WELLCOME CARE HOMES LIMITED

MEDICATION POLICY

The aim of this policy is to:

- *promote the safe handling of medications within the care home*
- *to provide a clear audit trail of all medications from entry to exit*

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1. Receiving of Medication

At the time of admission staff must confirm details of the resident's medication from an authoritative source.

All medications brought into the home must be in the containers in which they were originally supplied. Under no circumstances must the container label be altered or changed in any way. If a label becomes detached or illegible then the drug/medicine must be referred back to the supplying pharmacy and if necessary, the prescribing GP.

All medications brought into the home as a result of a resident's recent admission, discharge from hospital, or transfer from another care home; or medicines newly prescribed in an acute situation, must be recorded in on Medicine Administration Record (MAR) chart.

The 'MAR' chart must show:

- Name and room number of the resident for whom it is prescribed.
- Recent photograph of resident.
- Name, strength and dose of medication.
- Specific instructions e.g. 'before/after food' or 'do not take with indigestion medication' or 'give covertly'.
- Details of previous history or any known allergies or drug interactions.
- Date of receipt.
- Quantity received.
- Signature of staff member receiving the medicines and witness signature.

NB. Prior to a resident's admission to the Home, the person responsible for care delivery must confirm any specific arrangements for the agreed procedure with regard to medication.

In the case of a hospital discharge, a computerised 'MAR' chart must be requested from the hospital discharge coordinator, in addition to the usual hospital 'discharge letter'. This will minimise the risk of transcribing error in the event of handwriting a 'MAR' chart. The person in charge at the time of the admission must send a copy of the discharge letter and/or printed 'MAR' chart provided by the hospital to the home's supplying pharmacist as soon as possible.

Medicines brought in from a resident's own home by relatives/friends should be carefully checked with GP and/or pharmacist to ensure that they are currently prescribed for that resident; or do not pose risk of a drug interaction with normal medications. The receiving PERSON in charge at the time of admission must check all medications and quantities with person handing over the medication; and both parties to sign the MAR chart.

2. Procedure for Obtaining and Ordering of Medication

- Responsibility for prescribing of all medication for residents will be that of the individuals' GP.
- Regular prescribed medication is dispensed every four weeks. It must be requested on 'repeat request forms' sent from the resident's surgery.
- The person responsible for ordering must take a photocopy of the request and the prescription received for the home's records, prior to sending to Pharmacy.
- The prescriptions must be checked against the order and sent to the supplying Community Pharmacist, Boots Pharmacy, Lampeter.
- The medication is dispensed in boxes and must be checked on delivery against the order and signed & countersigned as correct on the 'MAR' chart by 2 senior carers, responsible for receiving the medications into the home.

  NB. New 'MAR' charts provided at the start of each new medication cycle, must be checked by a person in charge of the shift. In the event of duplications, discontinued items or errors, the supplying pharmacist must be notified immediately and a replacement 'MAR' chart requested. This request must be recorded on a 'referral to other health professionals' form, used within the care documentation filing system.

- 'Patient Information Leaflets' (PILS) must be checked for specific storage instructions or administration advice. These leaflets must be maintained on file and accessible to staff, residents and visiting health professionals.
- Prescriptions required outside of the regular medication regime are obtained either directly from the GP, if called out or, collected from the respective surgery and dispensed from an appropriate pharmacy. This medication must be checked, entered on the 'MAR' chart, signed and countersigned by 2 appropriately qualified persons.

  NB. In the event of a prescription being dispensed by a pharmacy other than the regular dispensary, the person in charge at the time, must ensure that the regular supplying pharmacist is made aware of the newly prescribed medications Immediately.
- Delivery of monthly medications will be the responsibility of the supplying pharmacy until received into the home. At the time of receipt of monthly medications. Staff sign to say received not checked. This order must be checked as soon as possible after delivery and problems reported immediately back to pharmacy and incident report completed and passed to the Manager.
- Emergency medications, required out of normal delivery times must be collected by a responsible person and handed over to the person in charge of the home.

