administration of medicines.

Risk

Understand why the medicine is required.
Has the resident got capacity and have they chosen the care home to administer their medicines?

Consent

The level of capacity must be constantly reviewed and where necessary, expert help should be sought.
If capacity is lacking, a full capacity and best interest form needs completing for a resident.

Review

This will be dependent on each resident's change of circumstances due to their physical and mental wellness.

Periods of Illness

During periods of illness all relevant risk assessments relating to the safe administration of medicines must be reviewed and updated.
Any change must be detailed within the resident's care plan.

Monitoring

- Maximum of 3 days refusing a medicine (or according to the resident's care plan), then seek urgent GP contact. If the medication is a critical medicine such as warfarin, insulin, Parkinson's medication etc this should be reported and monitored straight away.
- Check a minimum of 28 days to ensure those residents who wish and are able to self-administer, can continue to do so
- Care Homes MUST have clear communication channels when or how to raise concerns or incidents relating to medication
- Care Homes Staff should ensure that the resident's GP is contacted to find out about any allergies and intolerances to medicines or their ingredients. This information should be accurately recorded on the medicines administration record and shared with the team(s) providing care to the resident.

Time sensitive medicines - Care Quality Commission (cqc.org.uk)

Critical Medicine list FINAL.pdf (ekhuftformulary.nhs.uk)

REMEMBER

Mental Capacity Guidelines and Best Interest Assessment need to be followed and completed for those who are lacking capacity.

Procedure 3
Administration of Medicines

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PROCEDURE 3: **ADMINISTRATION OF MEDICINES**

3.1 Administration of medicines

3.2 "When Required" PRN medicines

3.3 Administration of controlled drugs, and other medicines requiring witnessing & two signatures

3.4 Administration of CDs by visiting health professional

3.5 Administration of warfarin and anti-coagulants

PROCEDURE 3.1: ADMINISTRATION OF MEDICINES

Infection Control

Infection Control and administration of medications – Good practice advises robust hand hygiene.

- Avoid touching face after handling drug charts, medication containers and hardware until hand hygiene has been performed.
- Increase frequency of surface decontamination and cleaning, taking particular attention to commonly touched items by multiple people; drug trolley, cupboards, keys, medicine containers. If possible, use disposable medicine pots and spoons, or ensure they are sterilised after individual use.
- Residents who have an infection or suspected, it may be beneficial to keep all individual medications and charts within lockable storage within the individual's room.
- Medication should be administered by a suitably competent member of staff and recorded on the medication administration list. This can be found [Care Home to Complete]. [Nursing homes who restrict the administration of PRN or other medication to nurses should add here].
- During the administration, staff should stay focused on the task, and not be interrupted by phone calls or other distractions.

REMEMBER

Promote the dignity and comfort of a resident throughout the administration process.

Before Starting the Administration process

Make sure that you have everything you need including water, beakers, and disposable spoons.

Wash your hands and wear correct PPE, as required.

During the Administration Process

Do not leave any medication records or equipment unattended.

After the Administration Process

Dispose of clinical waste safely, store medication and records correctly

[Care home to add local practice]

REMEMBER

Wash your hands before starting any other task.

Before each administration, check:

Is this the right person? Use photo ID to confirm
[Describe local practice of where photo ID is]

Check that the name, form, strength and dose of the medication on the medicine label corresponds with the Medicine Administration Chart (MAR sheet)

Check that the medication is correct.

Do you have consent to administer? Even if the resident does not have mental capacity to consent, it is still polite to ask and you are more likely to get their cooperation.

Has the medication already been taken?
If unsure, check **before** giving the dose

Is there any evidence that there was a problem with the last dose?
If unsure, check **before** giving the dose

Do you have up to date knowledge of the medication that you will be administering?

REMEMBER

[Care Home] will check the medicine and agree with the resident the best time for them to take their prescribed medicines and agree that busy times should be avoided.

Remember – Dignity and Respect at **all** times.

If there is any discrepancy, refer to the pharmacy immediately.

Check the expiry date of the medication and that it is fit for use.

Ensure that the resident is in a comfortable position before administering any medicines.

Give the medicine, keeping the resident in control as much as possible.

Remind the resident of any special instructions for oral medication.

Provide water for the tablets to be swallowed.

Observe the resident taking the medication and act accordingly if there is any discomfort or adverse reaction.

Record the administration of each medicine by initialling the correct date space on the MAR sheet. Enable the resident to have as much control as possible.

Wash your hands if possible. If not possible, use a hand sanitising gel to minimise the risk of cross infection.

Dropped, Spoiled or Spilled Medication

Retrieve
Retrieve the medication if possible, wipe up spillages.

Return
Place in an envelope or clear pouch and label with spoilt medication, residents name and what medication it is, place in local disposal area away from other medication still in use.

Record
Record on the MAR sheet which tablet has not been given and why

Replace
Replace the tablet by [local practice]

Report
Report the incident to [care home to complete] who will arrange for additional stock if necessary *(see procedure 1.3)*.

Follow Up
The manager, [care home to complete] should review incidents to identify any potential changes to be made to processes, re-training needs or medication review.

PROCEDURE 3.2: "WHEN REQUIRED" PRN MEDICINES

Medication may be prescribed to be taken Pro Re Nata (PRN), which means 'as needed'.

REMEMBER

For residents who may not have the mental capacity to make the decision that the medication is needed, a clear protocol should be agreed between the prescriber and the care home, setting out:

- The medication name, form, strength, and dosage.
- What are the indications that the medication may be required?
- Consider alternative courses of action to relieve symptoms, or address behaviour.
- Check that the maximum daily/weekly dosage has not been exceeded.
- Include details of escalation and review.
- Give a full explanation, and the reason for the medicine to be given and how it will aid the resident.

PRN medication must be administered strictly in accordance with the written instruction of the prescriber and the [if you have your own Medication Policy then add the Care Homes name here] Medicines Policy and Procedures

Before administering any PRN medicine, follow the individual's PRN protocol to ensure alternative responses have been considered.

Check the total amount taken in the last 24 hours does not exceed the maximum dose when this dose has been taken.

If a PRN medication is being administered regularly/frequently, this must be brought to the attention of the Medical Practitioner as it may be an indication that a review of that resident's regular medication is required.

If PRN medication is offered and refused by a resident, then staff must document this on the MAR sheet and the resident's care plan.

Residents must be closely monitored following the administration of PRN medication to assess whether the medication has had the desired effect.

PRN medication should be supplied in its original packaging as this enables the expiry date to be checked and reduces unnecessary medication waste.

PROCEDURE 3.3: ADMINISTRATION OF CONTROLLED DRUGS, AND OTHER MEDICINES REQUIRING WITNESSING & TWO SIGNATURES

The **whole process** of the administration of controlled drugs should be undertaken by a designated member of staff with the appropriate competence and witnessed by a suitably competent second member of staff.

Take the Medication Administration Record sheet for the resident to the controlled drug cupboard.

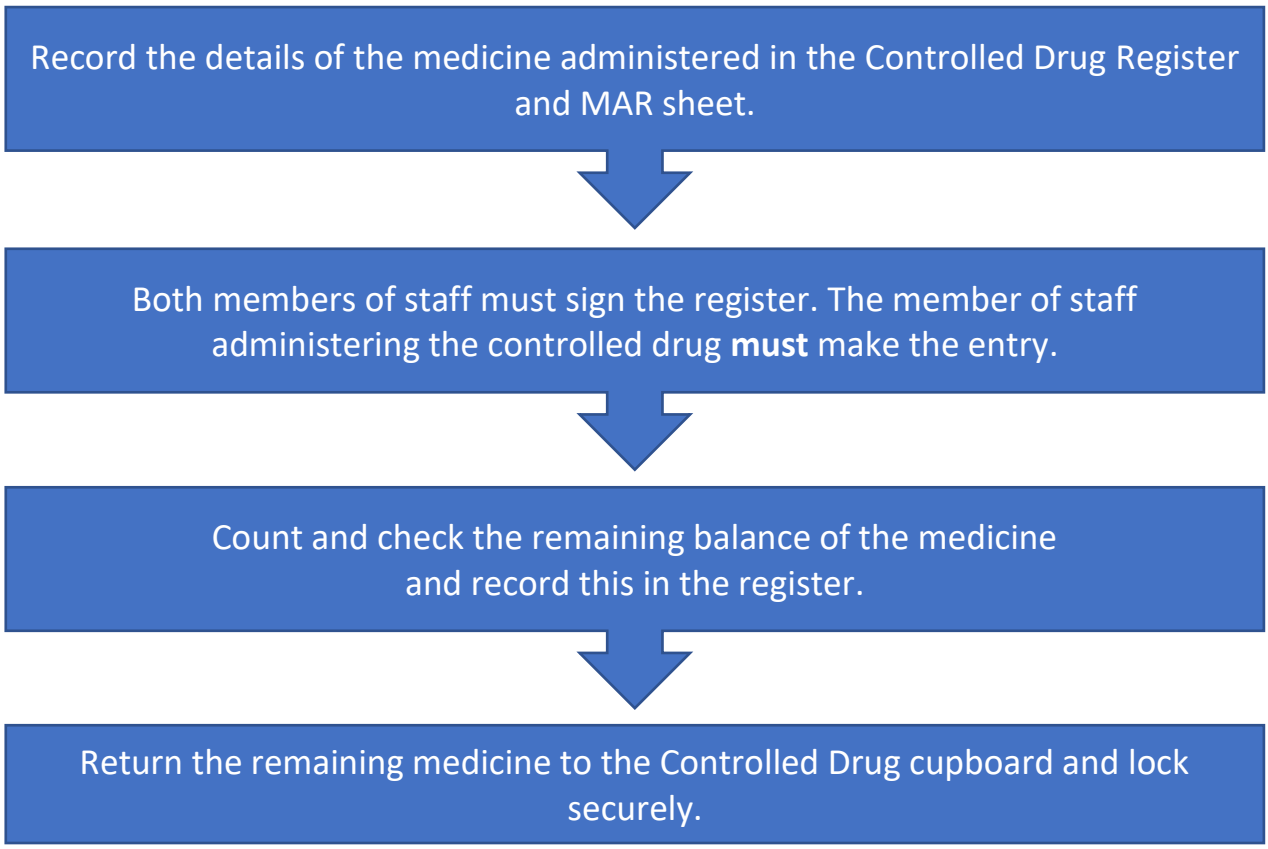
Remove appropriate medicine together with the Controlled Drug Register.

Both members of staff to check the resident's name on the medicines label. Note the amount of current medicine and compare against the Controlled Drug Register.

If the amounts do not match, report any discrepancies **IMMEDIATELY** to the manager.

Take the medicine to the resident.

In front of the resident, both members of staff should check the medication is correct, fit for use, check the label and then check the MAR sheet and take the prescribed amount of medicine from the container.


Record the details of the medicine administered in the Controlled Drug Register and MAR sheet.
Both members of staff must sign the register. The member of staff administering the controlled drug **must** make the entry.
Count and check the remaining balance of the medicine and record this in the register.
Return the remaining medicine to the Controlled Drug cupboard and lock securely.

PROCEDURE 3.4: ADMINISTRATION OF CDs BY VISITING HEALTH PROFESSIONAL

- The care home staff should ask the visiting healthcare professional to make their record of administration available to the care home.
- The healthcare professional should consider seeing the resident in the presence of care home staff.
- Care home staff should keep a record of medicines administered by healthcare professionals on the residents MAR sheet.
- If the CD is stored by the care home, appropriate records should be made in the CD register if it is then given to a visiting healthcare professional to administer. A second member of staff should witness the transfer.
- If the CD is transferred out of the care home e.g. when the resident is away from the care home a record should be made in the CD register and witnessed by a second member of staff.

