Medication Guidance
for
Home Based Care & Support Providers

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Version 3

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1. BACKGROUND

This document provides procedural guidance on managing medicines in home care settings. It should not be used alone but should be used in conjunction with Nottingham City/Nottinghamshire County Council policies, national guidance and providers own individual medication policies.

It has been produced to support providers in the development of their own policies, helping to meet the requirements of current legislation and CQC. It also supports NICE guidance 'Managing medicines for adults receiving social care in the community' (NG67) and Health & Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 which states that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

The information in this guidance is believed to be accurate and true at the time of writing. Changes in legislation and practice may arise before this document's next formal review. Staff should therefore use professional judgment, be aware of their own limitations, seek advice and consult with their line managers where necessary if they are unsure of what action to take.

The authors accept no liability for loss of any nature to persons, organisations or institutions that may arise as a result of any errors or omissions.

For the purpose of this guidance the terms 'service user' and 'care worker' will be used although other providers may use different terminology e.g. citizen, client, carer.

Capacity & Consent

The majority of service users take responsibility for taking their own medication and their independence should be supported as much as possible.

This part of the guidance should be read in conjunction with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice.

When support with medication is deemed necessary consent for the care worker to administer medication must be given by the service user and recorded appropriately in line with the Mental Capacity Act.

If the service user does not have capacity to consent, then the service must check if there is a Lasting Power of Attorney (for health and welfare) who may have authority to make the decision about assistance with medication. If not, the 2-stage test and a best interest decision should be undertaken on their behalf by an appropriate professional, consulting relevant people, taking into account any advance statements. All discussions and decisions should be documented and an individual person-centred care plan around medication must also be completed.

Reporting Concerns

Care workers must immediately report any concerns relating to a service user's medication to their line manager.

2. AIMS & GENERAL PRINCIPLES

The aim of this document is to provide clear guidance to care workers, service users, and their relatives as to the nature of support that may be given with medication administration by paid care workers in the home care setting.

Service users should be supported to remain as independent as possible for as long as possible and to receive assistance with their medication only when necessary.

All medications need to be stored correctly, administered safely, and recorded and disposed of appropriately.

Assistance with medication should be carried out in a professional manner and by care workers who have received medication training, are assessed as competent, and have the skills and experience to keep people safe.

3. ROLES & RESPONSIBILITIES

All medicines are potentially harmful if not used correctly, and care must be taken in their storage, administration, control and safe disposal.

All home care providers must ensure that local medicine policies and procedures are in place and reviewed regularly and that staff adhere to them. It is recommended that service managers evidence that staff have read and understood any policies, procedures and guidance.

Home care providers will have different staff levels and job titles within their organisations. The following is a general guide. Staff should work within their own job descriptions.

Senior Care Worker/Team Leader

- Ensure that all care workers can access/view a copy of their company's medicine policy and other relevant local/national guidance.
- Provide information to all care workers as part of their induction training, as to what medication tasks they can and cannot undertake prior to receiving medication training and being signed off as competent. Records should be kept of the date training is undertaken and the date of competency sign off.
- Ensure any relevant risk assessments are carried out at the first visit with a service user, any necessary information is obtained and that the service user has the required medication and a Medication Administration Record (MAR) chart (paper or electronic) in place prior to commencing with the service. Ensuring the service user's name and the name of the medication on the container match the MAR chart. Any family involvement should also be documented clearly.
- Ensure any reported medication changes are updated promptly on the person-centred care plan and ensure arrangements have been made to update the MAR chart. Ensure this is checked and counter-signed by another company care worker. The person-centred care plan should be signed and dated by the service user and appropriate home care staff.
- Ensure an up to date authorised signatories list of those staff who administer medication is maintained alongside the person centred care plan in order that signatories in the MAR can be easily identified.

Care Worker

- Must adhere to company policies and procedures relating to medication.
- Not undertake medication tasks unless they have received training and been signed off as competent.
- Record all provision of support with medication as detailed in the MAR including any refusal/omission of medication along with the reason.
- Ensure authorised signature sheet in the person-centred care plan is completed in order for their signature to be identified.
- Talk to the service user about the support they are providing with their medication. The views of the service user should be taken into account and acted upon as appropriate.
- Notify line manager of any changes to a service user's medication or observations/concerns about a service user's condition.
- Inform line manager immediately of any potential risks identified, errors or near-misses either by self or others and any discrepancies in quantities of medication in the service user's home.
- Ensure medicines are stored appropriately, and documented correctly in the care plan and MAR chart

4. TRAINING & COMPETENCY ASSESSMENTS

Care workers who support with medication must receive appropriate safe handling and awareness of medicines training preferably by an accredited training provider.

It is recommended that refresher training should be undertaken annually.

Annual competency assessments in medicines administration should be completed for all care workers who support with medication (see appendix 8 for an example).

Both training and competency assessments should be documented and signed off by the authorised and appropriately trained assessor and the care worker. Records should be made of the date they were completed and when they are next due.

5. ASSESSING LEVELS OF SUPPORT

It is the home care provider's responsibility to assess the level of support each service user requires when entering the service along with undertaking any relevant risk assessments. This will be used to develop a care plan. Where support with medicines is identified a MAR chart should be produced.

If more than one provider or a family member is sharing responsibility with the home care service for the administration of any part of the medication regime, all roles and responsibilities MUST be recorded in the care plan and daily running records. This is to ensure that there is continuity of records in order to reduce any risk of an inappropriate dose/overdose being given.

All information should be accessible when supporting the service user in their home.

6. ORDERING, COLLECTION & STORAGE OF MEDICATION

Appropriate arrangements must be taken to ensure there is a continuous supply of medication for the service user. It must be clearly documented how the service user orders their medication, how it is obtained (collected) and who is responsible for this. Care workers must provide ID when requested to do so by the pharmacist.

Care workers may order/collect prescriptions from the surgery and/or medicines from the pharmacy if a service user does not have capacity or any alternative means to do this. Care workers may also take delivery of medicines delivered by the community pharmacy if required. This should be agreed and documented in the care plan.

Usually no more than 28 days' supply of medicines, including those on repeat prescriptions should be requested for a service user at any one time.

The pharmacist will supply medicines in appropriate packaging for the service user to administer their own medication when appropriate.

The pharmacist may advise that a Monitored Dosage System or other compliance aid may be appropriate. These devices are available free of charge to patients eligible under the Equality Act 2010. The community pharmacist is able to assess eligibility. The service user or a relative may wish to fund the use of such a device if they are assessed as being ineligible.

If the person conducting the initial assessment considers that the service user is unable to manage medication supplied in individual bottles or boxes without assistance, they must contact the pharmacy nominated by the service user to discuss alternative forms of packaging.

If the care worker considers that the service user is experiencing difficulties managing their own medicines due to the nature of the medicine container, they must report this to their line manager who will be responsible for contacting the service user's GP and/or pharmacist to discuss what action is needed.

All medication should be stored in a secure location in the service user's home that is accessible to adults but not children. This may also apply to the service user or someone living with them if it is deemed not appropriate for them to have access to the medication.

Some medication may require refrigerated storage (2-8°C). These medicines should be stored (if possible) in a door compartment that can be reserved for medicines or held in a separate re-sealable container in the main fridge to avoid cross contamination with food. Medicines should not be stored in or adjacent to the ice box/freezer compartment of the main refrigerator.

The label on the medicine should indicate any special storage conditions. Storage arrangements should be noted on the service user's care plan.

7. MEDICATION SUPPORT TASKS

Care workers may assist a service user to take medication that has been prescribed by the service user's doctor, or other practitioner responsible for aspects of the service user's care.