- All drugs received into the home must be recorded, signed for at the time of receipt and immediately stored in the appropriate, lockable medication trolley.

  NB. Under no circumstances must medications be left out in unlocked areas.

3. Verbal Instruction from G.P. or other health professionals

Only in the event of an emergency must a verbal instruction for medication be considered.

Only the Senior Carer can accept verbal instructions from a GP or prescribing consultant; and must request a faxed/emailed written confirmation of the instructions as soon as possible.

The Senior Carer receiving the verbal message should repeat the instructions back to ensure that they are accurate, and record onto 'MAR' chart at the time of receipt of message.

The Senior responsible for receiving the verbal message should ask another suitably qualified person to check the details and countersign.

NB. The Senior Carer responsible for receiving the verbal message must advise the supplying pharmacist, and request a printed 'MAR' chart as soon as possible.

In the event of a prescription being dispensed by a pharmacy, other than the regular dispensary, the Senior Carer in charge at the time, must ensure that the regular supplying pharmacist is made aware of the newly prescribed medications.

All Messages received must be acted upon immediately.

4. Alterations Made to Medications by Visiting Doctors

It is the responsibility of the Senior in charge to ensure that any changes made to medications, following visits made by doctors, are appropriately documented.

The Senior Carer responsible for medications will ask the prescribing doctor (wherever possible) to write up clear instructions on the 'MAR' chart, with particular attention to any medications that may be stopped. Details should include the date to commence/stop, reason for changes, and the doctor's signature.

Should a doctor decline to write the changes directly on the 'MAR' chart then the Senior in charge of the home must follow the procedure set out in section 3 then the person in charge must make the record on the MAR chart in the doctors presence asking him/her to check the details and document in GP notes. This must be recorded "in the presence of the GP". The GP must be asked to complete the GP notes.

NB. It is the responsibility of the accompanying Senior to ensure that any alterations made to 'MAR' charts are legible and understood. In the event of a problem the Senior must request a new printed 'MAR' chart form the supplying pharmacy as soon as possible.

5. Storage of Medication.

All drugs/medicines will be stored in designated locked cabinets or refrigerators as appropriate. These are located in the Medication Room (15) first floor.

Keys for the medication storage units/fridge will be held by the authorised person responsible for medications at that time, or Manager/Deputy Manager and must be kept separate to the homes master key system.

Current medication held in boxes are stored in the appropriate trolleys, which must be bolted to the wall in the Medication Room when not in use.

Dressings used by visiting nurses and required are stored in Nurses designated room.

Nutritional supplements or any other such therapeutic items, required for residents are stored in the locked medication room (15) first floor.

Controlled drugs (CDs) are stored in a locked metal cabinet in the Medication Room on the first floor. This cabinet must only be used to store CDs; and must only be accessed by authorised personnel. The Controlled Drugs Administration book (CDA) is to be kept with the CD medications on top of the locked cabinet.

Medication storage areas must be clean and maintained in line with infection control measures. All medicinal items must be stored in appropriate containers, off the floor to avoid contamination.

Medication storage areas are temperature controlled. Medication and treatments must be stored at less than 25 degrees and away from direct sunlight, unless otherwise stated by the suppliers. Window blinds are to be kept closed. Temperature readings must be recorded daily by the Senior in charge. Timing of temperature checks should be varied to assess the consistency of temperatures during various times of the day.

NB. Any problems identified must be immediately reported to the manager, using an 'incident report' form.

A medication storage refrigerator is available in the Medication Room (Room 15). This must be kept locked and the temperature maintained at 2 – 8^{o} C. Daily temperature checks must be recorded by the person charge using a log sheet posted on the wall by the fridge. Temperature readouts will be verified weekly with a digital thermometer with readings recorded in the record book.

NB. Any problems identified must be immediately reported to the manager using an 'incident report' form.

Thermometers must be regularly recalibrated (at least annually) or new ones purchased every 6 months. It must be reported to the manager if two or more consecutive temperature readings fall above 7^{o} C.