REMEMBER

Where PRN controlled drugs are administered in nursing homes, any dosage calculations must be checked by a second competent member of staff.

REMEMBER

When administering CD patches, also record the site of application and frequency of rotation of site.
The patch should be checked daily to make sure it is still in place.
Rotation is in accordance with manufacturers guidance.

REMEMBER

If there is a discrepancy, inform [care home to complete] immediately.

Others to be informed are as follows:

- [Care home to complete]
- [Care home to complete]
- [Care home to complete]
- [Care home to complete]

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PROCEDURE 3.5: ADMINISTRATION OF WARFARIN AND ANTI-COAGULANTS

REMEMBER

The **whole** process must be handwritten on the MAR Sheet.

Below is an example using warfarin 1mg tablets, with a dose of two tablets to be taken each day.
The MAR sheet will state, for example, warfarin 1mg tablets - take as directed.

Before the administration of warfarin, an authorised member of staff must:

Only administer when the anti-coagulant record book has been amended or a text/email has been received from the INR clinic.

Handwrite the detail of dosage on the MAR sheet but only up until the next INR is due.

a) Write Warfarin. Then underneath the 'as directed' the number of tablets to be taken in words
e.g., if the dose is 2mg daily, write 'TWO to be taken each day'

b) Write the number of tablets in figures e.g. 2 in the box below where the dose will be signed for.
This will act as a 2nd check for the person to administer 2 tablets

c) If the dose is only to be given on alternate days, put an X through the days when it is NOT to be administered

Check the entry against the person's yellow anticoagulant book/ letter and sign

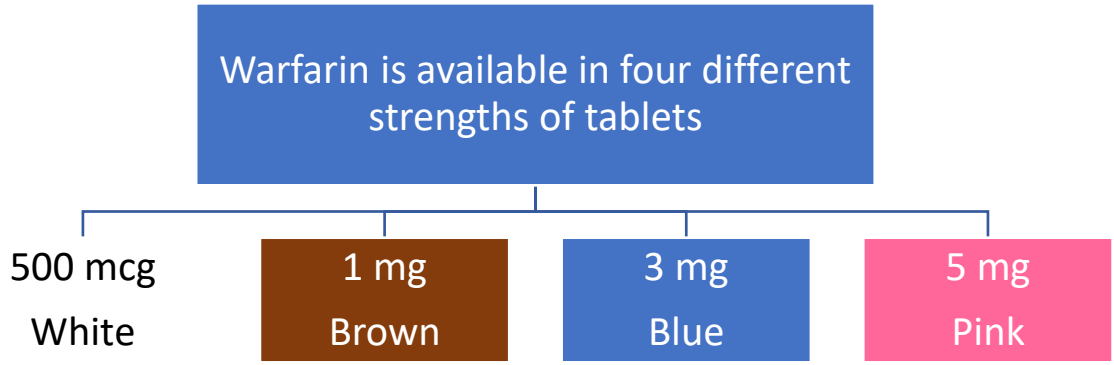
Ask a second authorised member of staff to check carefully and countersign the entry.

REMEMBER

[Care home] staff responsible for administering medicines should add a cross reference (for example, 'see warfarin administration record') to the resident's medicines administration record when a medicine has a separate administration record.

Hints & Tips
ADMINISTRATION OF WARFARIN

REMEMBER



IF IN DOUBT – CHECK WITH YOUR PHARMACY

[CARE HOME TO REPLACE THIS PAGE WITH CURRENT TABLET/ DOSAGE DESCRIPTION]

REMEMBER

Direct Acting Oral Anticoagulants (DOAC's) include Apixaban, Dabidatran Elexilate, Edoxaban & Rivaroxaban. Whilst these medications do not require INR monitoring, they do require blood tests to assess renal function throughout treatment.
DOAC's treatment require an Anticoagulant Alert Card to be issued and retained.

Procedure 4
Support with Homely Remedies
(Non-prescribed medications)

Lincolnshire Care Homes
Medicines Management
WORKING IN PARTNERSHIP WITH HEALTH AND SOCIAL CARE

CareinLincs Workforce Development
Lincolnshire Care Association
Lincolnshire County Council
NHS Lincolnshire Integrated Care Board
United Lincolnshire Hospitals NHS Trust

PROCEDURE 4: **SUPPORT WITH HOMELY REMEDIES** *(Non-prescribed medications)*

4.1 Supporting Residents with Homely Remedies and Over the Counter Medication [Non-prescribed]

4.2 Oral Nutritional Supplements

Introduction

Non-prescribed Medication is a term which covers:
Treatment of minor ailments, such as headaches, coughs, or indigestion available to purchase over the counter.

Medication which does not require a prescription but has traditionally been prescribed on a PRN basis.

[Due to the frailty of residents within Residential Homes, and potential fluctuations in mental capacity, their usage should be discussed with the relevant clinician]

- It is good practice, on admission, to discuss health needs and medicines with the residents and their family. This should also include the use of the homely remedies.

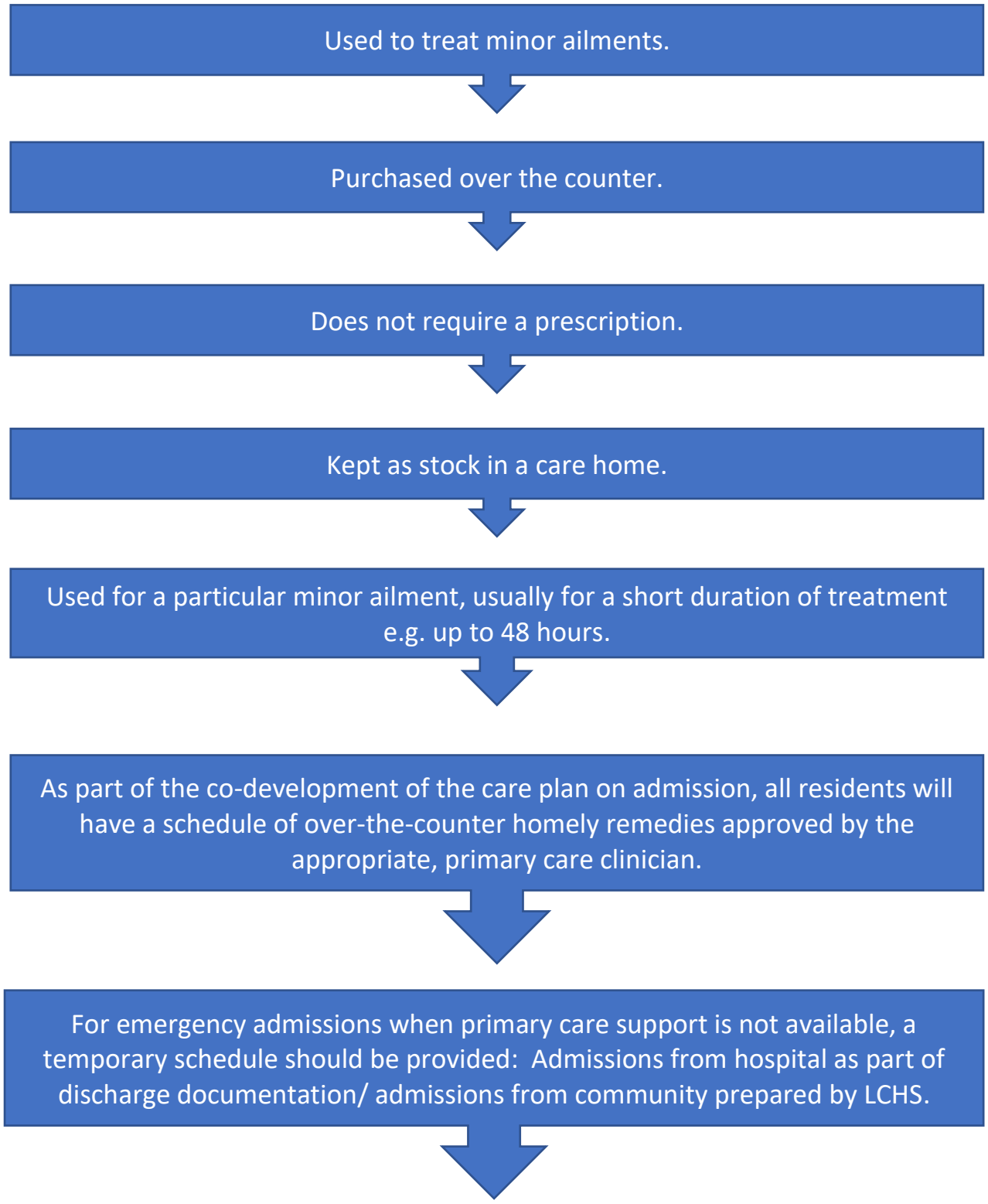
  Residents and their families should always be involved in these discussions and the resident's consent should always be sought. If a Person lacks capacity to make decisions, then the decisions may be made by the family or at a best interest.

- It is advised that the manager discusses the use of homely remedies with the residents' own GP. An agreement is made in the particular medicines and the length of time they can be given without resources back to the GP.

- Residents or relatives may bring in their own homely remedies which have been approved by their own GP. These are not for general use in the Home and must remain specific to that resident.

  They should be counted into the Home and administered and recorded in the same way as all other medication on a MAR.

PROCEDURE 4.1: SUPPORTING RESIDENTS WITH HOMELY REMEDIES AND OVER THE COUNTER MEDICATION [NON-PRESCRIBED]



The schedule of over-the-counter medication will show for each type of situation, the type of dosage and duration for the medication which may be taken.

Wherever possible, residents should be supported to make their own decisions about accessing over the counter medicines.

Residents who may lack the mental capacity to make the decision to access non-prescribed medication should have a Best Interest Decisions making tool within the care plan, including how the need will be recognised.

The Care Home will hold and replenish stocks of potential over the counter medications as agreed with the relevant ICB.

Individual residents who manage their own prescribed medication are able to ask the Care Home to manage over the counter medication on their behalf, if they wish.

REMEMBER

Over the counter / Homely Remedies

- Over-the-counter medication should be treated in the same way as prescribed medication.
- Care staff should check the care plan before supporting a resident with over-the-counter medication.
- Support with over-the-counter medication is subject to the Medication Management Policy.
- Reviews of medication should include a review of the over-the-counter medication. schedule.
- If the symptoms persist after the medication has been given for the time shown on the schedule, **seek medical advice**.
- If the residents condition deteriorates **seek medical advice** at once, e.g. up to 48 hours.
- All homely remedies should be clearly identifiable as "homely remedy".
- Homely remedies should be stored securely separated from the prescribed medication.
- Ensure there is a detailed homely remedy protocol and an authorised list of staff for administration of homely remedies.

REMEMBER

Non-prescribed medication

- Non-prescribed medication should be treated in the same way as prescribed medication.
- Care staff should check the care plan before supporting a resident with non-prescribed medication.
- Support with non-prescribed medication is subject to the Medication Management Policy.
- Reviews of medication should include a review of the Non-Prescribed Medication Schedule.
- Reviews of non-prescribed medicines will be triggered by [Care Home to complete]
- If the symptoms persist after the medication has been given for the time shown on the schedule, **seek medical advice.**
- If the resident's condition deteriorates **seek medical advice** at once.

PROCEDURE 4.2: ORAL NUTRITIONAL SUPPLEMENTS (ONS)

[Care Home] supports the concept of "Food First" and will provide additional nutrition through the use of fortified food and drink, where appropriate.