Care workers should only administer medication from medicine containers, including monitored dosage systems or other compliance aids, which have been assembled or supplied by a pharmacist, hospital pharmacy or dispensing doctor practice.

Labels on medicines supplied by a pharmacy or doctors dispensing practice **must not** be altered by anyone. If a label has been altered in any way, then an appropriate health professional must be contacted immediately, and their advice sought before the medication is administered.

If a care worker has any concerns or doubts regarding medication, they should contact their line manager immediately for advice and guidance.

General Support Tasks (level 2)

All care workers, who have undertaken appropriate training on the management of medicines and signed off as competent, may provide assistance with the following:

- Medication taken by mouth (oral preparations) e.g. tablets, capsules and oral liquids.
- Medication applied externally to the skin e.g. ointments, creams, lotions.
- Medication applied to the eye or ear (drops or ointment).
- Medication applied to the nose (cream, spray or drops)
- Medication in inhaler form via a spacer device or by preparing an inhaler device i.e. inserting capsule into a device.
- Medication delivered via a transdermal patch.
- Drink thickeners.
- Support with compression stockings where they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place. (Providers who employ nurses may not require a shared care agreement. Please check with the prescriber).

Medication Support Tasks with a higher level of risk (level 3)

Administration of the following may only be given after specific training from a health care professional. The home care manager must be satisfied that staff are competent and confident in carrying out such tasks. Overall responsibility will be retained by health with clear documentation provided, detailing roles and responsibilities of care workers. A risk assessment must be undertaken by the care provider and a detailed care plan specific to the task put in place. Any concerns must be immediately reported to line manager and health care professional.

- Buccal midazolam
- Laxative suppositories
- Adrenaline auto-injectors e.g. EpiPen
- Support with Thrombo-Embolic Deterrent stockings provided the service has been informed of the treatment duration for these.
- Support with nebulisers (care workers must have received instructions on the use of the particular device).
- Assist with oxygen via a pre-set facility only (assist person to fit mask, switch machine on/off, reporting low cylinder contents).
- Support with medication via a PEG (Percutaneous Endoscopic Gastrostomy) e.g. clean PEG site, inserting medication, escalating problems.

Support Tasks care workers should not undertake

Invasive medical or medication procedures will be predominantly the responsibility of health care professionals who are qualified and competent practitioners with appropriate training, skills and knowledge.

The following tasks are not recommended to be carried out by care workers: These tasks will normally be undertaken by nurses.

- Injections or procedures which break the skin (except adrenaline auto-injectors),
- Pessaries, enemas, rectal or vaginal creams,
- Application of dressings involving wound care (unless, in exceptional circumstances, as a directive from a community nursing team).
- Syringe drivers
- Any procedure that requires the care worker to make a clinical judgement.

8. ADMINISTRATION OF MEDICATION

Administration Procedure

Administration of medication for the purposes of these guidelines means assisting the service user to take medication. It includes the following:

a) Reminding (prompting) the service user to take their medication.
b) Helping the service user to take medication from the container.
c) Removing the dose of medication from the container and assisting the service user to take the dose

Care Workers must adhere to the following administration procedure:

- Check that they are giving the right medication to the right service user by asking their name or asking an informal carer if unsure.
- Check verbally that the service user has not already taken or been given the medication. Also check the MAR chart.
- Check that the service user's name, the name of the medication on the container and the dosage instructions on the label match with the MAR chart. If there is a discrepancy the line manager must be notified.
- Check that there have been no recent changes in medication. If there is a discrepancy the line manager must be notified.
- Check the containers have been assembled by a community/hospital pharmacy or doctors dispensing practice and are clearly labelled. If the label becomes detached from the container, is illegible or has been altered medication must not be administered. The line manager should be contacted for further advice or NHS 111 if out of hours. If the label is attached to the outer packaging it is essential that the packaging is retained for reference.
- Check that the medication has not exceeded its expiry date. The date of opening should be marked on eye drop bottles, liquid bottles, and creams etc. (see appendix 6). The Care worker must inform their line manager of any medication that has expired.
- Check the dosage instructions and any other specific instructions regarding time of administration e.g. before food.
- Check it is the correct time to administer the medication, paying attention to pain killing medication e.g. paracetamol, that must have at least four hours between doses.
- Check the label to determine if medication should be dissolved / dispersed in water before administration.
- Check the way in which the medication is to be administered e.g. eye drops left or right eye, etc.
- Measure doses of liquid medication using a 5ml medicine spoon, a graduated medicine measure or an oral syringe supplied by the pharmacist. Where a service user is experiencing difficulties with liquid medicines the line manager should be contacted.

- Check old patch has been removed before applying a new one. Ensuring old patch is disposed of safely and gloves are worn.
- Ensure that if a thickening agent is prescribed this is mixed to the correct consistency as stipulated on the label if this is not stated this must be confirmed to avoid a choke risk.
- Ensure that compression stockings, if applicable, are applied correctly according to manufacturer's instructions.
- Appropriate hand hygiene must occur before and after any administering medication and before and after the wearing of disposable gloves.
- Medication must not be handled; solid dose forms e.g. tablets or capsules should be passed to the service user on a spoon or saucer. Disposable gloves must be worn by care workers where the dose has to be placed in the service user's mouth.
- Disposable gloves should be worn when applying skin treatments (e.g. creams, ointments, lotions). **Fire Hazard: all paraffin-containing emollients (regardless of paraffin concentration) and paraffin-free emollients, when used in large quantities, pose a fire risk which could result in severe or fatal burns. Service users should be kept away from naked flames, ignited cigarettes or open fires after the use of such preparations. Care should be taken when service users are prescribed oxygen alongside emollients. It is recommended that oil free preparations should be used where there will be direct contact with oxygen e.g. on the face including nasal passages and lips, due to the risk associated with high pressure gases and oil based products. Paraffin based products can also block nasal prongs as well as being a fire risk. The prescriber should be contacted in these circumstances for advice and a risk assessment undertaken (see appendix 10 for additional information).**
- Check the service user has taken their medication and record this on the MAR chart straight away in the correct day and time box, using the appropriate code, if required, followed by the care workers initials.
- Ensure that medication is returned to its safe storage place
- Report any concerns about the service user experiencing any side effects from their medication.
- Report any concerns about any aspects of medication support in relation to a service user who lacks capacity at once to line manager (or if out of hours the person on call)

Crushing tablets, opening capsules or splitting tablets

Tablets must **not** routinely be crushed, or capsules opened. There may be circumstances however where tablets or capsules may need to be crushed or opened to enable the service user to take their medication. This should be carried out with the service user's consent.

In these circumstances the following must apply: -

- Crushing or opening must be authorised by the prescriber with guidance from the pharmacist as the efficacy and legal status of the medicine can be altered.
- Information and authorisation must be recorded in the care plan.
- The direction to crush/open should be added to the dispensing label by the GP practice/Pharmacy.
- The correct equipment should be used to crush tablets e.g. a pill crusher, available from community pharmacies.

Occasionally it may be necessary to split a tablet to achieve the required dose. If this is required, this should ideally be done by the service user's community pharmacy or dispensing doctor. If this is not possible a tablet cutter can be purchased from the pharmacy for a small cost. Ensure the directions are followed precisely. Seek pharmacist's advice if necessary.

Imprecise, ambiguous directions

If medication is labelled with imprecise or ambiguous directions e.g. 'take as directed', 'take as before', 'apply to the affected part' the care worker must seek clarification in writing through their line manager and/or service user's GP or community pharmacist and then noted in the care plan and on the MAR chart.

PRN medicines

Medication with a when required (PRN) dose is usually prescribed to treat short term or intermittent conditions. The service user may not need the medication at every dosage time.