The fridge must be cleaned and defrosted regularly with a record maintained of the date of cleaning and the person responsible. **NB. Any problems identified must be immediately reported to the manager using an 'incident report' form.**

Medications brought into the home must be immediately stored, and recorded in by the receiving person in charge on the day
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Advice should be sought from the supplying pharmacist if any concerns or doubts arise.

6. Administering Medication

Senior Carer on duty will be responsible for administration of all medicines. All staff responsible for administering medications are required to follow the procedure below on 'administration of medications'.

An up to date list of all staff, authorised to administer medication and their sample signatures will be maintained on the front of the 'MAR' chart file.

NB. No staff member will administer intravenous medications, or manage syringe drivers.

A record will be maintained of the date of most recent, staff competency assessment; with evidence to show that all staff responsible for medications have read, understood and will adhere to the home's medication policy.

In order to minimise interruptions, which increase risk of drug error or delays in medications, the person responsible for the medication round must:

- ensure that staff breaks are avoided during medication rounds
- wear the appropriate tunic provided to advise visitors that a medication round is in progress.
- COVID no visitors present through lockdown

All medications, including oral preparations, patches, topical creams, inhalers and eye drops must be administered according to the instructions given by the pharmacist.
NB. If in doubt contact the pharmacist for advice.

Liquid medicines, eye/ear drops, ointments and creams must be dated on opening.

Medicines liable to abuse must be managed and recorded in the same way as controlled drugs – see under point 7 below.

Procedural Guidance for the Administration of Medicines.

1. Wash hands and dry using a disposable towel
2. Unlock the trolley
3. Check to ensure that the trolley is fully stocked and prepared for the round
4. Do not leave trolley unlocked at anytime
5. Trained staff are to proceed to residents who have chosen to stay in bedrooms first accompanied by a member of staff, who will stand at the doorway to prevent another resident entering room.
6. Trained member of staff to then proceed to dining room to complete drugs round
7. Check details on individual ‘MAR’ chart to determine which drugs are due and route of administration
8. Check the identity of the resident against the details on the ‘MAR’ chart
9. Select the required medication, check the expiry date and dosage requirements
10. Dispense drugs from individual resident’s ‘blister pack’, into medication pot without touching by hand; take to resident.
11. Hand the medication pot to the resident, along with a suitable drink. Observe the resident to ensure that all medication is swallowed.
12. Ointments and creams should be applied using protective gloves. Eye and ear drops must be directly applied according to instructions on the label.
13. Record and sign ‘MAR’ chart; or ‘TMAR’ (Topical MAR) chart for administration of ointment and creams. If a resident refuses medication; or medication is omitted for whatever reason, this should be recorded and noted in the appropriate place on ‘MAR’ chart.
14. Proceed to the next resident.
15. When medication round is complete, lock the trolley and return to the Medication Room.

NB. Medications must never be dispensed for someone else to administer at a later time or date.

'MAR' charts must be signed for each resident at the time of administration, and not completed collectively at the end of the medication round.

Medication must never be pre-dispensed into pots routinely, and handed round to residents.

Medication refused or not taken for whatever reason, must be noted using the appropriate code on the 'MAR' chart.

Medication refused for three consecutive days, or on a regular basis must be reported to the GP.

Residents must never, under any circumstances, be given medicines or external treatments which have been prescribed for another resident.

If an emergency arises requiring the attention of the senior person whilst administering medication, the trolley must be locked/secured until they return.

In the event of administration of 'flu vaccines' and follow-up monitoring for risk of anaphylaxis, the senior carer in charge must request that GP or Community Nurses take responsibility. Flu vaccines or Adrenalin is not stored at the home. In the event that a reaction may occur when GP or Community nurses have left, then the person in charge must call '999' and request an emergency ambulance.

7. Controlled Drugs (CDs)

Controlled drugs will be stored in a specifically designated locked cupboard located in the medication room which is to be kept locked.

The appropriately trained Senior Carer in charge will be responsible for the safe handling and administration of all controlled drugs.