If a resident is losing weight or has a MUST score of 2 or more, or the BMI is less than 18kg/m2 or unintentional weight loss of more than 10% in the last 3 to 6 months or BMI less than 20kg/m2 and an unintentional weight loss of more than 5% in past 3 to 6 months [the manager] will contact [add name] for advice.

The dietician may recommend changes to the diet rather than ONS.

If ONS are needed, the amount, method of delivery and monitoring should be agreed with [add name] and included in the person-centred care plan.

Residents who use ONS should have a detailed Food Diary including details of ONS given and consumed.

Residents who return from hospital who have been prescribed ONS may not have been referred to a dietician during their hospital stay, they may have required ONS whilst acutely ill or following surgery. Therefore, it is important to establish the goal of having ONS within the first week of admission or readmission and then monitored and reviewed by a GP or dietician as directed. Monitoring will involve keeping records of weight, BMI, changes in food intake and compliance with ONS. If residents require ONS prescribed long term, this needs to be reviewed 3 monthly with a GP or dietician.

Procedure 5
Administration using specialised techniques

Lincolnshire Care Homes
Medicines Management
WORKING IN PARTNERSHIP WITH HEALTH AND SOCIAL CARE

CareinLincs Workforce Development
Lincolnshire Care Association
Lincolnshire COUNTY COUNCIL
NHS Lincolnshire Integrated Care Board
United Lincolnshire Hospitals NHS Trust

PROCEDURE 5: **ADMINISTRATION USING SPECIALISED TECHNIQUES**

5.1 Epileptic Medication

5.2 Intra-Venous Infusion *(Nursing Homes only)*

5.3 Assisting with Oxygen

5.4 Nebulisers

5.5 Medicated Patches

5.6 Subcutaneous Injections including Insulin *(Nursing Homes only)*

5.7 Percutaneous Endoscopic Gastrostomy

5.8 Medication via the Rectum or Vagina

5.9 Eye, Nose and Ear Drops

5.10 Topical Medication including Emollients

[Care Home to add further specialised techniques administered by the Care Home]

Introduction

When undertaking any specialised techniques, senior staff **must**:

Get approval from the Registered Manager.

Clearly document the specialised technique in the care plan.

Obtain full instructions, training, and an assessment of competence from the relevant healthcare professional.

Document the training received, including:

- Date of training
- Name and qualifications of trainer
- Who has been trained
- What the training covered
- Who has been signed off as competent
- Reassessment date

REMEMBER

Competency **must** be assessed before each new task of each resident.

Administration by Specialised Techniques

Which ones are your organisation able to do?
Record on Index [Care Home to Complete]

Competence – record and review gaps, care plan, consent

REMEMBER
Dignity and Respect at **all times.**

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need
(including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initialling the correct date space on the MAR Sheet and enable the resident to have as much control as possible.

PROCEDURE 5.1: EPILEPTIC MEDICATION

BUCCAL MIDAZOLAM

Buccal Midazolam is recommended as the treatment of choice. It is often more socially acceptable, convenient to administer and preferred by individuals. However, treatment options (Buccal Midazolam or rectal Diazepam) should be discussed and decided as part of a shared decision-making process.

In addition to the suite of medication management policies and procedures, staff should be aware of the following:

- Buccolam is only licenced for use in children under 18 years of age. Use in adults is an off-label indication
- Epistatus is an unlicenced 'special' formulation
- Midazolam is a schedule 3 controlled drug

RECTAL DIAZEPAM

Indications for the use of rectal diazepam

When it is not possible to administer medicine by mouth.

As discussed with prescriber.

Application as shown on prescription.

As detailed in the support plan.

Reason for administering – Seizure lasts more than the agreed time (often 5 minutes).

A Risk Assessment should be carried out.

Information on who to contact:
[Care home to complete]

Due to the sensitive and invasive nature, consider consent and suitability as a first line treatment.

Staff should familiarise themselves with the terminology widely used when discussing epilepsy.

The Resident should have a Seizure Management Plan which sits within the Medication Administration Record and a core plan that is agreed between the person, family and/or carers where appropriate, and primary care and secondary care providers. This should include lifestyle issues as well as medical issues.

The Seizure Management Plan should be held with the Medication Administration Record and be included in any medication reviews undertaken.

Residents with a diagnosis of epilepsy should have a regular structured review. This review should be carried out at least yearly by either the GP or specialist, depending on how well the epilepsy is controlled and/or the presence of specific lifestyle issues.

On discovering the individual who is having a seizure, the staff member should seek support by raising the alarm or calling out whilst staying with the individual. Trained staff may administer medication as per the Seizure Management Plan.

IMPORTANT INFORMATION

Staff supporting residents with a long-term condition such as epilepsy, should have sufficient knowledge to be able to support the individual or signpost to further information.

Staff should have access to:

- Epilepsy awareness training
- Training on the administration of rescue medication *(Buccal Midazolam and Rectal Diazepam)*

Training should be provided by a specialist epilepsy nurse and the Registered Manager should contact the local specialist nurse to source appropriate training.

STATUS EPILEPTICUS

Status Epilepticus is when a seizure lasts longer than 5 minutes or when seizures occur close together and the person does not recover between seizures.

It is a medical emergency!

Where staff are trained and competent to do so, they should administer Buccal Midazolam or Rectal Diazepam as prescribed and per treatment plan.

Where medication has not been prescribed, or prescribed regimes have been ineffective, **staff must call 999**

In the event of admission to hospital, staff should advise the ambulance/hospital staff exactly what rescue medication has been given and when and a record of any routine medications that are prescribed.

Information can be found via Overview | Epilepsies in children, young people, and adults | Guidance | NICE

Staff should familiarise themselves with the common medications used for the management of epilepsy.

Any rescue medication (Buccal Midazolam or Rectal Diazepam) prescribed for the control of prolonged convulsive epileptic seizures, must be initiated by or upon the recommendation of a specialist prescriber (i.e. a Neurologist specialising in the management of epilepsy). For individuals with a learning disability, this may be in collaboration with a Learning Disability Consultant (and other clinicians involved in their care).

Staff should have access to:

- Epilepsy awareness training
- Training on the administration of rescue medication (Buccal Midazolam and Rectal Diazepam)

PROCEDURE 5.2: ADMINISITRATION OF INTRA-VENOUS INFUSIONS [Nursing Home Only]

REMEMBER

Only undertake the procedure if you have received the correct training and specialised support to allow the use of IV Fluids to take place in the Nursing Home

- Wherever possible, two qualified Nurses should check the medication that is to be administered. If not, one **must** be registered to administer IV Medication and have had the relevant training to support best practice.

- In exceptional circumstances where there is no second trained Nurse, then a competent and trained carer may be used to support the checking of the dose and calculation of the IV infusion.

- In relation to the administration of the IV Infusion, the Nurse **must** follow the duty of care and monitor the resident and their responses (www.rcn.org.uk).

- All nurses can access the online Specialist Pharmacist Service for advice – www.sps.nhs.uk.

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

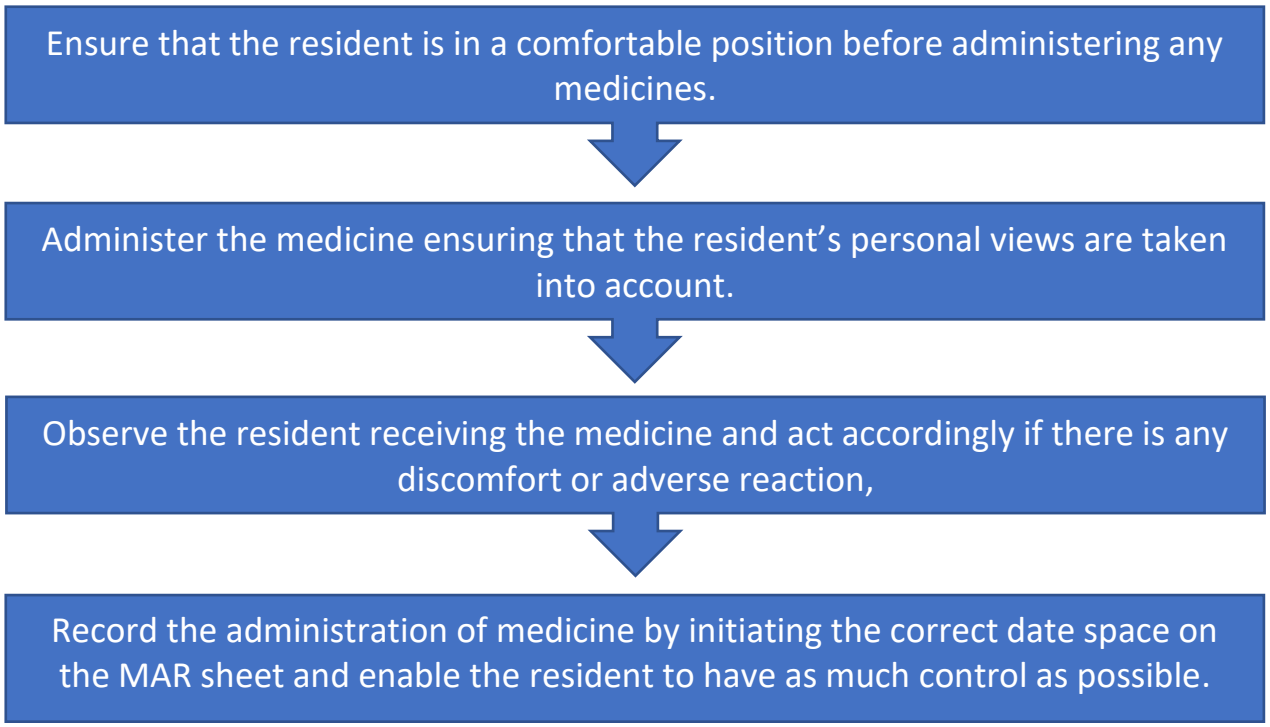
Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.


Ensure that the resident is in a comfortable position before administering any medicines.
Administer the medicine ensuring that the resident's personal views are taken into account.
Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction,
Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.3: ASSISTING WITH OXYGEN

IMPORTANT

Before any care worker assists a resident with oxygen, there **must** be an individual care plan detailing the oxygen therapy.

Before any care worker assists a resident, they **must**:

- Undertake specific training on the practical aspects of caring for residents needing oxygen.
- Undertake refresher training every 2 years.
- Complete competency assessments and/or knowledge checks every 6 months.
- Familiarise themselves with the resident's individual care plan and protocol for assisting with oxygen.

** ALL TRAINING AND COMPETENCY ASSESSMENTS **MUST** BE DOCUMENTED **

REMEMBER

- Where oxygen is being administered or stored, smoking **must not** be allowed.
- Oxygen cylinders **must** be stored in a dry, clean, secure, well-ventilated area.
- Full and empty cylinders must be stored separately.

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.4: ADMINISTRATION OF NEBULISERS

IMPORTANT

All residents who have been prescribed nebuliser medication will need to have a full medical assessment to determine dose, type, and frequency of medication.

Wash your hands with soap and water before preparing the nebuliser for use. This will help to prevent germs from getting in the lungs.

If using a machine:

- Place the machine on a hard surface.
- Check to see if the air filter is clean. If it is dirty, rinse it using cold water and let it air dry.
- Plug in the machine and follow the equipment's instructions.

Prepare the medicine:

- If the medicine is premixed, open it and place it in the nebulizer medicine container.
- If you must mix medicines, place the correct amounts into the container using a dropper or syringe.
- **If needed** add saline (Sodium Chloride 0.9% solution) to your medicine container. **Do not** use homemade saline solution in a nebuliser.

Connect the container to the machine using the tubing.
Connect the mask or mouthpiece to the top of the container.