Sufficient information should be available to care workers which details the condition for which the medicine should be given, any signs or symptoms they may exhibit, the interval between doses and the maximum dose in a 24-hour period. Where the label does not provide this information, confirmation should be sought from the service user's GP via their line manager. An up to date PRN protocol should be made available with this information (see appendix 2 for an example).

Any concerns relating to changes in use i.e. increasing or decreasing use should be referred to the GP via the line manager.

Variable Dose Medication

If Care workers have any queries or concerns about the dose of medication required, they should not give any medication and contact their line manager for advice.

Medicines may be prescribed in a variable dose regime most commonly in the following categories:

a) **Where the dosage schedule is described at the time the prescriber writes the prescription**
For example: Paracetamol 500mg tablets – one or two tablets to be taken up to three or four times a day if required for pain.

The care worker has to ensure if it is appropriate to administer the medication (i.e. is the service user complaining of pain, has the service user received treatment in the previous six to eight hours) and must obtain directions from the service user as to the quantity of medication needed (e.g. one or two tablets). This should be the service user's decision, but if the service user has been taking the maximum dose for several doses the GP should be contacted as the dosage may need to be adjusted. The care worker should also refer to the PRN protocol kept with the MAR chart or care plan.

The care worker must record on the MAR the dose/quantity of the medicine in addition to entering their initials in the recording panel.

For example:

Time/date	
Breakfast	2 tabs, BJ
Dinner	
Tea	1 tab, IRJ
Supper	

b) **Where the dosage is dependent on additional information being provided**
For example: Warfarin tablets. The service user's required dose will be dependent upon results of routine lab tests.

It must be documented in the care plan how any communication relating to changed doses will be addressed and whose responsibility this is.

The service user should have a separate record card onto which the dosage is entered by the laboratory service following a routine blood test. Alternatively, details of the appropriate dosage will be posted to the service user's home or GP surgery.

The care worker must ask the service user for the current dosage paperwork and should enter the dose administered on the recording panel in the MAR along with their initials.

If a service user is not able to supply the current dosage paperwork, the care worker should immediately contact their line manager in order that advice and guidance can be obtained.

c) Sliding Scale Dosage Schedules

Examples of this include:

1) Incrementally reduce the dose of a drug over a defined period of time in order to achieve a complete withdrawal of the medication or to reach a maintenance dose

2) Incrementally increase the dose of a drug to achieve a satisfactory maintenance dose of the medication

Information on the dosage scheduling may be shown on the label, or frequently on a separate chart supplied by the hospital, GP practice or community pharmacy. Where separate details of the dose schedule are provided, the label may indicate this e.g. medicine to be taken as directed on the accompanying chart.
Care workers must always refer to any accompanying information or charts carefully to avoid mistakes and check if they are unsure.

Food & drink interactions

Some medicines can interact with certain foods and drinks. One of the most common ones is grapefruit juice. Similarly, milk can also affect some medicines by reducing the amount of drug that is absorbed by the body. The pharmacist may add this information onto the label.

Alcohol can interfere with the action of many drugs. Where a known interaction exists between a medicine and alcohol, a warning will appear on the label of the medicine container. If the service user appears to be intoxicated with alcohol or other substances, staff must not administer any medicine until their line manager (or person on-call) has been informed.

Further information on interactions can be found in the patient Information leaflet, in the BNF https://bnf.nice.org.uk/ or by talking to a community pharmacist.

Food supplements & thickening agents

Both of these items may be administered by the service providing they are prescribed and documented on the MAR chart.

Staff must ensure that they follow the mixing instructions on the label of thickening agents. This will include using the appropriate measuring spoon provided to ensure that the consistency made up is that specified on the dispensing label

Advice must be sought from the prescriber or speech and language therapy service in relation to the other medication prescribed to the service user to ensure this is not a choking risk also.

Non-prescribed medicines & self-care remedies

Care workers must not offer advice or support with non-prescribed medicines and remedies. It may be dangerous to do so as the service user may be allergic, or it may interact with a prescribed medicine.

Where care workers are asked by the service user to assist with administration or the purchasing of non-prescribed medicines, they must either refer service user to their GP or pharmacist or contact their line manager who can obtain further advice from the GP or pharmacist.

Before contacting the line manager, the care worker must ask the service user what other medicines they are taking as the GP or pharmacist will need this information to determine if it is safe for the service user to take the non-prescribed medication. This course of action must be followed in both circumstances where a care worker is responsible for assisting and where a service user manages their own medication.

If a Health Care Professional recommends purchasing an over-the-counter medicine it is important that the provider obtains written confirmation of the medicine to be purchased, dosage directions and length of treatment etc. This information should be kept with the care plan and the medicine added to the MAR chart by an appropriate person (and checked for accuracy).

Barrier creams may be left in the service users' home by visiting district nurses. These may have no pharmacy dispensing labels on them. In these circumstances it is important that before application care workers obtain information from the service who supplied the barrier cream regarding the directions for use and document this in the care notes before adding onto the MAR chart by an appropriate person (and checked for accuracy).

9. REFUSALS

A service user who uses the service may choose to refuse their medicines. This may be for many reasons. It may be that the tablets are too large to swallow, or they do not like the taste or their side effects.

A service user must never be forced to take their medication, but some degree of encouragement may be given. If a service user refuses their medication or does not take their medication the care worker should inform their line manager. The line manager should contact the prescriber for advice and where refusal falls within part of a defined course of treatment or time sensitive medication (a pharmacist can advise you), the GP needs to be informed after the first refusal.

The reason for refusal should be documented on the MAR and in the daily record.

10. COVERT MEDICATION

Medication must always be administered by consent with the full agreement and understanding of the service user.

"Covert administration" is a term used when medicines are administered in a disguised form without the knowledge or consent of the person receiving them e.g. hidden in food or a drink. Giving medication by deception is potentially an assault.

Covert administration is sometimes justified and necessary but must never be used where the service user is deemed to have capacity to make an informed decision about their medical treatment.

Efforts may also be made to amend the timings or formulation of medication before covert administration is considered. Contact the service users GP.

Giving medicines covertly must only take place within legal and best practice frameworks to protect the service user receiving the medicines and the care worker giving the medicines.

Covert administration decisions can only be made within the boundaries of a multi-disciplinary team and must not be undertaken without their agreement in writing. Written confirmation should also be obtained from a pharmacist that the medication can be administered in a particular way (i.e. medication is suitable to be mixed with a certain food or liquid).

Only medication which is regarded as essential for the service user's health and well-being, or for the safety of others, should be considered for administration in a covert way.

11. RECORD KEEPING & MAR CHARTS

Where care workers assist service users with their medication this should be recorded in their care plan.

Where medicine administration is supported by a family member it is not expected that the MAR chart should be completed by the family member. However, what their involvement is must be clearly documented in the care plan for auditable purposes to ensure the care worker can identify if medication has already been administered and at what time.

A MAR chart (either paper or electronic) should be in place for each service user who is receiving assistance with the administration of their medication from a care worker i.e. reminding/prompting, assisting and administering.

The MAR chart must be checked, for any medication changes, each time the care worker attends the service user's home (printed MAR charts must be kept in an agreed location in the service user's home).

The legal direction to administer a medication is as per the medication dispensing label. The MAR chart is a record of the medication given/taken. Both the dispensing label and MAR chart must be an exact match. If this is not the case, the medication must not be supported with, and the line manager must be contacted immediately.

MAR charts must be completed correctly and in full to ensure a service user's safety. Medication details e.g. name of medication, formulation, strength, and dosage instructions must be in indelible ink (if handwritten), use capital letters and words instead of numbers e.g. "Two to be taken in the morning" not "2 to be taken in the morning".