All administration, recording, checking and monitoring must be carried out and signed by an appropriately trained staff and witness.

The book used to record all movement of controlled drugs in the home must be immediately completed by the senior carer responsible for the task at the time. This

book will be kept in the metal CD cupboard, located in the medication room on the first floor Room 15.

The stock balance of controlled drugs must be checked on a weekly basis **(Tuesday of each week)** by 2 suitably qualified staff; and findings recorded in the 'CDA' book.

Procedural Guidance for the Administration of Controlled Drugs.

1. Take a second person along who is appropriately trained to witness drug administration; or a competent person to check the entire procedure
2. Wash hands and dry using a disposable towel
3. Unlock the controlled drugs cupboard
4. Check details on 'MAR' chart to determine which drugs are due and route of administration
5. Select the required medication' checking expiry date and dosage requirements
6. Check the stock for each prescribed drug against the last entry in the 'CDA' book
7. Remove the appropriate dose from original container and place in a suitable receptacle
8. Lock the 'CD' cupboard
9. Enter required details, including date, time and name of resident in the 'CDA' book
10. Take the medication to resident along with the individual's 'MAR' chart
11. Check the identity of the resident against the details on the 'MAR' chart
12. Administer the medication according to prescription advice on 'MAR' chart
13. Ensure that the resident takes all medication
14. Remove medication pot that may have any drug residue
15. Both senior/carer return to the 'CDA' book and appropriately sign the register and the resident's 'MAR' chart
16. Dispose of medication pots
17. Wash and dry your hands

NB. If a resident refuses medication or, medication is omitted for whatever reason, this must be recorded and noted in the appropriate place on the 'MAR' chart and 'CDA' book.

Medication refused for two consecutive days or on a regular basis must be reported to the GP.

8. Recording of Medication

‘MAR’ charts will be provided by the supplying pharmacy. These must be referred to for identification of the resident, and also for clear instruction about all medications prescribed.

Electronic copies of ‘MAR’ charts must be used and held in the designated file. Each resident will have a front sheet preceding their ‘MAR’ chart/s. This sheet will include a recent photograph of the resident, their full name and, their preferred choice of name, date of birth, room number occupied, and any special instructions such as allergies.

The ‘MAR’ chart will show the resident’s full name, date of birth, room number in the home, known allergies and details of adverse drug reactions; and details of all medications including name, strength, form, dose, times when due, route of administration and any special instructions (eg before/after food). There will also be a place for staff to record the date and quantity of medications received into the home.

A hand-written ‘MAR’ chart may only be used in exceptional circumstances, such as when a new resident arrives.

In the event of a new admission, a Senior Carer may enter medication details by hand onto a spare ‘MAR’ chart; but must request an electronic copy from the pharmacist as soon as possible. The hand-written record must be checked for accuracy by a second suitably trained person, prior to its use.

The pharmacist must be informed of any new admission as soon as possible, to arrange for the resident to be added to their database.

All medication brought into the home must be accurately recorded onto ‘MAR’ chart and ‘CD’ book if appropriate.

Hospital-dispensed medicines must be added to a ‘MAR’ chart, by directly copying all of the information from the label of each medicine dispensed. (See section 1 above)

Information must include the full name of the drug (written in capital letters); strength and form; full dose and any additional information to help ensure correct administration. Use of abbreviations must be avoided.

All handwritten entries to ‘MAR’ charts must be signed, checked, countersigned and dated by a second appropriately trained member of staff.

Any Patient Information Leaflet (PIL) provided with medicines must be used to check for any special requirements including storage and administration details. Any such specific advice must be included on the ‘MAR’ charts.

All medication administered to residents must be signed for at the time of administration.

All controlled drugs must be checked and signed by trained staff with a witness.

All medicines destroyed or prepared for leaving the home in the event of discontinuation, a resident being discharged from the home, or admitted to hospital, must be signed for on the 'MAR' chart and recorded in the appropriate book.

If, for any reason a medication is omitted, the appropriate code must be recorded against the relevant medication, and also the reason for the omission recorded on the back of the 'MAR' chart.