Place the mouthpiece between their teeth. Request the resident closes their lips around it. You may instead help the resident by placing the **mask on their face**.
Turn on the machine. Keep the medicine container in an upright position.
Request the resident to breathe in and out slowly and deeply through their mouth until the mist is gone or there is no more mist coming out.
The whole **treatment may take up to 20 minutes**.
Clean the machine and return to its dedicated place of storage.

Administration of Medicines Check

REMEMBER
Dignity and Respect at all times.

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.5: ADMINISTRATION OF MEDICATED PATCHES

IMPORTANT

- The patch may be a Controlled Drug. If it is, you must follow the controlled drugs procedure.
- All patches should be recorded on a body map by initialling and dating the site used. Records must show the site of application and the frequency of rotation of the site.
- Be aware of residents wishes and concerns.
- Remove the old patch before administering a new one.
- All patches removed should be disposed of safely in line with disposal procedure 9, avoiding risk to staff. **Do not** put them in the waste bin.
- Encourage self-administration to support choice and control for resident's safety.
- Follow the guidance in the care plan about areas to use, and the order of rotation.

REMEMBER

Encourage inclusion and independence, and dignity and respect at all times.

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.6: ASSISTING WITH INSULIN

IMPORTANT

Residents who require insulin can be assisted, but are responsible for their own administration.

IMPORTANT

Before any nurse/ care assistant assists a resident:

There **must** be:

- An individual care plan detailing the checks, treatment, and responsibilities of all those involved in this care.
- Details of the action to take if the resident has a hypoglycaemic attack.
- Details of the relative importance of mealtimes and information on foods that should be avoided.

They **must:**

- Undertake specific training on the practical aspects of caring for residents with diabetes plus correct preparation of the prescribed dose.
- Undertake refresher training every 2 years.
- Complete competency assessments and/or knowledge checks every 6 months.
- Familiarise themselves with the resident's individual care plan and protocol for assisting with insulin.

*All training and competency assessments **must** be documented.*

Reference: Diabetes and insulin use - Care Quality Commission (cqc.org.uk)

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.7: ADMINISTRATION OF MEDICINES THROUGH A PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG)

REMEMBER

- Non-registered staff must only undertake this task if they have had resident specific training and have been signed off as competent by an appropriate registered nurse.

Reference:

Delegating medicines administration - Care Quality Commission (cqc.org.uk)
Delegation - The Nursing and Midwifery Council (nmc.org.uk)

- A competent Nurse **must** have completed PEG competency training and be up to date.

Care of the PEG Tube

This routine care can be performed by the resident and/or the carers with suitable training.

Examine the skin for infection/irritation around the site.

Note the measuring guide number at the end of the external fixation device.

Remove the tube from the fixation device and ease away from the abdomen.

Clean the stoma site with sterile saline.

Dry the area with gauze.

Rotate the gastrostomy tube to prevent adherence to sides of the track.

Re-attach the external fixation device to the abdomen.

Attach the gastrostomy tube gently to the fixation devise and position as before according to the mark/ number on.

Avoid bulky dressings.

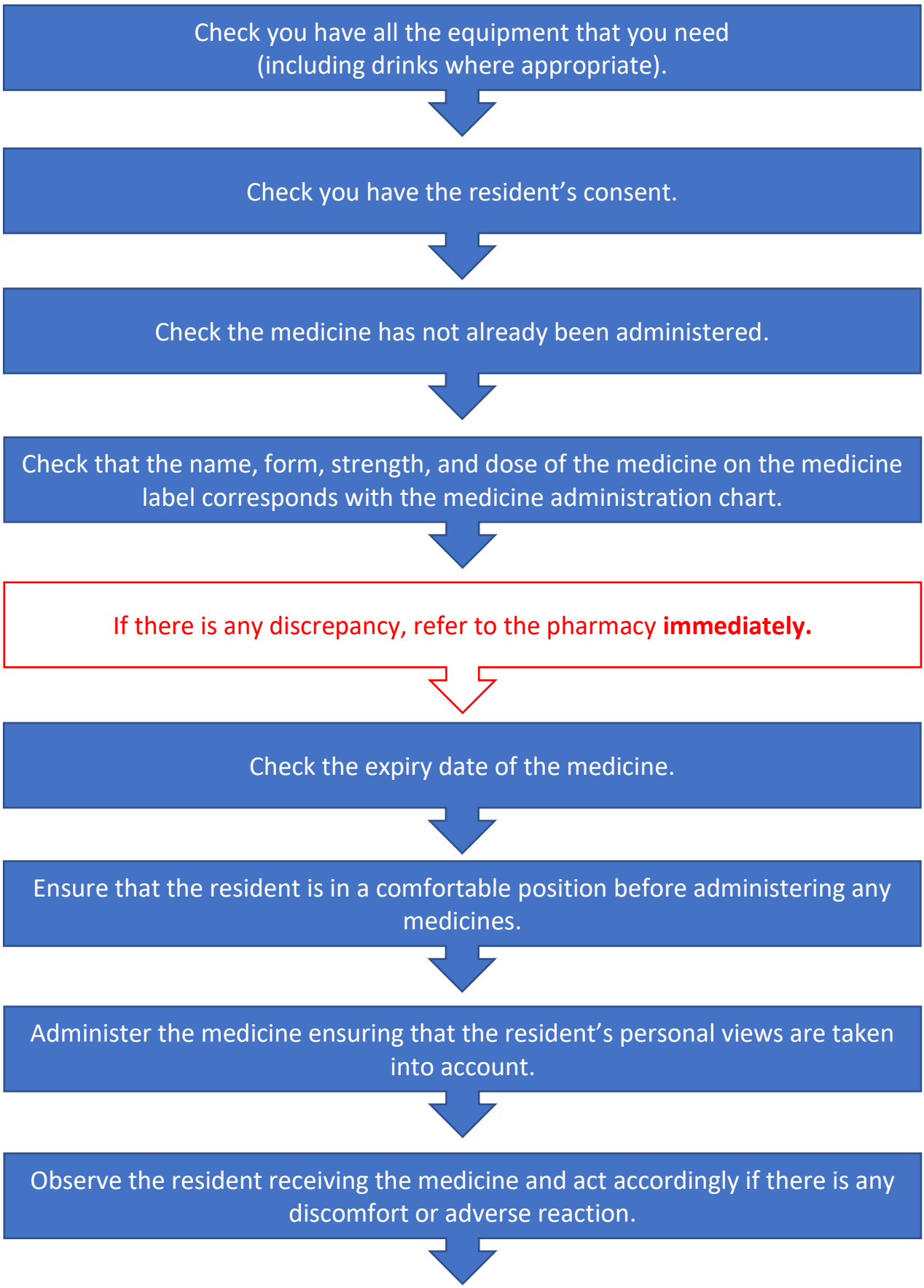
Administration of Medicines Check

REMEMBER

Dignity and Respect at all times.

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.


Check you have all the equipment that you need (including drinks where appropriate).
Check you have the resident's consent.
Check the medicine has not already been administered.
Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.
If there is any discrepancy, refer to the pharmacy immediately.
Check the expiry date of the medicine.
Ensure that the resident is in a comfortable position before administering any medicines.
Administer the medicine ensuring that the resident's personal views are taken into account.
Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.8: ADMINISTRATION OF PRESCRIBED MEDICATION VIA THE RECTUM OR VAGINA

REMEMBER

Ensure privacy and dignity at all times. Staff who administer medication must have been competency assessed to ensure safe and best practice.

Gather necessary equipment.

Follow the written instructions on the MAR.

Wash your hands, then check the resident's identification and explain the procedure to them. Apply medical/ examination gloves, place resident in the Sims' left lateral position with the upper leg flexed for rectal application. For vaginal application, lie on their back with their legs slightly apart.

For rectal administration open the package of lubricant and remove the foil wrapper from the suppository, then apply a small amount of lubricant to the suppository and lubricate the gloved index finger.

Insert the suppository into the rectal canal beyond the internal sphincter about 4 inches (for an adult) into the rectum, then withdraw the finger and wipe the anal area with tissue.

Ask the resident to remain in bed for 15 minutes and to resist the urge to defecate. Remove gloves, wash hands and ensure their call bell is in easy reach.

For rectal medication, support the resident to the toilet or which method of toileting they prefer.

For vaginal medication, insert the pessary 1 inch into the vagina.
Support the resident's dignity and personal hygiene preferences as detailed in their care plan.

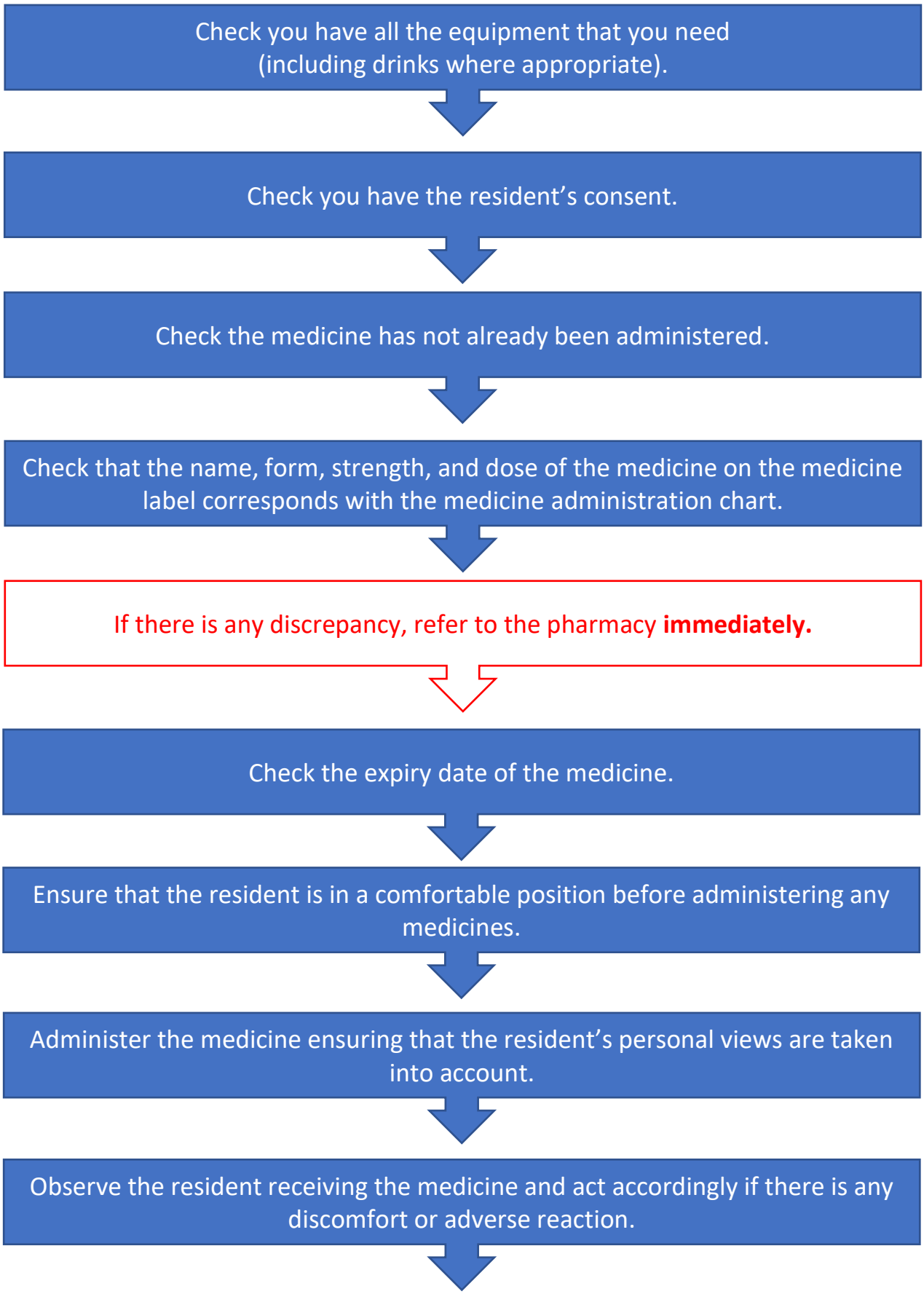
Record the name of the drug, dosage, route, and time of administration on MAR. Observe the effectiveness of medication and record in relevant care plan.