It is recommended that all MAR charts are checked for accuracy by a second member of staff. Similarly handwritten entries must be signed by the staff member who entered the information and countersigned by the next staff member who undertakes a visit to that service user to ensure that the MAR chart has been completed correctly.
If the staff member has any concerns, they must contact their line manager or person on-call immediately.

Please note: “As per blister pack “must not be written on the MAR chart as it is not accepted by the CQC. This is because it does not satisfy the requirement of “which medications are prescribed for the person” and hence does not support a clear audit trail for the service user’s care.

Care workers must record details of administration on the MAR chart (printed and electronic) at the time the medication is administered by entering their initials or signature in the appropriate box. Non-administration of prescribed medication must be recorded on the MAR chart, including why it hasn’t been given/taken, and must be reported to their line manager.

Where a service user receives support with medication from a care worker and new medication is received into their home the quantity and date received should be recorded on the MAR chart (printed and electronic). This also applies if there is discontinuation of medication or a change of dose.

The current MAR (printed) should be the only one kept in the service user’s home. Completed MAR charts must be sent to the service provider’s branch or team office for auditing and then stored in the service user’s file.

Electronic MAR Charts (eMAR)

Electronic MAR charts must contain the same information as the paper MAR chart (see above). It is important that providers ensure that the eMAR system used supports all service user’s’ needs e.g. monitoring of medicines, recording allergy and drug intolerances, data protection, safeguarding and near miss reporting, audit, medicines review and medicines reconciliation. Providers should ensure that:

- Staff receive robust training
- The member of staff making each entry can be identified
- Entries cannot be altered at a later date
- Access controls are in place to prevent unauthorised access to records
- Staff are aware not to share login details and the person logged into the eMAR is the person actually administering the medication to the service user
- A process is in place to get medicines information off the system if service user is to go into hospital
- Adequate back-ups are in place to prevent data loss
- Staff know what to do if internet/power failures or issues out of 9-5pm working hours
- Reporting and audit systems are used to look for anomalies/recording issues
- Staff are aware of what procedure to follow if an item is prescribed mid cycle and may not have been dispensed by their normal pharmacy

MAR chart audits

MAR charts must be audited by the home care manager (see appendix 9 for an example). Audits should include the following as a minimum:

- Does the MAR chart include the service users details e.g. name, address, date of birth and any allergies?
- Does the MAR chart clearly identify the start date including the year?
- Does the MAR chart list all the medicines prescribed?
- Has the MAR been checked for accuracy and any handwritten entries on printed MAR been signed by the staff member transcribing and countersigned by a second staff member who has undertaken an accuracy check?

- Do all entries show the name, strength and form of the medicine and full directions for use?
- Do all entries show any additional information/warnings e.g. take with or after food?
- Are MAR charts signed for each individual medicine administered i.e. no gaps?
- Has non-administration of medicines been recorded correctly?
- Were all medicines available for staff to administer at the time of their visit i.e. no 'none availables'?
- When a variable dose is prescribed is the dose administered recorded?
- Is there sufficient information to allow care staff to give 'as required' medicines safely, e.g. PRN protocol in place
- Is there evidence that care workers are checking expiry dates?

Recording application of topical products (creams, ointments, patches)

A MAR chart must document all prescribed creams/ointments and where they are to be applied. A body map is recommended (see example in appendix 4).

Patches must be applied to clean, dry, non-irritated skin generally on the torso, upper arm, or shoulder area. Staff must record application on the MAR chart as well as on a patch application record which also details where the patch has been applied (see example in appendix 3a & 3b). Before another patch is applied the old one must be located, carefully removed, and disposed of whilst wearing disposable gloves. Staff should refer to the manufacturers leaflet for information on where to apply the patch, rotation requirements and any special instructions. Further information on patches can be found in appendix 7.

12. DISPOSAL OF MEDICATION

All medication prescribed for the service user is their property and must never be removed by a care worker from the service user's home without written consent.

Medication no longer required or expired should be returned to a community pharmacist. This should, wherever possible, remain the responsibility of the service user and/or their family. It may be necessary for a care worker to dispose of a service user's medication if they are unable to undertake this task.

The care worker must obtain written consent from the service user and sought approval from their line manager prior to returning medication.

Details of medication returned should be recorded and signed by the pharmacist upon receipt (see example form appendix 1). This record should be kept with the care plan. The care worker should also record details of medication returned on the MAR chart.

When a single dose of medication requires disposal e.g. if dropped on the floor or service user has refused after it has been taken out of the container it should be placed in an envelope identifying it as waste medication and returned to the pharmacy as above. It should not be flushed down the toilet or placed in the domestic waste. Liquid medicine doses should be put into a paper tissue and disposed of in the general waste.

In the event of a service user's death all medication should remain in the service user's home for seven days in case there is a coroner's inquest.

13. ERROR & NEAR MISS REPORTING

Any instances of error involving medication must be reported to the line manager immediately (or if out of hours the person on call). Medical advice must be sought and followed via the service user's GP, NHS 111, or out of hour's service (GP telephone service will direct you to the out of hours service) as appropriate. This also applies to errors that staff identify but have not made themselves e.g. errors made by prescribers, pharmacists and other care workers. To ensure duty of candour, the service user's family/NOK should also be notified.

The service user should be informed as appropriate. MAR charts and daily records should also be documented with what has happened and advice given.

Following report of an error or circumstances where an error could have occurred (a near miss) the home care manager must investigate systems and processes to identify contributing factors and implement appropriate actions. This should be documented.

The home care manager should facilitate shared learning with colleagues to prevent reoccurrence of the error. At all times support must be provided to employees who report errors or near misses in order to encourage an environment of openness and shared learning. It is also everyone's responsibility to report to safeguarding if necessary. Managers must ensure care workers are aware of the procedure to follow.

14. GIVING ADVICE ON MEDICAL ISSUES

Advice on medicines is the responsibility of the service user's GP, pharmacist or clinician who has responsibility for the service user's medical care. Care workers must not advise on medication issues. Any question should be referred to the service user's GP or pharmacist.

The prescriber will decide whether to explain to the service user the nature of an illness and the implications of any treatment. This decision will be respected by care workers.

Patient information leaflets are included with prescribed medicines dispensed by a community pharmacist, dispensing doctor, or hospital pharmacy. Care workers may need to assist service users to access this information e.g. by reading the leaflet to them if required.

Some pharmacies are open longer hours and are available for medicines advice. Pharmacy opening times can be found on Find a Pharmacy - NHS website.

15. CONFIDENTIALITY

Care workers must not discuss or disclose a service user's medical history or treatment to a relative or lay person. Any questions must be re-directed to the service user, the service user's medical practitioner or line manager.

Appendix 1

CONSENT TO RETURN UNWANTED OR DISCONTINUED MEDICATION TO THE PHARMACY/DISPENSING GP SURGERY

I (*name of person*) ……. agree that the following medicines can be removed from my home and returned to a local pharmacy/GP dispensing practice for safe disposal by …… (*Name of care staff*)

Name, strength and form of medicine	Quantity

Signed …… **Date** ……

Care worker…… **Date** ……

Manager …… **Date** ……..

FOR PHARMACY/DISPENSING GP USE ONLY

I …… confirm that the above medicines have been returned to *…… for safe disposal.