Any recording mistakes must be corrected with a single line through and the correction written clearly alongside; it must be signed, dated and timed. **Under no circumstances should correction fluid be used to delete an entry.**

In the event of a visiting health professional administering medication to a resident at the home, they must be asked to sign the 'MAR' chart appropriately. Alternatively, a separate record may be kept of medicines administered by external agents; this must be held on or with the resident's 'MAR' chart to assist with health/medication reviews.

Monitoring charts that determine medication doses, such as Warfarin or Insulin, must be held with the MAR chart and referred to at each medication administration.

9. Anticoagulant Medications

Anticoagulant tablets such as Warfarin must not be received in monitored dose systems, as dosage is variable depending on the 'Prothrombin Time Test' blood clotting results expressed as INR (International Normalised Ratio).

Residents receiving anticoagulant therapy will need regular blood tests to determine the therapy dose. A blood sample must be taken by a suitably qualified nurse or phlebotomist, from the relevant GP practice; and sent off to the local hospital haematology department as soon as possible after extraction. Frequency of blood-testing will be determined by the resident's GP.

NB. A suitable 'sharps box' will be in place for discarded needles and syringes. Each new 'sharps box' must be dated at the time of opening and also at the time of sealing.

Procedural Guidance for Caring for Residents Taking Prescribed Oral Anticoagulants

1. Ensure that the resident has their own oral anticoagulant control index and that it has been fully completed with the following details:
    - Demographic information
    - Indication for anticoagulant
    - Proposed duration of treatment
    - Target INR range
    - Dose
    - Date of next INR test

NB. The date and time of the blood test will be recommended by the anticoagulant clinic. This prescribed regime must be adhered to.

The GP notes must be updated with each new INR result; dosage of medication amended accordingly, and the due date for next INR test.

2. Administer the anticoagulant medication, according to the applicable procedural guidance above in section 6 on the administration of medications, with the exception of point 8, as anticoagulants will be dispensed in a bottle system.

NB. Ensure the daily dose of anticoagulant therapy (Warfarin) is correct, according to the directions on the resident's 'yellow book'.

Anticoagulant medications must be administered at the same time each day, as prescribed by the GP.

The person responsible for medication administration must liaise with all health professionals involved in the resident's care.

Should an error in the administered dosage arise, this must be immediately reported to the GP as a matter of urgency. The procedure for managing medication errors as stated in section 14 below, must be followed.

Anticoagulant therapy must be clearly shown in the resident's care plan.

10. Insulin Medication Management and Procedural Guidance

Any insulin vials or cartridges which are not open should be stored in the refrigerator between 2°c and 8°c; unless otherwise stated.

Any opened insulin vial or cartridge can be safely stored at ambient temperature for up to one month (please refer to insulin manufacturer's recommendations).

Avoid exposure to extreme temperatures.

For better comfort and insulin efficiency, it is advisable to remove insulin from the refrigerator, at least one hour prior to injection: cold insulin increases the pain of the injection and slows insulin absorption.

Insulin must be given by a community nurse.

NB. Insulin must be given according to the prescription, paying special attention to meal times; and quantity of food and drinks taken pre and post injection.

Food and drink intake must be carefully monitored for all residents on insulin.

Blood glucose monitoring must be carried out prior to injection. Any professional judgement made, that may result in any deviation of the prescription, must be recorded in the resident's care notes.

Any concerns such as low blood glucose levels must be discussed with a GP prior to giving an insulin injection.

Blood glucose monitoring equipment must be recalibrated, or replaced at least annually as part of the routine internal maintenance of equipment. The date of recalibration or replacement must be recorded.

Used syringes and needles must be discarded in an appropriate 'sharps box'. Each new 'sharps box' must be dated at time of opening and also at the time of sealing.

11. Occasional Medication

Occasional medications, prescribed for 'when necessary' (PRN); or short courses of all medications must be handled and managed in the same way as regular medications. Staff must be alert to the possibility of any adverse reactions.