Administration of Medicines Check

REMEMBER
Dignity and Respect at all times.

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.


Check you have all the equipment that you need (including drinks where appropriate).
Check you have the resident's consent.
Check the medicine has not already been administered.
Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.
If there is any discrepancy, refer to the pharmacy immediately.
Check the expiry date of the medicine.
Ensure that the resident is in a comfortable position before administering any medicines.
Administer the medicine ensuring that the resident's personal views are taken into account.
Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.9: ADMINISTRATION OF EYE, NOSE AND EAR DROPS

IMPORTANT

Always wash and dry your hands before handling eye, nose or ear drops.

Check that the resident is in a comfortable position before administration of drops.

Clean areas for administration e.g. eye, ear or nose.

Check the expiry date of the drops and re-check you have the correct dose.

Explain the procedure to the resident.

Apply drops to the area:

Eye

Instil the eye drop into the space [fornix] created by gently pulling down the lower lid. Wipe away any excess fluid.

Ear

Shake the bottle. Draw up the correct dose, pull the ear backwards. Add the correct number of drops into designated ear. Keep ear tilted for a further 20 seconds.

Nose

Suggest the resident blows their nose to expel before administration of drops. Gently insert bottle tip into one nostril. Request the breaths in as the drops are inserted.

Check the resident and observe for any reactions.

Ensure that the resident is left in a comfortable position.

Record the administration of medicine by initialling the correct date space on the MAR sheet.

If the drops are within the expiry date, then return them to the fridge/ designated storage area.

Administration of Medicines Check

REMEMBER

Dignity and Respect at all times.

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.

PROCEDURE 5.10: TOPICAL MEDICATION incl. EMOLLIENTS

Identify resident and explain the procedure, considering their wishes and preferences.

Verify medication usage and instruction on how to apply.

Wash off old topical medication with soap and water and dry area thoroughly.

Expose skin area where topical ointment is to be applied.

Ensure resident's privacy and dignity at all times.

Apply topical medication using disposable gloves, if necessary, as per manufacturer's directions.

Discard soiled supplies in appropriate containers in the Home.

Document administration, dose [if needed], time and site.

REMEMBER

Use body map documentation showing site[s] where topical.

If a TMAR (topical MAR) is in use to record topical medicines which are stored in the resident's room, remember to sign this after administration of creams, ointments etc. and indicate on the body map where the medicine has been applied.

IMPORTANT

- All emollients pose a risk for residents and staff.
- All emollients, for example White Soft Paraffin, White Soft Paraffin 50%, or Emulsifying ointment, in contact with dressings and clothing is easily ignited by a naked flame.
- The risk will be greater when these preparations are applied to large areas of the body and clothing, or dressings become soaked with the ointment.
- People should be told to keep away from fire, flames, or other potential cause of ignition and not to smoke when using these preparations.

Examples of emollients. This is NOT an exhaustive list:

- WSP White Soft Paraffin 100%
- Zinc ointment BP 72.25%
- Diprobase ointment 95%
- Emulsifying ointment 50%
- Liquid Paraffin 50%/WSP 50% ointment 50%
- Emollient aerosol spray 50%
- Zin and Salicylic acid paste BT 50%
- Dithranol Ointment = contains soft yellow paraffin
- Epaderm – contains emulsifying wax, liquid paraffin and yellow soft paraffin
- Hydromol Ointment = contains emulsifying wax, liquid paraffin and yellow soft paraffin
- Imuderm Liquid = contains liquid paraffin

IMPORTANT

Where emollients are used, care staff **must**:

- Undertake a risk assessment, as all emollients are seen as a Fire Risk.
- Assess the smoking status of a person BEFORE commencing treatment - Offer stop smoking support.
- Provide the person with information about the potential fire risks of smoking (or being near to people who are smoking), or exposure to any open flame or other potential cause of ignition during treatment. This should be given in both verbal and written form.
- Regularly change clothing or bedding impregnated with any emollients (preferably on a daily basis) and ensure that specific washing instructions at high temperature are followed.
- Record full information in the person's care plan.
- Ascertain if the person is subject to additional fire risk e.g. using oxygen.
- Ensure fire safety information is displayed prominently in every area where people may be treated with significant quantities of emollients.
- Ensure staff know what to do if a person does not comply with safety advice and instructions during treatment involving significant quantities of emollients.
- If appropriate, discuss with the GP whether a paraffin-free alternative can be prescribed.

Procedure 6
Recording

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PROCEDURE 6: **RECORDING**

6.1 Record Keeping

6.2 Handwriting on MAR sheet

6.3 Handwriting on pre-printed MAR sheets due to new medication

6.4 Handwriting on pre-printed MAR sheets if dose changes

6.5 Handling verbal orders

PROCEDURE 6.1: RECORD KEEPING

Record keeping is an important part of the assurance process. Care homes should add any other records and where they are located to the list below.

Medicines Ordered	[Care home to complete locally]
Medicines Received	On Medication Administration Record sheet or stock record
Medicines Administered	By signing on the Medication Administration Record sheet
Medicines refused or not administered	Using correct code on the Medication Administration
PRN 'when required' medicines protocol	In the care plan
Medicines for disposal	[Care home to complete locally]
Details of staff training and competency	[Care home to complete locally]
Signature/ Initials of Administered	[Care home to complete locally]

REMEMBER

Handwritten MAR Sheets

1. Use pharmacy-produced printed Medication Administration Record sheets wherever possible.

2. Handwritten Medication Administration Record sheets should be prepared as per procedure for preparation of handwritten Medication Administration Record sheets.

3. Blank [Care Home] Medication Administration Record sheets are available for any changes or new medicines.

4. File used Medication Administration Record sheets [in the appropriate resident's records at the end of each month].

5. Retain used Medication Administration Record sheets in line with GDPR Compliant retention policy.

All entries must be legible. They may be typed, written in pen, or be electronic.

PROCEDURE 6.2: HANDWRITING ON MAR SHEETS

Where a pre-printed Medication Administration Record sheet is not available a competent authorised staff member should:

Complete the name, address [room number] date of birth and any allergies.

Copy each medication name, form, strength, dose and frequency on to Medication Administration Record sheet directly from the medicines label.

Count the medication received and enter details onto Medication Administration Record sheet.

Sign and date the entry.

Ask a second suitably trained member of staff to witness both the new entry and the original fax or label.

If the witness agrees, then they should countersign; if not then they should challenge.

PROCEDURE 6.3: HANDWRITING ON PRE-PRINTED MAR SHEETS DUE TO NEW MEDICATION

If a handwritten entry or a pre-printed Medication Administration Record sheet is required because of an interim supply, a senior designated staff member should:

- Check they have the correct Medication Administration Record sheet.
- Mark the original medication as discontinued and record the new medicine. Copy name of medicine, form, strength, dose and frequency on to Medication Administration Record sheet. Add the date and time of the first dose. These details will come from the label or record of verbal instructions.
- Ask a second suitably trained member of staff to check the entry.
- If both agree in all details, the witness should countersign.
- Make a clear recording on the Medication Administration Record Sheet of where the authorisation has come from.

PROCEDURE 6.4: HANDWRITING ON PRE-PRINTED MEDICATION ADMINISTRATION RECORD SHEETS IF DOSE CHANGES

If a handwritten entry or a pre-printed Medication Administration Record sheet is required because of a **dose change**, a senior designated member of staff should:

Check they have the correct Medication Administration Record Sheet.. Mark old dose or changed medication as discontinued so there is no confusion and not given twice.

Record the new medicine, copy name of medicine, form, strength, dose and frequency on to Medication Administration Record sheet. Add the date and time of the first dose.

Ask a second suitably trained member of staff to check the entry.
These details will come from the label or record of verbal instructions.

Record on the medication administration record sheet and in the care plan where the authorisation for the change of dose has come from.

PROCEDURE 6.5: HANDLING VERBAL ORDERS

Wherever possible written instructions of dose changes, additional medicines or discontinuation of medicines should be obtained from the prescriber.

In exceptional circumstances, or an emergency, the manager or the senior designated person should accept verbal orders by telephone or video link.

Verbal orders given in person should be recorded by care staff in [add where] and checked and signed by the prescriber.

If at all possible, two members of staff should listen to the verbal instructions.

The manager, or senior designated person, should record the instructions as they are being given in the [add the local name of record].

The instructions should be read back to confirm accuracy and the entry signed and dated.

If care staff do not understand any of the terms used, they should ask for clarification.

An [email or fax] should be sent by [care home/prescriber] to give written confirmation of the instructions before the next dose of medication is given.

The manager should make an entry on the MAR sheet which is checked by the second person who heard the instructions and both should sign.

If in doubt, CHECK that you have heard and understood correctly.

Procedure 7
Refusal of Medicines

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PROCEDURE 7: **REFUSAL OF MEDICINES**

If a resident refuses medication, the care worker **must**:

Respect the resident's refusal to take medicines where the resident has capacity and establish the reason for the refusal.

Give the resident a second opportunity to take their medication after 15-30 minutes, if appropriate. Ensure that this is highlighted within the care plan.

Suggest to an alternative member of staff that they explain and reassure the resident.

If the resident still refuses, record the reason for the refusal on the back of the MAR sheet and use the code for non-administration on the front of the MAR sheet.

Report the refusal to a senior member of staff who will decide whether to inform the prescriber, depending on the medicine and the resident's condition.

A senior member of staff will discuss the reason for refusal at the medication review with the resident's GP.

Dispose of any medication already removed from the container via the disposal procedure and record disposal.

When a resident consistently refuses to take their medication, contact the GP after 3 days of refusal. However, if this is a time critical medication contact GP/ pharmacist **immediately** or as soon as practicable for advice.

Note:

This procedure is under review to consider Mental Capacity Act and clinical view on reporting of refusal.

REMEMBER

If there is a concern that the resident may not have the mental capacity to make the decision to refuse medication, follow Mental Capacity Act guidelines medication will be administered to manage risk and safe administration.

If the resident agrees, contact the GP who prescribed the medicine and inform the supplying pharmacy to prevent further supply and overstock.

Procedure 8
Medicine Handling for Residents who will be absent from the home

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PROCEDURE 8: **MEDICINE HANDLING FOR RESIDENTS WHO WILL BE ABSENT FROM THE HOME**

1. Undertake a Risk Assessment

Resident

How long is the resident away for?

Who are they accompanied by, and are they competent?

What is the nature of the medicines they are taking?

Plan as much as possible when resident is intending to go out

May need to ask prescriber for a separate supply.

2. Consider the following options:

Missing the dose out altogether
(after confirmation from prescriber)

Giving the dose early or later
(after confirmation from prescriber)

Giving the original dispensed medicine to the relative/ carer/ resident themselves
(if competent to administer)

Obtaining a separate labelled supply for 'leave'
(advanced warning required to obtain a prescription and get it dispensed)

Taking out the dose required and putting it in a labelled container according to the procedure above.