Signed ……

Date……

* Name and address of pharmacy/dispensing GP surgery

Appendix 2

PRN Protocol

Name of Service User		**DOB**	
GP Details			

Medication to be administered "as required"

Name of medication		**Form** e.g., tablet, liquid etc.	
Strength		**Route of Administration**	
Reason for administration (signs & symptoms)			
How does the service user express or indicate a need for this medicine? (verbal or non-verbal)			
Dosage (if variable, define circumstances of what to give when, consider lowest dose first)			
How and when the dose can be repeated (minimum time intervals)			
Maximum dose in 24 hours			
Special instructions i.e. with or after food etc.			
Expected/desired outcome			
Other medicines to be aware of (possible interactions)			
When should the prescriber be contacted or called?			

Written by:		**Checked by:**	
Date:		**Review date:**	

Appendix 3a

Patch Application Record

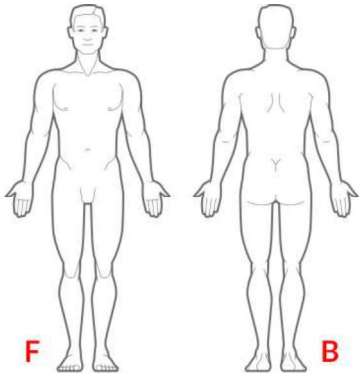
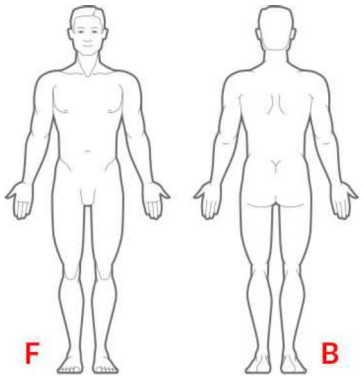
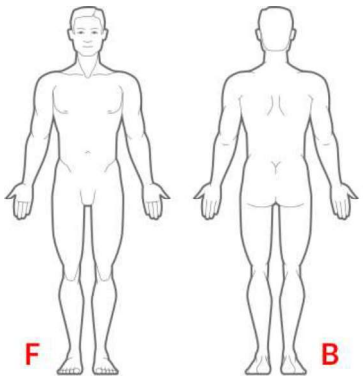
Name of Service User			
Name of patch		**Strength**	
Frequency of change			

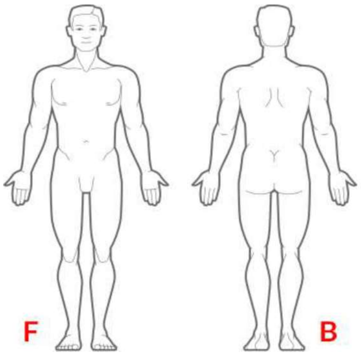
The patch should be checked on a daily basis to make sure it is still in place and initialed by the staff member undertaking the check.

The site of application should be rotated in accordance with the manufacturer guidance.

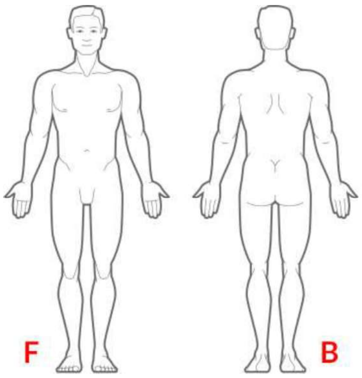
The old patch must be folded in half and stuck together before disposal, in accordance with the company policy.

Please indicate where the patch has been applied using a cross (**x**). If more than one patch is in use please indicate with a separate symbol, e.g., **o.** Remember to complete the MAR chart**.**

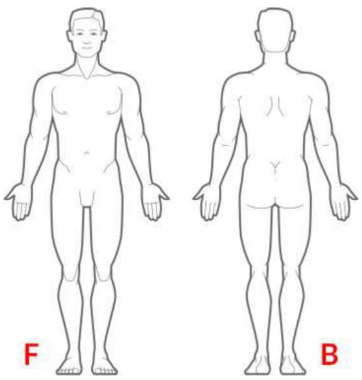
	**Date Patch Applied**		**Time**			
	Applied By					
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed		**Time**			
	Removed By					
	**Date Patch Applied**		**Time**			
	Applied by					
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed		**Time**			
	Removed By					
	**Date Patch Applied**		**Time**			
	Applied By					
	Daily Patch Check	2	3	4	5	6
	Date Patch Removed		**Time**			
	Removed By					



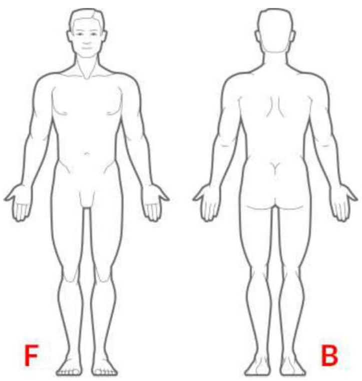
Date Patch Applied					**Time**	
Applied By						
Daily Patch Check	2	3	4	5	6	
Date Patch Removed					**Time**	
Removed By						



Date Patch Applied					**Time**	
Applied By						
Daily Patch Check	2	3	4	5	6	
Date Patch Removed					**Time**	
Removed By						



Date Patch Applied					**Time**	
Applied By						
Daily Patch Check	2	3	4	5	6	
Date Patch Removed					**Time**	
Removed By						



Date Patch Applied					**Time**	
Applied By						
Daily Patch Check	2	3	4	5	6	
Date Patch Removed					**Time**	
Removed By						

Appendix 3b

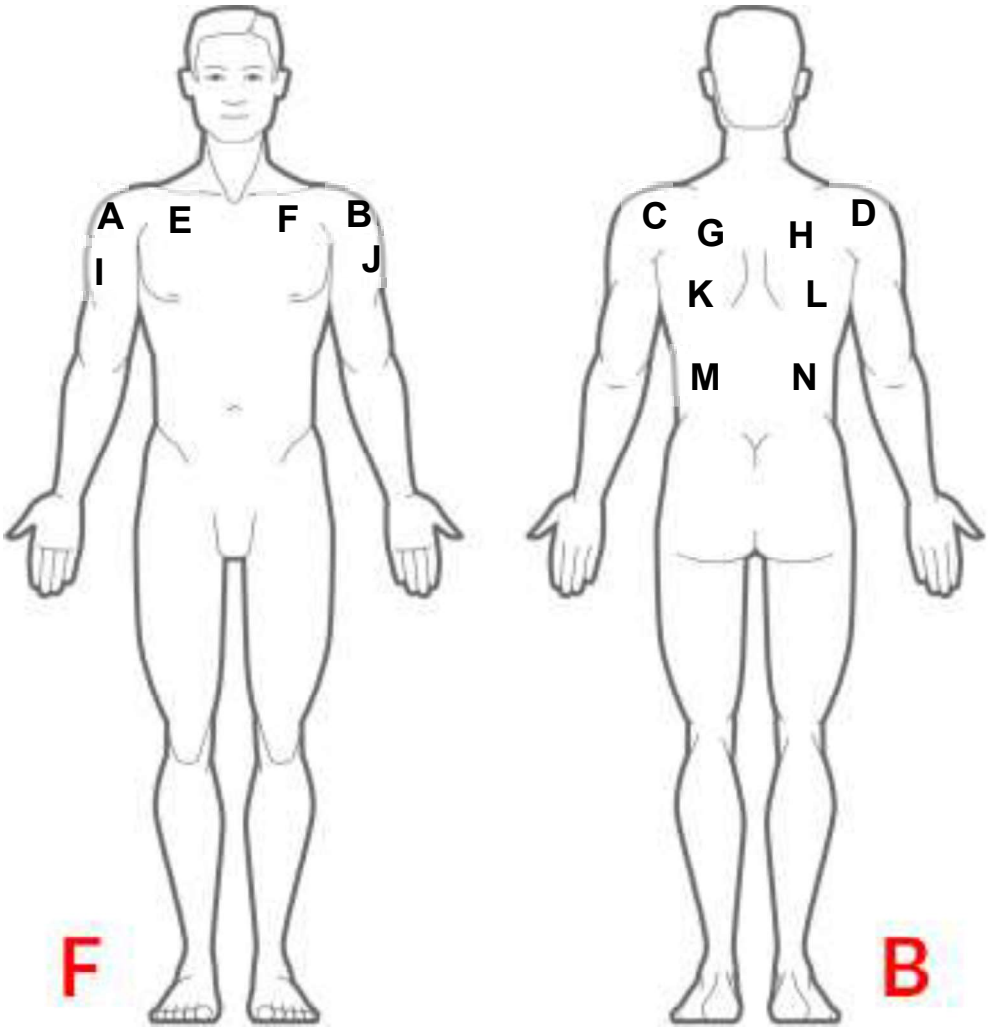
Patch Application Record (14 day patch rotation)

Name of Service User			
Name of patch		**Strength**	
Frequency of change			

The site of application should be rotated in accordance with the individual manufacturer guidance.