Following a doctor's visit, it is the responsibility of the Senior Carer in charge to ensure that information is recorded in the 'Communication Diary'; and in the resident's care records as soon as possible.

In the event of 'PRN' prescribed medication given, staff must record the following information on the back of the 'MAR' chart: the circumstances that lead to the

medication being required; the dose and time given; and whether the desired outcome was achieved.

In the event of a variable dose prescribed, the minimum dose must be given initially. This may be repeated if necessary, according to the times recommended in the PIL.

If, after three doses, the desired outcome was not achieved then a request must be made for a GP assessment.

A separate 'PRN' medication form with the resident's name, must be completed for each 'PRN medication in use. This form should be held with the resident's 'MAR' chart (see page 24 for copy of form).

When a 'PRN' medication is regularly administered, a request must be made for a medication review by the resident's GP.

The use of 'PRN' medications must be included in the resident's medication care plan.

'PRN' medications must be maintained in the original packaging.

'Homely remedies' are defined as, non-prescribed medication that can be 'bought over the counter'.

Staff must not administer any 'homely remedy's.

NB. Staff must be alerted to visitors bringing in medications. All 'homely remedies' brought in by visitors must be handed to the person in charge, for appropriate storage and management.

12. Self Administration of Medication.

In a residential care setting, there may be residents who wish to maintain control of administering their own medication.

The Senior in charge will undertake a Self- Medicating Risk Assessment with the resident and, if necessary, their appointed responsible carer/relative. The supplying pharmacist and/or resident's GP should be involved to help identify potential problems and suggest possible solutions. The risk assessment will consider:

- The personal choices of each individual resident
- If self-administration will pose a risk to other residents

- If the resident is willing to cooperate with risk assessment and re-assessment and occasional monitoring of stock control
- If the resident is able to follow the medication instructions
- If the resident is able to take the correct dose at the right time and in the right way
- How often a reassessment should take place, depending on each individual
- How the medication will be stored
- How the medication may be audited and recorded
- How much medication will be issued to the resident
- Responsibility of staff, which will be written in the resident's individual care plan.

The resident and/or representative must then read and sign the document to indicate that they have understood the issues raised; and also, to recognise that the home manager has a duty to monitor and check that each resident is able to safely self-administer their own medications.

Discussions will determine a method of self-administration, dispensing arrangements (boxes, nomad trays, cassettes or weekly blister pack dispensers); and suitable storage arrangements. All parties involved will sign and date the completed risk assessment.

Procedures must be in place to order medication and to safely hand over to the resident.

Recording will include the same details as for all other medications brought into the home. The amount of medication should be given to the resident in manageable stages, as determined by the risk assessment. Any surplus drugs will be stored in the main medication storage cupboards.

A 'MAR' chart must be in place, stating that the resident is 'self-administering' their own medication. The 'MAR' chart will be maintained in the same way as all others, noting any prescription changes made by GP.

The person responsible for each medication round will view the 'MAR' chart, and ask the resident if they have had their medication, to help ensure that medication is being taken in line with dispensing instructions.

A lockable storage facility will be provided in the resident's room. Resident's permission must be sought to allow staff access, in order to monitor and review medication. A record of monitoring/audit must be signed by both parties (staff carrying out the audit and the resident).

13. Refusal / Covert Administration of Medicines.

A resident with mental capacity has a legal right to refuse treatments. Staff must respect residents' wishes. Failure to do so is unlawful, and is a breach of the resident's Human

Rights, and may constitute abuse under the homes' policy on the safeguarding of vulnerable adults.

If medication is refused, the reason must be recorded at back of 'MAR' chart, and in resident's daily care records. In the event of regular refusal, the GP and/or Pharmacist must be informed.

If the resident is having a meal or sleeping then the medication must be given as soon after, as is reasonably practicable.

Covert administration of medication is defined as disguising medications without the knowledge and consent of the resident (eg added to food or drink).

NB. Medications must never be crushed or changed from the form dispensed as this could adversely affect their efficacy.