3. If the option to 'Take out the dose required and putting it in a labelled container' is selected, the following protocol must be applied:

This option should be used for a single dose only.

Only a designated and competent member of staff is authorised to undertake the task.

A second member of care staff **must** be present to check and act as a witness and counter signatory.

The medicine must be dispensed into a clean bottle or daily dosing aid and labelled with the name of the medicine, strength, form, quantity, dose, name of resident and date. Any additional instructions e.g. take after food, must also be added. These instructions should be copied directly from the original pharmacy-labelled container.

For Controlled Drugs (CDs) refer to the CD procedure.
A log recording medicines taken out of the home should be completed using the in/out log. Any medicine returning to the home should also be signed back.

Procedure 9
Disposal of Medicines

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PROCEDURE 9: **DISPOSAL OF MEDICINES**

PROCEDURE 9.1: DISPOSAL OF MEDICINES

There are several reasons why medicines may no longer be required:

- The medication was not used because the resident was in hospital.
- It has been spoiled e.g. dropped on the floor.
- It has passed its expiry or use by date.
- It has been stopped by the prescriber.
- The resident has passed away.
- It was refused by the resident.
- The resident has moved to another care service or gone home.

IMPORTANT

- Syringes and needles should be placed in a sharps box as soon as they have been used. Take the sharps box with you to where the medication will be administered.

- **Never** put unwanted medicines down the sink or toilet.
  Small doses of liquids which have been measured, but not taken, should be placed into the [local practice as per home policy] and returned to the medication supplier as agreed.

REMEMBER

If someone dies, put their medicines to one side in the medicine's cupboard separated from current stock and labelled clearly:

- "DO NOT USE"
- "DO NOT DISPOSE OF UNTIL 10 DAYS AFTER DEATH OR EARLIER IF THE CORONER GIVES PERMISSION"

Methods of Disposal

- Put single tablets which have been refused or spoiled in an envelope and write the name of the resident, the name of the medicine and the date on it.

- Place unwanted medicine in a designated disposal area (in a tamper proof container) and make an entry in the Returned Medicines Book, recording the medicine name, strength, quantity, and the resident's name.

- Ask the pharmacy to take the medicines for disposal when they next visit. The pharmacy needs to date and sign the Returned Medicines Book as a receipt of collection.

- Biodose and/or blister packs, if not fully used, should be returned to the medication supplier.

PROCEDURE 9.2: DISPOSAL OF CONTROLLED DRUGS (CDs) – CARE HOMES WITH NURSING

The Home will need to plan for the collection of waste medications with a Waste Management Regulations licensed waste disposal company.
CDs must be denatured before being handed to the waste disposal company.

Homes should have a denaturing (doom) kit, and a current T28 Waste Exemption Certificate to comply with the legislation that is overseen by the Environment Agency.

CDs which are no longer required due to changes in medication should be marked as "For Disposal" and stored within the locked CD cupboard separately from the main stock of CDs.

Within [*reasonable time limit*], a designated nurse who is competent in the use of the denaturing kit and an authorised witness (who does not need to be a nurse) should denature the CDs.
[add the detailed instructions for your kit]

The details of the destruction should be entered into the CD record by the nurse and witnessed by the second member of staff.
A record of the waste transfer note needs to be made by the appropriate member of Care Home staff.

[add the local practice on disposal of denatured waste]

CDs prescribed for residents who have died should be stored for 10 days (or until permission to destroy has been received by the coroner), and then disposed of as above.

PROCEDURE 9.3: DISPOSAL OF CONTROLLED DRUGS (CDs) – CARE HOMES WITHOUT NURSING

CDs should be returned to the relevant pharmacist or dispensing doctor at the earliest opportunity for appropriate destruction.

CDs which are no longer required due to changes in medication should be marked as “For Disposal” and stored within the locked CD cupboard separate from the main stock of CDs.

CDs should be given to the pharmacy delivery driver at the earliest possible opportunity, who should provide a signed collection note or sign the CD record.

Two members of staff should be present when CDs are checked and handed over.

The disposal should be recorded in the CD book by the senior member of staff and witnessed by a second person.

Good practice involves one staff member making the record of controlled drug destruction in the Controlled Drugs Register and a second member of staff to check and sign the record.

This helps to verify that the register is accurate. Some pharmacists will sign the register to acknowledge receipt. This is not a legal requirement. Produce a returns sheet and have the Driver / Pharmacy sign this.

Relevant details of any such transfer for disposal should be entered into the CD register and signed by a trained and competent member of staff returning the drug.

CDs prescribed for residents who have died should be retained for 10 days or until released by the coroner if sooner, and then returned on the next delivery.

“Just in Case” boxes should be returned to the palliative team that provided them (after 10 days).

Procedure 10
Administration of Covert Medication

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PROCEDURE 10: **ADMINISTRATION OF COVERT MEDICATION**

Covert Medication is the administration of medicines in a disguised form without the knowledge of the person receiving it.

REMEMBER

- Prescribers should no longer use instructions such as "just mix with food" as instruction for covert medication.
- Clarify reason(s) for an individual to refuse medication(s).
- Review medication and consider if deprescribing is appropriate as first line approach.
- Agree steps to be taken.
- Covert administration should be a last resort.
- Review the need for covert medication regularly [Care home to specify].
- Check with pharmacist that a medication will not be affected by being given covertly.
- Be medication specific, time limited, reviewed regularly, transparent, inclusive and in the individual's best interest.

When an individual persistently refuses medications, covert medication **may** need to be considered.

Complete an MCA to determine residents' ability to understand potential consequences of persistently refusing medication. Test mental capacity against the five key statutory principles in assessing capacity.

Resident HAS CAPACITY

Review medication with the resident and family and document decisions to stop any medications.

COVERT ADMINISTRATION IS NOT APPROPRIATE AT THIS TIME.

Resident LACKS CAPACITY

Can the decision be delayed? Is capacity likely to improve? Are family or friends available? Does an IMCA need to be involved? Is there someone with registered lasting power of attorney or a deputy for the Court of Protection who can make personal welfare choices?

- If no; Medication should be reviewed for clinical need. Stop medications as the first least restrictive option and document . Prescriber to consult with multidisciplinary team and resident representative to make a best interest decision. Complete best interest decision documentation for individual resident refusing and each medication should be documented individually.

COVERT ADMINISTRATION

- Agree steps to be taken and follow local policies for individuals requiring covert administration to ensure best practice.
- Complete documentation [care home to complete] to enable care staff with authorisation to covertly administer medication.
- Document review process, which needs agreeing within best interest decision.
- Observe resident to see if declining food and drink as a result of covert medication, as their general condition may deteriorate.
- If the resident is declining food and drink or deteriorating , stop covert administration following GP review.
- If the resident is eating and drinking, and generally well, continue with regular **reviews**

Step by Step

Any individual capable of making a decision has the right to accept or refuse medical treatment, including medication, even when a refusal could potentially lead to further illness or even death.

"Best Interests" is a way of making objective decisions. The Mental Capacity Act 2005 provides a checklist which must be followed when making or thinking of making a decision for someone.

If having completed a best interests decision to administer medication covertly, the suitability of each medication must be considered each time a new medicine is started.

Ensure good and accurate record keeping is maintained for safety and quality of care. Personalised instructions for each medicine to be given covertly should be in place.
Each time medication is given covertly, in accordance with the care plan, it should be documented on the back of MAR sheet clearly.

Offer the medication overtly each time and only proceed to covert administration after refusal and documented steps.
Mix the medication with the smallest volume of food or drink possible, some food and drink interact with medication and these must be documented in the care plan.
Administer medication immediately after mixing it, do not leave for the individual to manage themselves.

The need for continued covert administration should be reviewed within time scales that reflect the physical and mental state of each individual.

This should be agreed at time of implementing covert administration within best interest decision.

Procedure 11
Errors, Adverse Reactions and Escalation

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PROCEDURE 11: **ERRORS, ADVERSE REACTIONS AND ESCALATION**

PROCEDURE 11.1: ERRORS, ADVERSE REACTIONS AND ESCALATION - General

Errors in medication can lead to serious consequences for residents.

Care must be taken when undertaking any tasks in relation to medication to minimise the risks of error.

[Care Home name] will encourage an open and transparent culture in which staff feel confident to report any mistakes or concerns.

If you believe that an error in the administration of medicines or recording of medicines has been made, notify [add name] at once.

DO NOT GIVE ANY FURTHER MEDICATION until advice has been received.

[Add name] will contact the appropriate clinician (may want to localise) for advice.

Explain **calmly** to the resident that there has been an error and that medical advice has been sought. Care staff should carefully observe the resident whilst waiting for advice – if the resident becomes acutely unwell, dial 999

After the safety of the resident has been assured, complete a [Medication Errors and Incidents Reflection] in as much detail as possible.

IMPORTANT

Based on the needs of the residents who have not received their medication, additional resources may be needed to complete the round.

[Care Home] staff should find out the root cause of medicines-related incidents.

PROCEDURE 11.2: RESIDENTIAL HOME (WITHOUT A REGISTERED NURSE)

If a resident has an adverse reaction to medication such as [Care Home to complete]

Dial **999** if life-threatening.

At anytime, if the resident deteriorates, dial **999**

Otherwise, contact pharmacist for advice.

Out of Hours, contact 111
or CAS for Care Homes contact 0300 123 4868 Option 6 (24/7 line)

Record the incident, the advice sought, action taken and the effect.

If the advice was **not** from the prescriber, notify them and request alternative medication if needed.
(Only request alternative medication if the adverse reaction was from the medication and not another source, e.g. Insect bite/ sting, food)

PROCEDURE 11.3: NURSING HOME

PROCEDURE 11.4: ERRORS REPORTING

IMPORTANT

Care Homes with or without Nursing

If you need to report a medication error to Safeguarding, this also needs escalating to the CQC.

REMEMBER

The NMC will need to be informed if a Nurse administers a medication that causes severe reaction requiring further medical intervention.

The [Duty Manager] should inform the person (relatives etc) of what has taken place.

The Manager will review the Medication Errors and Incidents Reflection with the member of staff within [add timescales] and an appropriate course of action agreed. This may include:

- Retraining
- Supervision
- Disciplinary action (if behaviour is malicious or reckless)
- Review Medication Administration Procedures

The Manager should consider whether or not the incident should be reported to:

- Safeguarding
- CQC
- Local Commissioners
- Other regulatory bodies

- State which medicines-related issues need to be reported under local safeguarding processes.
- Report to the CQC about medicines errors in the following circumstances: death, injury, abuse or allegation of abuse. Who the incident was reported to or investigated by.

REMEMBER

Detailed records of all medication errors should be maintained and reviewed on a regular basis to identify potential trends which may require changes to training or procedures.

Care home providers are responsible for delivering training to all staff administering medications. This **must** include when, how, and who to escalate and report all medication errors (especially CDs). Staff should know when, how, and who to escalate errors and adverse reactions.

All near misses **must** be recorded and investigated by the designated Medication Lead or identified individual.

Give people, their family, etc. information about who they can report medicines-related safety incidents or concerns to.

Your complaints process.

Any local authority, or local safeguarding, processes.

Relevant regulators' processes.

IMPORTANT

All Controlled Drug (CD) incidents need to be reported via the online reporting portal – www.cdreporting.co.uk

Procedure 12
Registered Guidance on Medication Alerts: Nationally & Locally

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PROCEDURE 12: **REGISTERED GUIDANCE ON MEDICATION ALERTS: NATIONALLY & LOCALLY**

12.1 Handling Drug Recalls

PROCEDURE 12.1: HANDLING DRUG RECALLS

A drug recall alert is issued if a medicine has been identified as being a hazard and no longer appropriate for use.