The old patch must be folded in half and stuck together before disposal, in accordance with the provider policy.

Please indicate where the patch has been applied using the coding system. Remember to complete the MAR chart.



Date Patch Applied	Applied By	Application Area (letter)	Date Patch Removed	Removed By

Appendix 4

Topical Medicines Application Record

Name of service user	Date of Birth	GP Name	Allergies

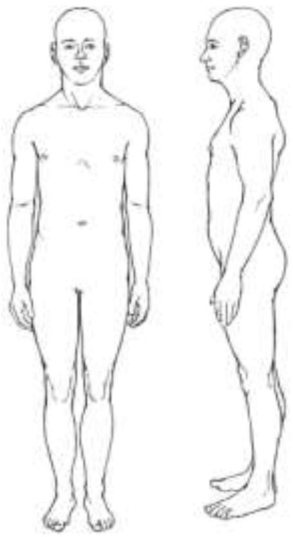
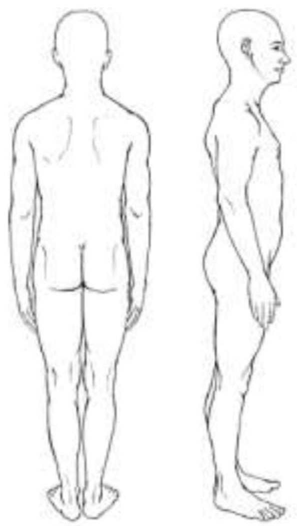
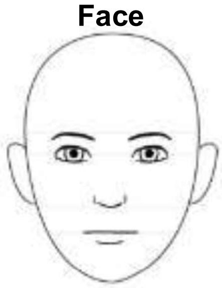
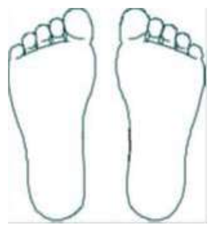
Name of Topical Preparation	Completed by	Checked by

Site of Application mark on body map

Frequency of Application e.g. daily or after washing

Month	Start Date	End Date

Body Map

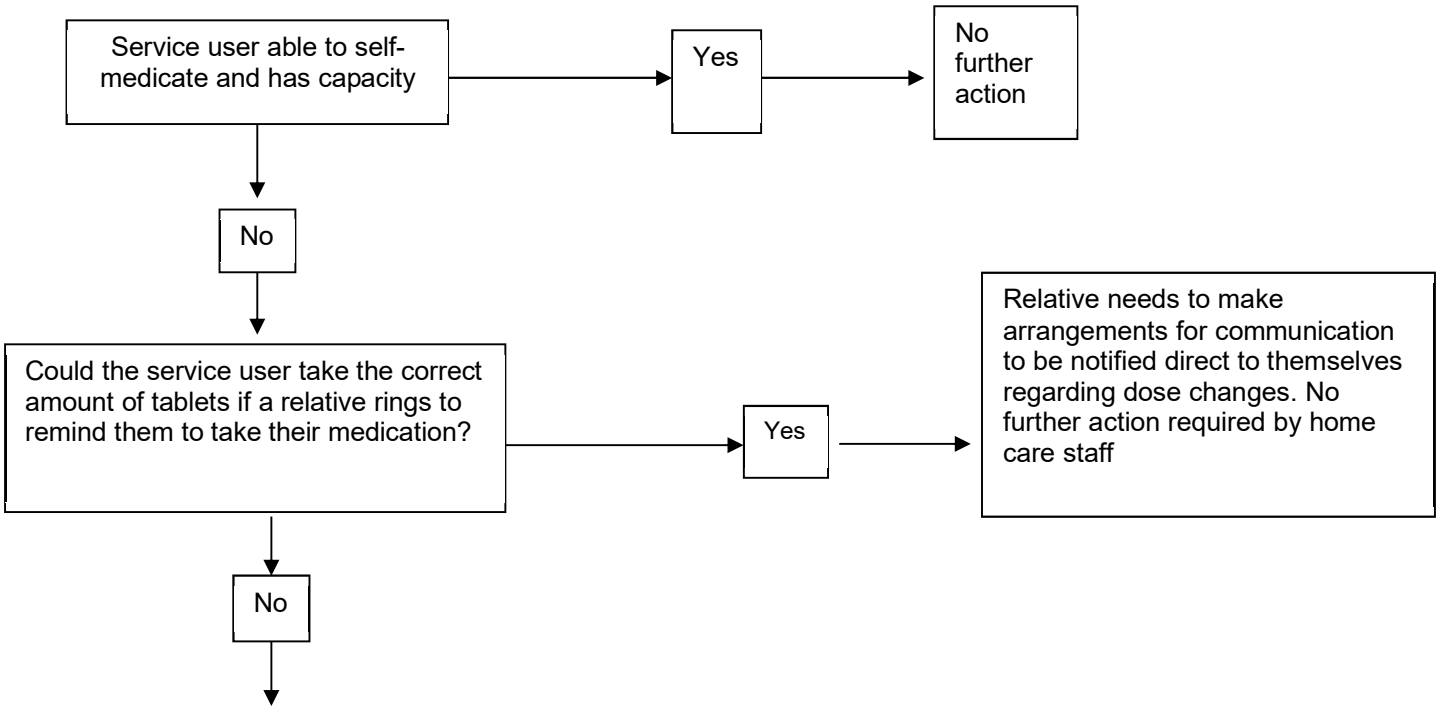
Front & Left Side	Back & Right Side	Face / Feet
		**Face**  **Feet** 

Date																						
Time/Sig																						
Date																						
Time/Sig																						
Date																						
Time/Sig																						

Storage e.g. fridge	Date opened	Expiry date after opening

Appendix 5

WARFARIN RISK ASSESSMENT



Undertake a risk assessment

The following should be considered in the risk assessment

- Ability to be able to receive and accept responsibility for receiving communication direct from the clinic that makes warfarin dose adjustments (currently either GP or hospital anticoagulation clinic). This may be by collecting the most recent INR charts from the GP surgery.
- Ability to receive urgent dose adjustments out of office hours (early evening).
- Being able to ensure that written confirmation of anticoagulation dose is attached to the Medication Administration Record (MAR). Plus, instruction in the MAR that warfarin is to be given in line with attached instruction.
- Ensuring that assistance with warfarin only occurs from an original labelled container from the pharmacy.
- Checking of who takes blood sample for INR test - community nurse, or GP practice.
- Ensuring the hospital anticoagulation clinic and/or GP practice are informed of specific arrangements as appropriate.
- Consideration of alternative medication being prescribed by GP.

Prior to assisting with warfarin at each administration time the following should be checked
- Check the dose required for that day on the attached instructions.
- Check when the next INR test is due, if that test date has already gone then there may be a more up to date test sheet available (check with line manager for further action).

Appendix 6 Expiry Dates of Medication

ALWAYS FOLLOW THE MANUFACTURERS GUIDANCE
ALWAYS WRITE ON THE PRODUCT THE DATE WHEN IT IS FIRST OPENED

Preparation	Expiry date once opened and stored in accordance with manufacturers guidance	Rationale/Information
Tablets/capsules in manufacturer's original blister	Manufacturer's expiry	Contents not open to environment.
Loose tablets/capsules in medicine bottles	Follow guidance in patient information leaflet (PIL) or maximum 12 months from date of dispensing	Stability of product once removed from original packaging
Tablets/capsules in MDS	8 weeks or expiry on MDS	Stability of product once removed from original packaging
Oral liquids in original manufacturer's bottle	12 months after opening or as per patient information leaflet (PIL) Some specials may be different Check to make sure storage in the fridge isn't required after opening/reconstitution e.g., some antibiotic liquids	Exposure of liquid to environment when dose is measured can introduce contamination. Specially prepared medicines often take longer to be manufactured and have short expiry dates (4 weeks) so it is important that the quantity ordered is not more than will be used before the expiry date. Citalopram drops expiry – 16 weeks Oramorph expiry – 90 days
Oral liquids in brown glass bottle	Follow guidance in patient information leaflet (PIL) or maximum 12 months from date of dispensing	Stability of product once removed from original packaging
Open top container (Tub/Jar) of cream/ointment	3 months after opening	Always follow manufacturer's expiry instructions on packaging or in patient information leaflet (PIL) Always check for signs of contamination. If there is a concern about appearance or the lid has been left off for a long period of time dispose of and re-order the item.
Tubes of cream/ointment	3 months after opening	
Pump dispenser packs of cream/ointment	Manufacturer's expiry date	
External liquids (e.g., Lotions, shampoos & bath oils)	Follow manufacturer's instructions on packaging or in patient information leaflet (PIL)	Limited exposure to the environment
Aerosols	Manufacturer's expiry date	Contents not open to the environment
Eye/ear/nose drops/ointment	Usually, 4 weeks after opening Follow information in patient information leaflet	Some newer drops/ointment may have a longer expiry once opened – always check. Single use containers should be discarded after use.
Liquid dietary supplements	Follow manufacturer's instructions on packaging or in patient information leaflet (PIL)	Contamination/deterioration when made up. Usually have a short shelf life once opened and may require fridge storage
Inhalers & Spacer devices	Inhalers – Follow manufacturer's instructions Spacer Devices - need replacing after 6 – 12 months.	Spacer devices should be washed as per manufacturers cleaning instructions
Insulin	**Unopened in fridge –** manufacturers expiry **Once opened –** 4 weeks unless otherwise stated. When in use can be kept at normal room temperature (below 25°C).	One pen / cartridge will often be sufficient for a month. (A box of 5 will rarely be needed every month). Order the nearest number of pens / cartridges needed per month to reduce stock piling.

These guidelines are subject to correct storage at ambient temperatures recommended by manufacturers and are based on their guidance and general consensus due to a lack of evidence-based information available

Appendix 7

Good Practice Guidance for the use of fentanyl patches

The following guidance has been produced to remind staff of the procedures that need to be followed to ensure the safe administration and management of transdermal fentanyl patches to all service users. This guidance also relates to all transdermal patches.
The use of fentanyl patches can be compromised by incorrect administration; in particular medication errors have been reported when old patches are not removed at the time of the new application.

Key Points

- Fentanyl is a controlled drug and so it is vital that care staff should be trained and deemed competent by a nurse before applying patches to service users.
- Fentanyl patches are worn continuously and should be **changed every 72 hours (3 days).** Ensure the prescribed dose and directions are followed correctly.
- Medication errors with fentanyl patches have been reported, highlighting the need to thoroughly check that old patches are removed from the service user before application of new patches.
- Used patches should be disposed of appropriately.
- An increased temperature / fever may also increase absorption and the service user should be monitored for side effects and toxicity. Advice from the service user's GP should be sought.
- Fentanyl patches can cause drowsiness, if affected the service user should be advised not to operate any tools or machinery. It is an offence to drive if their ability is impaired by the use of fentanyl patches.
- Alcohol can increase the side effects of fentanyl, increasing the risk of drowsiness.
- If a patch is accidentally swallowed, then dial 999 immediately.
- If a fentanyl patch is inadvertently transferred to another person, it should be removed immediately, and medical advice sought.
- If a service user has trouble breathing, shallow breathing, tiredness or extreme sleepiness, inability to think walk or talk normally, feels faint, dizzy, or confused, then these could be signs and symptoms of fentanyl overdose. Seek medical guidance immediately.

Application and removal of patch

- It is important that disposable gloves are worn by care workers applying patches as fentanyl is an extremely potent painkiller and it is important that care workers do not absorb any of the drug through their skin.
- Apply to clean, dry, non-inflamed, non-irradiated, hairless skin on the upper arm or trunk of the service user. The upper back may be preferable in a confused person to reduce the risk of unintended patch removal (first refer to local procedures on capacity and consent). Do not apply to broken skin.
- Press in place firmly with the palm of the hand for 30 seconds, body hair may be clipped but do not shave. Some service users may need a semi-permeable dressing to ensure adherence.
- Never cut patches prior to application or use damaged patches.
- Regularly check (daily) that the patch remains adhered to the skin properly.
- Service users can bathe or shower (with care) whilst wearing a patch, but the water should not be too hot.
- A new patch should not be applied immediately after a bath or a shower or immediately after using creams, talc, or soap on the skin.

- Always remove the old patch before applying a new one. The date of application should be carefully marked on the patch, or a patch chart used to indicate the date and position of the patch on the service user so that application sites can be rotated. The frequency of patch changes should be clear on the Medication Administration Record (MAR)
- Regularly rotate the site of application for each new patch and ideally the underlying skin should be allowed to rest for 7 days before applying another patch to the same area.
- When more than one patch containing the same medication is prescribed apply to the same area of the body but do not overlap the patches.
- If patch application is inadvertently omitted or delayed advice must be sort from the prescriber before application.
- Heat (e.g., hot baths, electric blankets, hot water bottles) should NEVER be applied over the top of the patch as it may enhance the absorption of fentanyl.
- Avoid excessive sun exposure.
- Site irritation, usually caused by the adhesive, may necessitate a change of brand and so should be discussed with the service user's GP.
- When ordering repeat fentanyl patches, it is important to ensure the service user has enough for continued therapy until the next supply is received, but it is also important not to over order the patches as the dosage of the patch may need to be changed.

(These are general principles that apply to all transdermal patches)

Disposal of fentanyl patches

- Please note that used patches still contain fentanyl and therefore should be treated with care and caution.
- After removal, fold the patch with the adhesive sides inwards.
- Place the old patch in the empty foil pack from which the new patch came out of and return to the supplying pharmacy for destruction- following the correct procedure.
- Remove gloves and wash hands thoroughly.

Adapted from;
NHS Oxfordshire 'Guidelines on the use of Transdermal Fentanyl Patches' and NHS Blackburn and Darwen 'The use of fentanyl patches for severe chronic pain – guidance for care homes and domiciliary.

NHS Wales Risk of harm from the inappropriate use and disposal of fentanyl patches Patient Safety Notice PSN 022/December 2015

Appendix 8

Competency Assessment in Service Users Home

Name of care worker:	**Date:**

Training and Policy

Has the care worker completed medicines training?	Yes/No
Has the care worker read the medication policy?	Yes/No

Administration of Medicines

Preparation and hygiene	
Did the care worker read the person's care plan prior to administration to establish any changes/information from previous visits	Yes/No
Did the care worker make sure that everything was properly prepared before starting to administer the medication, e.g., prepare a drink for the person	Yes/No
Did the care worker wash their hands before starting to administer any medication and follow appropriate hygiene measures whilst administering the medication? E.g. wear gloves when applying creams.	Yes/No
Consent	
Before preparing or administering the medication did the care worker obtain the person's consent?	Yes/No
Selection and preparation of medication	
Before selecting, preparing or administering any medication did the care worker read the MAR chart accurately?	Yes/No
Did the care worker check whether a dose had already been administered/taken by the person or if the medication had been changed?	Yes/No
If any directions are unclear or illegible on the MAR did the care worker take appropriate steps to clarify the directions?	Yes/No/None seen this time
Was the medication selected checked against the correct MAR chart including checking the person's name on the label and MAR?	Yes/No
If the directions on the MAR chart differed from those on the label did the care worker take the appropriate steps to satisfy themselves as to the correct dose to be given?	Yes/No/None seen this time
Was the correct medication and dose selected at the correct time? Was consideration given to timing in terms of food or other directions on the label?	Yes/No
Was the medication prepared according to the directions and information on the MAR chart or any accompanying protocol?	Yes/No
Did the care worker use the appropriate measure for any doses of liquid medication? E.g. oral syringe, graduated measuring cup?	Yes/No
Administration	
Did the care worker check the records to see how the individual prefers to take their medication or demonstrate that they knew this information and administer the medication accordingly?	Yes/No
Did the care worker offer information, support and reassurance throughout to the person, in a manner which encourages their co-	Yes/No

operation, promotes dignity and which is appropriate to their needs and concerns?	
Was the medicine administered correctly and a glass of water offered where appropriate? ***Please tick the items you have witnessed being administered and provide information on any detailed discussions or simulations had to address those not witnessed in the 'any other information' box below***	Yes/No

Medicine form	✓	**Medicine form**	✓	**Medicine form**	✓
Tablets/capsules		Liquids		Sachets/powders	
Inhaler devices		Eye drops		Eye ointment	
Ear drops		Nose drops		Nasal sprays	
Creams/ointments		Transdermal patches			

Did the care worker use the appropriate compliance aid where appropriate?	Yes/No/not applicable
Did the care worker visually witness the individual taking all their medication?	Yes/No
If medication was left for the person to take later was this done in accordance with a documented agreed plan and was this recorded on the MAR chart correctly?	Yes/No/None seen this time
If the medication was not taken was the appropriate advice sought and documented?	Yes/No/None seen this time

Record Keeping

Did the care worker sign the MAR chart (including patch record if appropriate) immediately after the medication was administered?	Yes/No
If the medication was not given was an appropriate code entered on the MAR chart?	Yes/No
Were the MAR charts kept in the file or returned to the file after the administration was complete? (printed charts)	Yes/No

Stock Control

Did the care worker check that there was sufficient medication at the person's home for at least one week?	Yes/No
If there are shortages in medication noted did the care worker take appropriate action to ensure the stock was replaced? E.g. alert the person/representative that more medication was required using the agreed process for that person or initiate the reordering process as appropriate for the individual	Yes/No/None seen this time
Was all medication returned to the agreed place once the process had been completed and placed tidily?	Yes/No
Did the care worker check the storage requirements for medicines and alert the person to any special requirements, if necessary? E.g. fridge storage	Yes/No

Ordering, Receipt, and Disposal of Medication

Where care workers are responsible, did the care worker record any medication received into the home using the correct documentation?	Yes/No/None seen this time/Not applicable
Where appropriate, did the care worker put new supplies of medication in the agreed place in such a way that the older supplies would be used first?	Yes/No/None seen this time/Not applicable

Where care workers are responsible, did the care worker order medication in accordance with the agreement for that person after checking currently held stock?	Yes/No/None seen this time/Not applicable
Was any out of date medication or medication no longer required dealt with in accordance with the documented agreement with the person?	Yes/No/None seen this time

Accessing advice and information

Does the care worker know who to contact if they need advice on medication?	Yes/No
Did the care worker refer the person to the patient information leaflet or to an appropriate health care professional if the individual wants advice on medication?	Yes/No/None seen this time
Is the care worker aware of what action to take if a person wants to take 'over the counter' medication?	Yes/No

Any other information *Please record any discussions with the care worker*

Outcome of Assessment

Following this part of the assessment the care worker has been assessed as (delete as appropriate)

- Demonstrating competence at this assessment to administer medication unsupervised.
- Requiring further supervision or training in order to administer medication unsupervised at this time (complete actions below).

Issues Identified/Actions required

Name of assessor _____Job Title _____

Signature of assessor _____

Signature of care worker _____

Date of assessment _____

This assessment must be reviewed by_____ or sooner if circumstances change

Appendix 9

Medicine Administration and MAR chart recording Audit

Home Care Provider……. Date Undertaken…….

Undertaken by……

Service User	Does the MAR chart include the service users details e.g., name, address, date of birth, allergies etc.?	Does the MAR chart clearly identify the start date including the year?	Does the MAR chart list all the medicines prescribed?	Has the MAR chart been checked for accuracy and TWO signatures in evidence for handwritten entries?	Do all entries show the name, strength and form of the medicine and full directions for use?	Do all entries show additional information & warnings e.g., take with or after food?	Are MAR charts signed for each individual medicine administered i.e., no gaps?	Has non-administration of medicines been recorded correctly i.e., correct codes and information documented on rear of MAR or in care notes?	Were all medicines available for staff to administer at the time of their visit i.e., no 'none available'?	When a variable dose is prescribed is the dose administered recorded?	Is there sufficient information to allow care staff to give 'as required' medicines safely, e.g., PRN protocol?	Is there evidence that care workers are checking expiry dates?
	Yes, No or N/A											

Where the answer to any of the above questions is 'No' please make notes about the issues on each chart below

Action Plan			
Action	**Who**	**When**	**Completed date and sign**

Appendix 10

Oxygen safety information for service users and care workers

Always read the information that comes with the equipment. The oxygen supplier can also provide further advice on general oxygen safety.

General advice

- Do not smoke or allow others to smoke near you.
- Do not use or store oxygen near naked flames such as candles, gas hobs, gas or open fires or similar. Check the information that came with the equipment for recommended distances from heat sources.
- Do switch off the oxygen when not in use
- Do make sure that the room is well ventilated.

Additional safety advice when using cream/ointments with oxygen

- Do not use cream/ointments underneath an oxygen mask or around the nasal cannula or on areas of the skin in contact with oxygen including your hands. Use a water-based lubricant.
- If you do need to use a cream or ointment on other areas use the minimum possible and rub in well.
- Do not use oil based make up.
- Do not handle oxygen equipment with greasy hands. Wash hands thoroughly before handling oxygen.
- Do not allow any oxygen equipment or oxygen including mask or nasal cannula to come into contact with the cream/ointment.
- Do not use cream/ointments to lubricate oxygen equipment. Only ever use products specifically provided or advised by the oxygen company on oxygen equipment.
- Do wash bedding and clothes regularly to reduce the build-up of cream/ointment. Wash at the highest temperature that the material will allow. For example, wash bedding at 60°C.
- Do protect soft furnishings from contact with creams and ointments.

If you have been prescribed a paraffin free product you must still follow the safety advice

Taken from North Yorkshire & Vale of York CCGs ‘using emollients with oxygen’ guidance