Any decision to administer medications covertly must meet with the NICE guidelines on 'Managing Medications in Care Homes' (March 2015) and be discussed with the resident's GP and relatives.

Covert administration of medicines must only be considered in the case of a resident who actively and consistently refuses their medication, but is judged not to have the mental capacity to understand the consequences of their refusal.

Residents assessed as lacking capacity, must have an agreed management plan in place following a 'best interests' meeting.

The management plan will include:

- Medication review by GP and pharmacist to advise on how to covertly administer
- Documented evidence of the 'best interest' meeting
- Clear procedural guidance to staff, shown in medication care plan and MAR chart
- An agreed date to review the decision for covert administration of medications
- Review date for reassessment of mental capacity.

14. Disposal of Medication.

To provide a full audit trail of medicines through the home, a record must be maintained of all medication disposed of or removed from the home. This may be due to death of a resident, discontinued treatment, drugs discharged with resident to home or hospital, drugs leaving the home with resident on leave, or drugs that have reached expiry date.

Stock medicines will be checked for expiry dates on a monthly basis, and discarded and replaced if necessary. A record of monthly stock audits will be maintained.

Following the death of a resident all relevant medicines will be retained in the appropriate drug cupboard for a period of + seven days to accommodate any potential request by HM Coroner. After this period of time the medicines may be disposed of as shown in the procedure below.

Medicines for disposal will be placed in a locked cupboard located in the medication room (15). They must be clearly labelled as 'unwanted drugs, awaiting disposal', until such time as can be returned to pharmacy

A record of all drugs for disposal will be maintained in a designated 'Drugs Disposal Book'; a separate section of which will be used for controlled drugs. The record must include:

1. Date of disposal
2. Means of disposal
3. Name and strength of medicine
4. Quantity removed or disposed of
5. Name of the resident for whom it was prescribed
6. Reason for disposal or removal
7. Signature of member of staff responsible
8. Counter signatory of second member of staff as witness.

The home will ensure continuity of medication administration when residents are away from the home for any period of time, e.g. going on leave.

Medications will be prepared by the pharmacist for planned leave and handed to the resident or a responsible adult, at the time of leaving the home.

For leave planned at short notice, medications will be issued in the dispenser, provided by the pharmacist showing clear prescription instructions.
NB. Secondary dispensing must not occur.

The person receiving the medication must sign the 'MAR' chart against the appropriate date of leaving the home, to agree the numbers of drugs received, and to take responsibility for them outside of the home.

On return to the home any surplus drugs must be returned to pharmacy, as staff at the home can't take responsibility for how medications have been stored away from the home.

The 'drugs returned' procedure, as stated above, must be followed.

A new supply of medications should be arranged for the resident's return.

15. Reporting of Adverse Reactions/ Drug Errors/ Incidents

All staff must be informed if a resident may be at risk of problems due to effects of medication. This information must be recorded in the Senior Daily Records, an incident form completed, held within the care documentation file; and the individual resident's MAR chart. The 'communication diary' must be used to record information shared between each Senior/care team.

An up to date copy of The British National Formulary (BNF) will be available in the home to refer to at all times. Patient Information Leaflets (PIL) will be maintained at the home for all drugs in use, and must be referred to.

Any adverse reaction noted, or medication error on the part of administering nurse must be reported immediately to the manager/deputy and recorded on an incident form.

Procedural Guidance for Staff to Follow in the Event of a Drug Administration Error or a Resident Having an Adverse Drug Reaction

In the event of a drug administration error, or a resident suffering an adverse reaction to the medication, immediate action must be taken. Report to the person in charge of the home at the time. The person in charge must:

a) Assess the situation with the help of the 'first aider' on duty
b) Check the resident's vital signs and observations i.e. blood pressure, pulse and respiration.
c) Report the incident to the relevant GP or call 999 if considered necessary.
d) Advise the resident's relatives.
e) Record the incident in the accident / incident book.
f) Report the incident to CIW and the relevant care commissioning agencies.
g) Report the incident to 'safeguarding' officer, if appropriate.
h) Keep the resident under careful observation for the next 24 hours, or as directed by the GP.