Medication Alerts are available by subscribing to email alerts with the Medicines and Healthcare Products Regulatory Agency - www.mhra.gov.uk

The Manager OR suitably qualified competent individual should read ALL relevant alerts and identify any alerts to medicines or medicine related equipment relevant to current residents of [Care Home].

Records of actions identified should be kept in line with [Care Home's policy for MHRA response].

Any relevant stock of medicines and equipment should be checked to identify any affected items.

Any medicine in stock affected by the recall should be removed, labelled (For return-drug recall) and locked away, separate from medicines in use, until arrangements are made for its return.

If medication **has not been** taken – order replacement.
If medicine **has been** taken – seek urgent clinical advice.

Equipment recalled should be replaced in an appropriate timescale.

The signed and dated record should be retained and filed.

Procedure 13
Auditing Medicines

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PROCEDURE 13: **AUDITING MEDICINES**

Auditing is part of the assurance process and is not a substitute for the responsibility of all those involved in the administration of medication for their professional competence.

Staff should check their own actions and those of the person administering the previous dose.

A Manager, or designated Deputy, must:

- Undertake regular audits in line with the assurance plan for the home.
- Keep records of all audits and results.
- Extend the audit where initial results indicate errors.
- Follow up all discrepancies with a focused action plan.
- Review the outcome of the action taken.

Before administering any medication, staff should confirm that:

The MAR sheet for the previous dose is signed.

There is no evidence to suggest that medication was not taken
e.g. Still in biodose pot.

IMPORTANT

Any discrepancies should be reported to [care home to complete] and investigated **BEFORE** any further medication is given.
This is the most essential step in the assurance process and the occurrence, together with any follow-up action, should be included in the audit records.

An audit and assurance plan should be prepared each year, including:

Sample sizes for each item to be checked.

Audit frequencies.

Levels of escalation when errors are identified during initial sample. This may include larger samples or more frequent checks.

The Audit Plan should include:

- Fridge temperatures
- Controlled Drugs (CDs)
- Review of MARs including gaps
- Loose medicines count
- Labelling of creams
- Use by date/ Date opened present on eye drops and liquid medicines,
- Date check of 'PRN' (when required) medicines,
- Stock control
- Medication reviews
- Staff competency checks
- Medicine's training of staff team
- Medication Policy and Procedures
- Environment
- Signature sheet

A suite of tools to support audit provided and completed by [Care Home].

An annual audit may be commissioned by a Clinical Pharmacist, or on a Peer-to-Peer basis.

An annual review of medication should be undertaken by a suitably competent clinician.

Procedure 14
Sharing Information Related to Medicine Management

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PROCEDURE 14: **SHARING INFORMATION RELATED TO MEDICINE MANAGEMENT**

IMPORTANT

Contact details should only be changed if the appropriate and responsible authority has sanctioned the need for the change.

Care Home to add list of important contact telephone numbers, e.g. Pharmacist, LCC etc:

Important Contacts:

Organisation Name:
Telephone Number:
Service Provided:

Organisation Name:
Telephone Number:
Service Provided:

Organisation Name:
Telephone Number:
Service Provided:

Organisation Name:
Telephone Number:
Service Provided:

Organisation Name:
Telephone Number:
Service Provided:

Procedure 15
Medicines Reviews
[Optimisation]

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PROCEDURE 15: **MEDICINES REVIEW [OPTIMISATION]**

Regular, effective review of medication by a competent clinician is essential to ensure that residents have a medication regime which is best for their overall wellbeing, and to minimise waste.

This process is also known as **Medicines Optimisation**

A review of medication by a clinical pharmacist/ primary care clinician/ suitably qualified clinician should be part of the development of the care plan when the resident moves in to [Care Home's name].

As part of this review, a date for the next regular review should be agreed and recorded by [Care Home name] and the clinician who did the review.

If the manager has concerns about medication, they should contact the [add name] for advice and, if necessary, arrange for a review before the next scheduled date.

Following periods of illness, or a stay in hospital, the manager should contact the [care home to complete] to discuss medication and if necessary, arrange for a medication review.

Procedure 16
Guidance on Competency & Training

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PROCEDURE 16: **GUIDANCE ON COMPETENCY & TRAINING**

16.1 Pandemics

16.2 Guidance on Competency and Training

PROCEDURE 16.1: PANDEMICS

IMPORTANT

During the recent pandemic of Covid-19, it was advised that medicines training is essential. CQC **require that** medicine training should continue throughout **any** pandemic.

Who requires training?

Any new staff; staff whose medicine training has expired or is about to; staff who have made an error (refer to own SOP); and Managers who require updating.

How can training be completed if it cannot be done face-to-face?

Training can be completed through normal IPC training routes, which could include local commissioned suppliers IPC support training (LCC/ NHS ICB); Pandemic safe face-to-face training; Virtual training (Opus); eLearning (LSAB) (Boots) or self-study distance learning route (Opus)

- https://portal.elfh.org.uk
- www.opuspharmserve.com
- www.scie.org.uk/training/
- www.skillsforcare.org.uk
- www.lincolnshire.gov.uk/safeguarding/lasb

PROCEDURE 16.2: GUIDANCE ON COMPETENCY & TRAINING

IMPORTANT

Any employee who will be undertaking administration of medicines **must:**

- Have a working knowledge of the Care Homes Medication Policy and Procedures.
- Complete an accredited learning programme which ensures the safe administration of the medication and practices. This will be recorded in the individual's training records.

For all individuals who will be administering medication - they **must** complete a knowledge-based learning programme.

Individuals should then undertake an appropriate number of supervised medication rounds with an individual who is competent to assess competency for the safe administration of medication.

The competency assessment tool should be completed by the competent individual who has shown they are compliant to administer medication safely.

Competency assessment and feedback to be given, recorded, signed by both parties, including date for reassessment.

Competency re-checks must be carried out in line with practice but at least on a yearly basis.

Re-training to be undertaken and cessation of administration of medicines if the employee is deemed to be unsafe or putting others at risk.

REMEMBER

- It should be the aim and objective of the individual who is administering medication to encourage, and always enable, the resident to self-administer, unless risk has been identified.
- **No individual** should administer any medication without the correct training and assessment to ensure the service is compliant and the resident is confident that they are to receive their medicines as part of a safe and risk assessed, caring process.
- Where specialist training, delegation of tasks and/or practice assessment is required, it is the responsibility of the employer to seek further training and for the employee to attend and become competent and safe.
- Care Home providers should make sure that any training needed by staff, to find out the root cause of medicines-related incidents, is specified in contracts with the commissioner.
- Care Home providers should ensure that **at least** two members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff.
- Care Home providers are responsible for delivering training to staff administering medications. This **must** include when, how and who to escalate and report all medication (specifically CDs) errors.

Procedure 17
Transferring of Medicines To and From Hospital

Lincolnshire Care Homes
Medicines Management
WORKING IN PARTNERSHIP WITH HEALTH AND SOCIAL CARE

CareinLincs Workforce Development
Lincolnshire Care Association
Lincolnshire County Council
NHS Lincolnshire Integrated Care Board
United Lincolnshire Hospitals NHS Trust

PROCEDURE 17: **TRANSFERRING OF MEDICINCES TO AND FROM HOSPITAL**

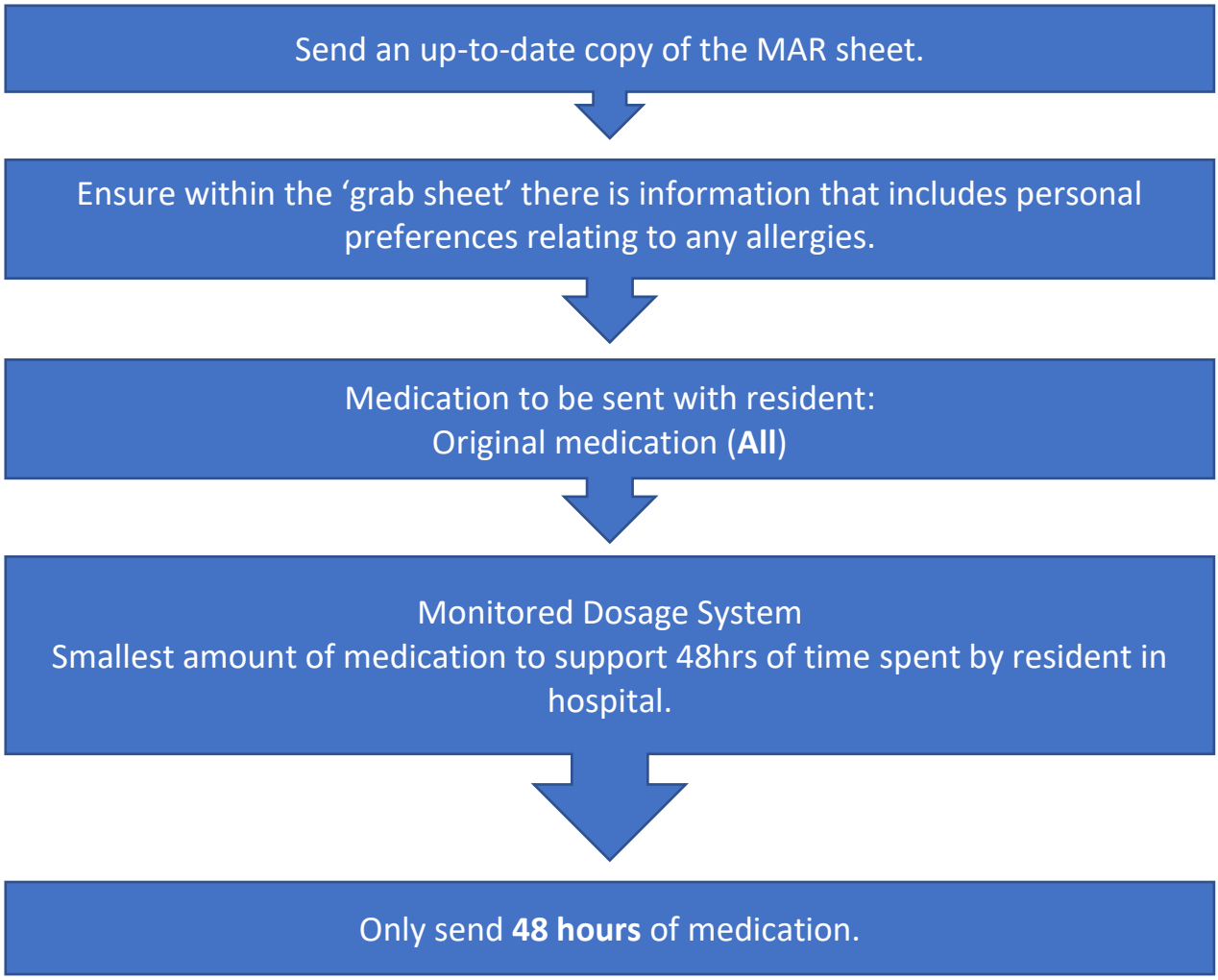
17.1 Transferring of Medicines into Hospital

17.2 Transferring of Medicines on Return from Hospital

IMPORTANT

This procedure is constantly **open to review.**

PROCEDURE 17.1: TRANSFERRING OF MEDICINES INTO HOSPITAL



PROCEDURE 17.2: TRANSFERRING OF MEDICINES ON RETURN FROM HOSPITAL

The hospital will send a copy of the current medication chart including the time of the last dose with all discharged residents returning, or travelling, to a Care Home.

On arrival, the Care Home **must** complete a full reconciliation and if there are no changes to medication, mark on the MAR sheet the period in hospital. Double sign and continue.

If there is new medication, or changes with dose or timings, then a new MAR will be required and contact **must** be made with the resident's GP and pharmacy within [24 hours] of discharge and order new prescription.

Problems with Discharge at Weekends from ULHT site:

- Always contact discharging Ward first.
- Patient flow cell on call: 07972 578724 (Saturday & Sunday, 9am to 5pm.
- Issues that may need follow-up, email: lhnt.patientflowcell@nhs.net

Procedure 18
Medication that Supports End of Life

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PROCEDURE 18: **MEDICATION THAT SUPPORTS END OF LIFE**

REMEMBER
Dignity and Respect at all times.

Administration of Medicines Check

Check the identity of the resident – use photos if appropriate.

Check your knowledge of the medicines to be administered.

Check you have all the equipment that you need (including drinks where appropriate).

Check you have the resident's consent.

Check the medicine has not already been administered.

Check that the name, form, strength, and dose of the medicine on the medicine label corresponds with the medicine administration chart.

If there is any discrepancy, refer to the pharmacy **immediately.**

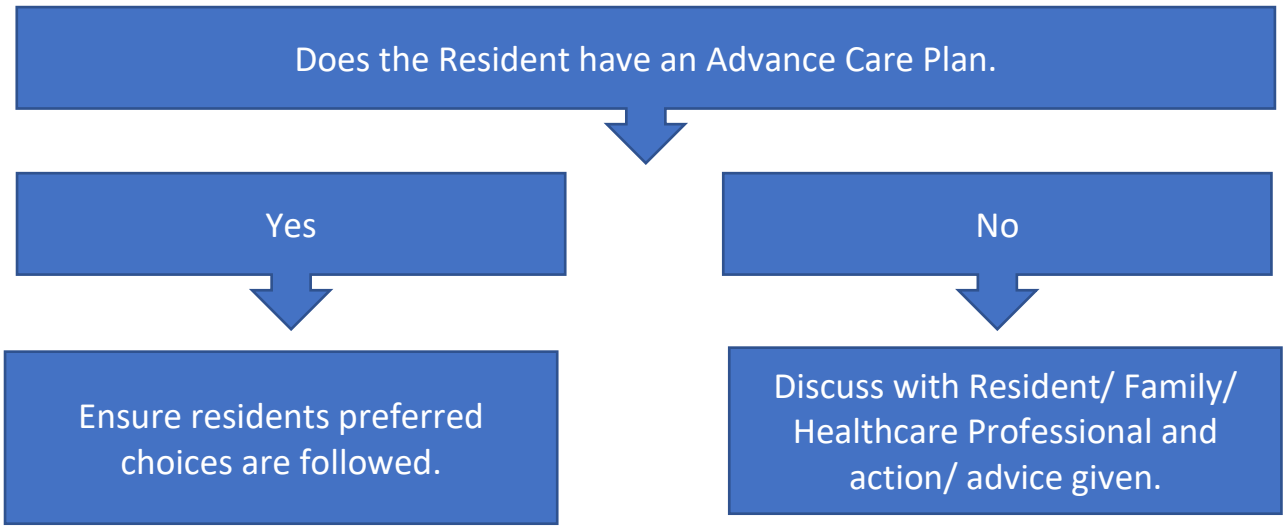
Check the expiry date of the medicine.

Ensure that the resident is in a comfortable position before administering any medicines.

Administer the medicine ensuring that the resident's personal views are taken into account.

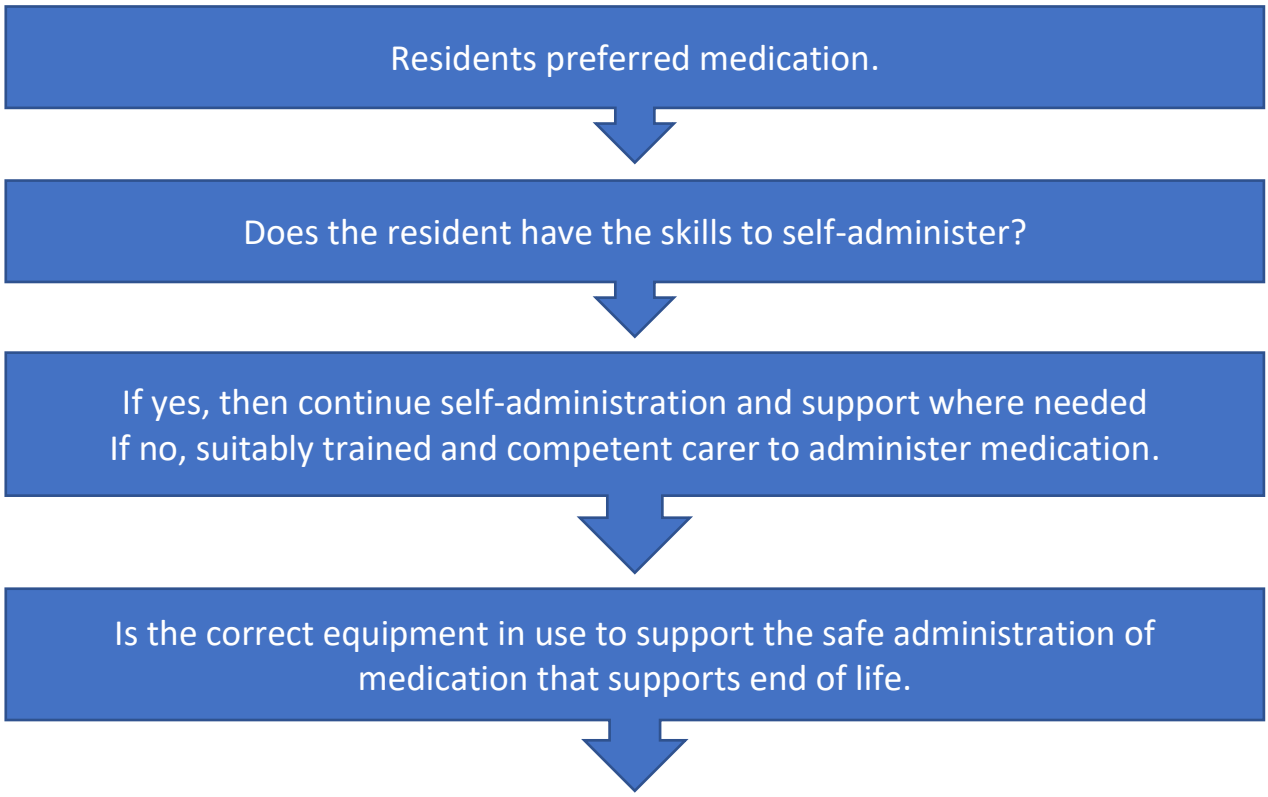
Observe the resident receiving the medicine and act accordingly if there is any discomfort or adverse reaction.

Record the administration of medicine by initiating the correct date space on the MAR sheet and enable the resident to have as much control as possible.



REMEMBER

All decisions regarding any Advance Care Plan and /or those residents who lack mental capacity, a capacity assessment and best interest document must be completed, and all relevant parties informed.



If no, then contact the end of life and Palliative Care Teams that are there to support the residents.

Supporting the Administration of Medication

Top Tips to Support Best Practice

- Advance Care Planning or Best Interest Decision to confirm persons preferences and wishes regarding end-of-life care.
- Pre-emptive medications prescribed and instructions to administer via the "Gold Sheet"
- Pre-emptive medications and disposables to administer to be stored in a plastic "just in case box". Along with a sharps bin.

IMPORTANT

Support Services available

Palliative Care Coordination Service - 08.00 - 18.00
Contact No: ***

District Nursing Service - 08.00 - 18.00
Contact No: ***

St Barnabas Community Services - 08.00 – 16.00
Contact No: ***

Marie Currie Rapid Response - 16.00 – 07.00
Contact No: ***

OOH Service (Green Card) - 18.00 – 07.00
Contact No: ***

Procedure 19
Service Level Agreement

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PROCEDURE 19: **SERVICE LEVEL AGREEMENT**

A service level agreement is a contract and commitment between a service provider and its external and internal customers that documents what services the provider will supply. It defines the service standard that the provider is obliged to meet.

Details of your service level agreements who to contact for which service agreement:

e.g. LCC, ICB, CHC, Community pharmacist with name, address, email etc

Procedure 20
Use of Thickeners

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PROCEDURE 20: **USE OF THICKENERS**

PROCEDURE 20.1: USE OF THICKENERS

Risk assess the storage of the thickeners to ensure it is accessible by staff but not by the residents [if appropriate].

Request SALT assessment to be undertaken.

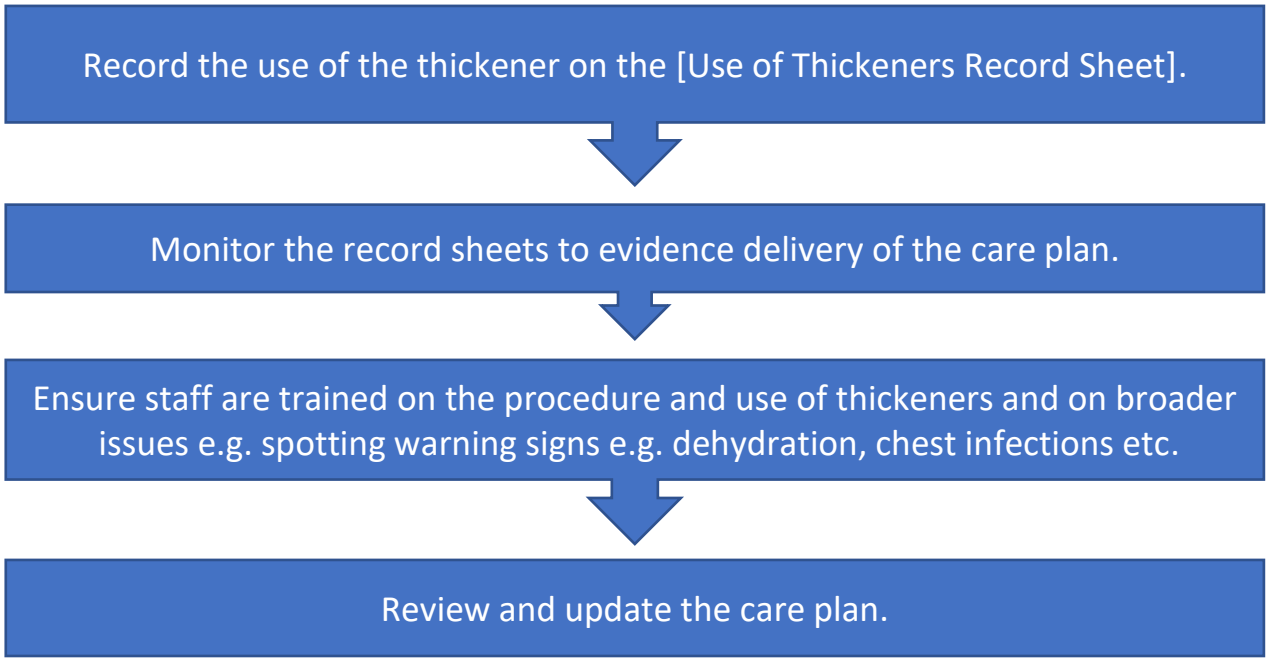
Develop care plan as a result of the SALT assessment.

Thicken the food, fluid, medicines as appropriate according to the detail in the care plan. The type of thickness and texture will be stated in the care plan.

REMEMBER

Only use the scoop provided with the thickener. Be aware that there are different scoops for different brands.

PROCEDURE 20.2: RECORDING, MONITORING & REVIEW OF THICKENERS



These procedures have been developed in cooperation with