NB. It is the responsibility for each Senior Carer who is authorised to administer medications, to read PILs for each drug administered, to familiarise themselves with that drug in order to monitor and observe for any potential adverse effects.

16. Use of Oxygen in the Home

Oxygen will not be stored at the home for emergency or occasional use. In the case of an emergency, an emergency ambulance must be called.

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17. Staff Training

No staff member will take responsibility for medications in the home until adequately trained. A medication competency assessment will form part of the induction training programme for all newly employed Senior Carers.

All staff who take responsibility for medications will be required to have annual training updates. At least one of their annual staff supervisions will be an observational (competency) assessment of medication administration.

All staff responsible for medications are required to read and familiarise themselves with the home's medication policy and work according to its procedural guidance.

All staff responsible for medications are required to read PILs and refer to a BNF if necessary, to familiarise themselves with each medication administered.

Registered nurses are required to comply with the NMC Code: Professional standards of practice and behaviour for nurses and midwives (31 March 2015).

NB the NMC Standards for medicines management were withdrawn on January 2019 but their website refers to other recognised guidance resources. Other useful information resources kept at the home are listed at the end of this policy document.

18. Quality assurance

Medications management will be an integral part of the homes' quality assurance. Outcomes of all audits undertaken will be included in the Home's six-monthly 'Quality Assurance Report'.

Quality assurance methods adopted in the home include:

- Monthly internal, medication audits, carried out by the Deputy Manager/Manager, to cover all aspects of medication management
- Annual inspections by the supplying, community pharmacist
- Annual medication reviews for individual residents, conducted by the supplying pharmacist as part of their contractual agreement.
- Annual inspection by CIW as part of the regulatory framework
- Annual inspection by commissioning agencies as part of contractual monitoring
- Internal stock control checks, carried out by 2 suitably qualified staff.
- Staff supervision and competency assessments.

NB. An audit checklist will be used to advise staff of what to record when undertaking a medication stock check. Routine medications and will be checked on a monthly basis (First Monday in each month) and CDs on a weekly basis (Tuesday of each week).

The two registered on duty at the time stated above for stock checks will be responsible for conducting the weekly and monthly checks.

NB. An annual medication review must be arranged with the supplying pharmacist and the GPs responsible for their residents. A record must be maintained of the date requested for each medication review, and the outcome of that request. This must be recorded using a 'referral to other health professionals' form maintained within the care documentation file for each resident.

Sources of information used in preparing this policy, and also available to staff for supplementary guidance held at the home:

- *An up to date copy of The British National Formulary (BNF)*
- *The handling of medicines in social care – Royal Pharmaceutical Society G.B.*
- *NICE guidelines on 'Managing Medications in Care Homes' (March 2015)*
- *Patient Information Leaflets for all medications in current use*

Signature of person responsible for this policy: *Dated:*

Designation: *Policy Review Date:*

Form for use with medications prescribed as 'when necessary' (PRN)

Name of Home

Resident name	D.O.B:

1 Name of Medicine:	Form:

Strength:	Route of Administration:

Dose and Intervals to be administered:

Maximum dose in 24 hours:

Is the medication prescribed or 'over the counter'?	

Special instructions:

REASON/S FOR ADMINISTRATION: when should the medication be given- describe in as much detail as possible the condition being treated i.e. Symptoms, indicators, behaviour/s, triggers, type of pain/s where? when? Etc.

2 Name of Medicine:	Form:

Strength:	Route of Administration:

Dose and Intervals to be administered:

Maximum dose in 24 hours:

Is the medication prescribed or 'over the counter'?	

Special Instructions:

REASON/S FOR ADMINISTRATION: when should the medication be given- describe in as much detail as possible the condition being treated i.e. Symptoms, indicators, behaviour/s triggers, type of pain/s where? when? Etc.

Prepared by……... Designation…….

Approved by…… Designation……

Date: …… Review Date……

Staff names and signatures to show receipt and understanding of this policy: