



Sheffield Medication Policy

Revised Version

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POLICY STATEMENT

Document Objectives: The majority of people take responsibility for administering their own medication and their independence with this task should be enabled wherever possible.

This policy is designed to cover those situations where people in domiciliary care, shared lives, supported living, day services and Short Breaks who are unable to administer their own medication and who require assistance with medication from Care Workers.

This policy aims to provide guidance for the Care Workers and Assessors on the safe administration and recording of medication.

The Sheffield Medication Policy complies with the requirements of Care Quality Commission (CQC), the organisation which regulates Service Providers and checks their compliance with this Policy. The Sheffield Medication Policy also meets [NICE Guidance NG67](#) "Managing medicines for adults receiving social care in the community".

This Policy should be read in conjunction with the [Mental Capacity Act 2005](#) and the [Sheffield Joint Policy on the Prevention and Management of the Use of Restraints](#).

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Group/Persons Consulted: This Medication Policy was first published in April 2003. Members of the Medication Policy Steering Group have contributed to this latest revision. The contribution of these and other stakeholders is gratefully acknowledged.

Monitoring Arrangements and Indicators: The written authorisation of the Person must be obtained following an assessment of their needs by an Assessor before a Care Worker administers any medication to the Person.

Where the Person appears to lack the mental capacity to give authorisation for this assistance, the Assessor will carry out the assessment of the Person's capacity to make this decision using the principles of the Mental Capacity Act.

The Assessor will identify the level of assistance required with the administration of medication and will undertake a risk assessment to support independent living. The Assessor will develop an appropriate Care/Service Plan to meet the need for assistance with medication in the 'best interests of the Person. If applicable they will work with any appointed advocate e.g. Lasting Power of Attorney (LPA).

Where the Assessor is aware of an Advance Decision THEY will record how the implications of this have been taken into account. The Care Worker shall then administer medication as prescribed by the GP or other authorised prescriber.

Training Implications: Care Workers and Social Workers will need to have attended specific training on the contents of this policy.

Equality Impact Assessment: Applies equally to all groups of staff.

Intended Recipients Who should:- All providers must ensure compliance with this document. Sheffield City Council will undertake periodic monitoring to ensure practice complies with the Medication Policy.

- **be aware of the document and where to access it**
 - **All Social Workers, Care Providers and their staff.**
 - **Prescribers and Community Pharmacies.**
 - **Secondary Care Providers**
- **understand the document**
 - **All Social Workers, Care Providers and their staff.**
 - **Community Pharmacies**
- **have a good working knowledge of the document**
 - **All Social Workers, Care Providers and their staff.**

Contact Details

Any concerns or questions around this policy should be directed to Practice Development Team adultspractice@sheffield.gov.uk

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GLOSSARY OF TERMS

Mental Capacity Terms	
Advocate	<p>Someone who provides support and representation for a person.</p> <p>Independent Mental Capacity Advocate (IMCA) – is a statutory safeguard for people who lack capacity to make some important decisions. This includes decisions about medical treatment when the person does not have family or friends who can represent them.</p>
Assessment of Capacity See: SCIE Mental Capacity at a Glance	<p>When should capacity be assessed?</p> <p>Capacity may need to be assessed where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. It cannot be decided that someone lacks capacity based upon age, appearance, condition or behaviour alone.</p> <p>The Mental Capacity Act has FIVE underpinning principles</p> <ol style="list-style-type: none"> 1. Assume: a person has capacity; unless otherwise proved. 2. Support: adults have the right to be supported to make their own decisions. 3. Unwise Decisions: individuals retain the right to make unwise decisions. 4. Best Interest: anything done on behalf of an adult without capacity must be done in the adults best interest. 5. Least Restrictive: ensure you achieve the desired outcome in the least restrictive way. <p>Principles 1 to 3 will support the process before or at the point of determining whether someone lacks capacity. Where there is a belief that capacity is lacking, principles 4 and 5 support the decision-making process.</p> <p>It will be important for health and social care staff who are supporting people to have an understanding of the Mental Capacity Act and must seek advice where they do not have the knowledge or experience to support decision making.</p>

	<p>Advance decisions to refuse treatment – the Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future.</p>
<p>Best interests and decision-making</p>	<p>If a person has been assessed as lacking capacity then any action or decision taken on behalf of that person must be made in their best interests (principle 4 of the Mental Capacity Act). The person who has to make the decision is known as the ‘decision-maker’ and will normally be responsible for the day-to-day care. It can also be a professional e.g. doctor, nurse or social worker who needs to make decisions about treatment.</p>
<p>Court of Protection and Appointed Deputies</p>	<p>The Mental Capacity Act (MCA) created a new court and a new public official to protect people who lack capacity and to supervise those making decisions on their behalf. The Court of Protection is able to appoint a Deputy, for example, because a person has an ongoing lack of capacity. The Court of Protection will tailor the powers of the Deputy according to the circumstances of the individual.</p>
<p>Attorneys appointed under Lasting Powers of Attorney (LPAs)</p>	<p>The Mental Capacity Act introduces a new form of Power of Attorney which allows people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack capacity to make those decisions for themselves.</p>
<p>Administration Terms</p>	
<p>Administration</p>	<p>Shall mean:</p> <ul style="list-style-type: none"> • The taking of an oral dose of medicine; • The application of external medication (e.g. ointment, cream, lotion or drops); • The operation of an inhaler device in order for the dose of medication to be inhaled.
<p>Appropriate Contact</p>	<p>The person appointed by the organisation responsible for medication to make appropriate decisions relating to the</p>

	administration of medication.
Assessor	Someone authorised to undertake an assessment of the person's ability to manage their medication. The Assessor is responsible for obtaining the authorisation of the person to enable a Care Worker to assist them with their medication.
Authorisation	Delegating the power or asking someone to carry out a task on one's behalf.
Carer	Shall mean the individual taking responsibility for the administration of medication to the person. This includes the informal carer who may be a family member or friend.
Care Worker	A person employed to provide support with medication.
Care/Service Plan	This phrase is used to refer to plans of care completed by the assessor or the care provider. The plan may also be known as a support plan. It may be an assessment of a person's need in order to procure a service. It may be the plan kept in the person's home for information and instruction to Care Workers, or others who are involved in helping the person with their medication.
Communication Sheet or Communication Log	This is the record kept in the person's home and on which Care Workers, or carers, may make a note of all aspects of the person's care including when this relates to medication. This supports communication between all people involved in the care of the person.
Consent	The free agreement to a course of action where a person has the capacity to do so. This may be given verbally or in writing, formally or informally, having taken into account and understanding the risks, consequences, benefits and purpose of that action.
Container	Shall mean the packaging of the medication supplied by the Pharmacist. For example glass or plastic bottle, foil strip or blister packaging, tube containing ointment or cream for external application. The container may also be a Monitored Dosage System (MDS) or other compliance aid.

Compliance Aid	A simple device designed to help people take their medication and maintain their independence in preference to having their medication administered.
Enteral Feeding Tubes	A tube inserted through a small incision in the abdomen into the stomach and is used for long-term feeding. Medication may be administered via the tube though some persons may still be able to take some medicines orally. Full guidance should be provided on the MAR chart or care/service plan.
Medication Administration Record (MAR) chart	The Medication Administration Record (MAR) provides a means to record the administration of medicine to a person. This should be used in conjunction with the label on the medication and the care/support plan
Medication	Shall mean a collective term for medicine(s). The term drug may also be used.
Non-prescribed medication	Medicines for minor ailments that could be bought over the counter, such as paracetamol for headaches or indigestion remedies.
PRN	Latin abbreviation meaning to be taken 'as required.'
Person	Shall mean the individual assessed by the Assessor to receive support services and assistance with their medication. The person may be referred to by others as the 'service user', 'client' or 'patient'.
Service Provider	Shall mean the organisation which has been contracted or commissioned to provide support services to the person.

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GENERAL PRINCIPLES

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

- It is the responsibility of the Assessor to obtain authorisation from the person and to make the initial assessment of whether the person has the capacity to give this authorisation.
- A person that has capacity must give their authorisation to administer medicines in writing (medication Authorisation Form) before the Care Worker may assist with the administration of medication. Where the Assessor has concluded, following an appropriate assessment, that the person lacks the capacity to provide authorisation (and it is in the best interests of the person to receive assistance) this must be noted on the Medication Administration Authorisation Form. This record must include the reasons and circumstance of the 'best interest' decision and who was involved in making this decision.
- Authorisation will be noted on the person's Care/Service Plan.
- Care Workers must only administer medication following authorisation by their appropriate contact where the authorisation of the person has been obtained or where the Assessor has completed an assessment identifying it is in the best interests of the person to receive assistance.
- Any concerns relating to a person's medication must be reported according to the care provider's relevant procedure.
- Where a person has responsibility for their own medicines and the Care Worker is concerned about the person's ability to continue to manage their own treatment, the care worker must report this to the appropriate contact according to their relevant procedure. In such cases the identified appropriate contact is responsible for arranging a further assessment of the person's need for assistance with their medication.

1. THE ROLE OF THE COMMUNITY PHARMACIST AND THEIR TEAMS

1.1 Pharmacists are responsible for the supply of medicines and appliances prescribed by a Doctor, Dentist, Nurse Practitioner or other authorised prescriber. Prescriptions may be NHS or private. A limited range of medicines may also be supplied in accordance with a patient Group Direction (PGD) or Patient Specific Direction (PSD) which permits the supply of medication in defined circumstances without a prescription.

1.2 Pharmacists can provide advice to persons and with their permission, to their families and Care Workers involved in their care on the proper use, storage and disposal of medicines.

- 1.3 Pharmacists keep computerised patient medication records of the medication that patients receive on prescription. These records provide useful information and can indicate potential drug interactions. Therefore the regular dispensing community pharmacist should be the first point of contact for queries about medication.
- 1.4 It is advisable to arrange for prescriptions to be dispensed at the person's regular pharmacy. The Pharmacist will be contacted by the Assessor, provided with a copy of the Authorisation form and requested to provide a MAR chart as per the [SCC Medication Administration Record Service](#) (November 2017).
- 1.5 Many pharmacies offer a collection and delivery service for medicines, though there may be a charge for this. Care Workers should contact their appropriate contact if a person has difficulty in obtaining prescriptions from their doctor or in arranging for medicines to be dispensed and collected from the pharmacy.
- 1.6 Pharmacists can advise on the use of alternative packaging of medicines. As an alternative to receiving formal care services an appropriate compliance aid or reminder chart may enable a person to retain responsibility for their own medication. The Care Worker should contact their appropriate contact if they consider that in seeking to maximise their independence a person would benefit from use of an appropriate compliance aid.

2. GUIDANCE FOR ASSESSORS

2.1 Introduction

2.1.1 Services providing support with medication to people in their own homes have agreed to adopt a common policy in relation to the management of medicines. Following assessment, these people have been identified as requiring support with the administration of medication. This Policy should be read in conjunction with the attached appendices.

2.2 The Medication Policy

2.2.1 The Policy and Code of Practice address a number of issues relating to the administration of medicine. Core features of the Policy and Code of Practice include:

- Clarity relating to the circumstances in which Care Workers can administer medication to people;
- Clarity over what types of medication may or may not be administered by Care Workers;
- The adoption of common medication records (MAR charts);
- The involvement of Community Pharmacists (and secondary care pharmacy services) in people supporting the Medication Policy and Code of Practice and issuing MAR charts;

- A common induction programme for all care staff, both in post and new recruits.

2.3 Medication Administration Records:

- 2.3.1 A common medication recording system is a core feature of the Policy and Good Practice Guide. A person who requires administration of medication should be issued with a MAR chart by their Pharmacist to cover the duration of the prescription.
- 2.3.2 Sheffield City Council has commissioned most community pharmacies to provide a MAR chart for persons who require medication to be administered. The Assessor should be aware of the details within the Service Specification.
- 2.3.3 A list of all prescribed medication that is included in the package of care at Level 1 (Prompt and Observe) or Level 2 (Administer) must be available in the person's home. In the case of Level 1 this may be a MAR chart or hard copy list of all current, prescribed medicines and in the case of Level 2 this will be the current MAR chart.
- 2.3.4 Where an electronic MAR chart is used to record administration consideration must be given to making a list of current medicines available to other care providers such as out of hours GPs, Community Nursing teams or ambulance services.

2.4 Role of the Assessor:

- 2.4.1 A good assessment of the person's needs should include:
- Engagement with the person (and their family members or carers if this has been agreed with the person) when assessing a person's medicines support needs. The assessor needs to consider how the person communicates;
 - A focus on how the person can be supported to manage their own medicines, taking into account:
 - The person's needs and preferences, including their social, cultural, emotional, religious and spiritual needs;
 - The person's expectations for confidentiality and advance care planning;
 - The person's understanding of why they are taking their medicines;
 - What they are able to do and what support is needed, for example, reading medicines labels, using inhalers or applying creams;
 - How they currently manage their medicines, for example, how they order, store and take their medicines;
 - Whether they have any problems taking their medicines, particularly if they are taking multiple medicines;
 - Whether they have nutritional and hydration needs, including the need for nutritional supplements or parenteral nutrition;

- Who to contact about their medicines (ideally the person themselves, if they choose to and are able to, or a family member, carer, Care Worker or care provider);
- The time and resources likely to be needed to check that the correct medicines have been supplied in accordance with the MAR chart and to administer them safely.

2.4.2 All discussions and decisions about the person's medicines support must be recorded, this includes both Level 1 and Level 2 provision of support. If the person needs medicines support, the following information must be included in the provider's care plan a copy of which must be held in the care provider's office,:

- The person's needs and preferences;
- The person's expectations for confidentiality and advance care planning;
- How consent for decisions about medicines will be sought;
- Details of who to contact about their medicines (the person or a named contact);
- A complete list of current medicines;
- What support is needed for each medicine;
- How the medicines support will be given;
- How and where the medicine will be stored;
- Who will be responsible for providing medicines support, particularly when it is agreed that more than one care provider is involved;
- When the medicines support will be reviewed, for example, after 6 weeks.

2.4.3 The assessor should seek advice and support from the appropriate health professional if, as part of the assessment they identify whether any changes or extra support may be helpful, for example, by checking if:

- The person's medicines regimen can be simplified;
- Information about time-sensitive medicines has been shared;
- Any medicines can be stopped;
- The formulation of a medicine can be change;
- Support can be provided for problems with medicines adherence;
- A review of the person's medicines may be needed.

2.4.4 It is the responsibility of the Assessor to determine by assessment if help with medication is required and they (or the agency/provider) should obtain the person's authorisation for this assistance. The authorisation will be confirmed using the Medication Administration Authorisation Form (Appendix 3).

- 2.4.5 Written authorisation for the administration of the medication must be obtained from the person before a Care Worker may administer medicines.
- 2.4.6 Details of authorisation must be kept on the person's file and copies should be given to the person and to the Service Provider. Authorisation must be reviewed and reaffirmed at least annually, or before this time if circumstances change e.g. admission to hospital. The Local Authority Assessment Team Manager is responsible for ensuring that reviews are conducted annually.
- 2.4.7 Where a person appears to lack the capacity to give authorisation for this assistance, the Assessor will carry out the assessment of the person's capacity to make this decision according to the Local Guidance and Code of Practice for the Mental Capacity Act. The Assessor will identify the level of assistance required and will undertake a risk assessment to support independent living. The Assessor will develop an appropriate Care/Service Plan to meet the need for assistance with medication in the best interests of the person and keep records of the reasons and circumstances of the 'best interests' decision including who was involved in making this decision. Under the Mental Capacity Act different people may be required to act as a decision maker, depending upon the decision to be taken e.g. whether or not it is appropriate to take steps to prevent the person accessing their own medication (i.e. restraint).
- 2.4.8 Where the person is assessed as lacking capacity to authorise the administration of medication, the Assessor will seek to establish if any Advance Decisions have been made by the person, if an Enduring Power of Attorney, Lasting Power of Attorney or Deputy is in existence and whether the person's previously expressed wishes and feelings have been identified and recorded.
- 2.4.9 In the above situation, the Assessor will state on the Authorisation form how it has been determined that the person lacks capacity and that medication should be administered as prescribed.
- 2.4.10 Where authorisation is refused, medication must not be administered by Care Workers.
- 2.4.11 Where the Assessor considers that refusal to authorise the assistance with medication will place the person at risk, the refusal should be reported to the person's doctor or other member of the GP practice team.
- 2.4.12 Where it is felt that refusal of authorisation by a person is not made of their own free will, i.e. coercion and control, this may constitute abuse.

- 2.4.13 A person must never be forced to take medication as this constitutes an assault, is abusive and illegal. Therefore consideration must be given to contacting the police authorities as well as referral to Adult Access where it will be considered as a safeguarding concern. (adultaccess@sheffield.gcsx.gov.uk)
- 2.4.14 The Assessor will note on the service procurement document where it is necessary to limit access by the person to their own medicines and complete the appropriate risk assessment according to the Sheffield Adult Safeguarding Board Prevention and Management of the Use of Restraint Framework and Good Practice. The issue of safekeeping could also apply to the MAR charts and the Care/Service Plan and these should be addressed and recorded in the assessment and service procurement document. This information will be transferred by the Care Coordinator or Appropriate contact on to the Care/Service Plan.
- 2.4.15 If the Assessor is aware of a risk of the person not complying with the assistance with medication, this should be noted on the assessment, Care/Service Plan and service procurement document together with guidance for the care provider about what to do in such circumstances.
- 2.4.16 The assessor will also record on the service procurement document if there are any Advanced Decisions in place.
- 2.4.17 In order to initiate support with medication the Assessor should indicate the required support with medication.
- 2.4.18 If there is more than one provider, provider(s) and a family carer, involved in assisting the person with their medication (including non-prescribed medicines) their respective roles and responsibilities should be clear from the service procurement document and Care/Service Plan which is kept in the person's home. Everyone, including the family carer, should follow these procedures and complete the MAR chart and/or the person's Communication Sheet.
- 2.4.19 The leaflet "Leaflet for Service Users, Relatives and Friends" (Appendix 4) must be given to the person, and, where appropriate with the person's permission, to any family members or informal carers for their information, especially if they are involved in assisting with the administration of medication as part of the Care/Service Plan. At the point of review a leaflet should be given to the person if they do not have one.
- 2.4.20 Following assessment the assessor should request the person to sign the Medication Administration Authorisation Form. The Assessor should ask the person to nominate a Community

Pharmacy that will be responsible for dispensing prescriptions, and this should be recorded on the Authorisation Form.

- 2.4.21 Most people receiving regular medication will use a single pharmacy for all their prescribed medication. Where this has not been the case the Assessor should agree with the person a pharmacy that will be approached to take responsibility for dispensing prescriptions.
- 2.4.22 The Assessor should provide the pharmacy with the fully completed Medication Authorisation Form (Appendix 2). The pharmacy should note this on the patient's medication record (PMR) to enable the future provision of MAR charts with the dispensed medicines according to the MAR Service Specification.
- 2.4.23 The Assessor should also provide the GP with a copy of the Medication Administration Authorisation Form. The surgery should be asked to note/record the appropriate 'Read Code' on the patient's notes.
- 2.4.24 Where there are concerns about medication regimes, the Assessor should request a review by the GP or seek advice from the Community Pharmacist to ensure these are effective and efficient for all parties.
- 2.4.25 Depending on the person's ability, the Assessor may identify that the only support necessary is to remind (prompt) the person to take their medication. The person must still be observed taking their medicine and this is documented in the person's notes, "medication prompt and observed".
- 2.4.26 Where the administration of medication is required at specific time intervals, the Care Coordinator or Assessor should check the essential requirements with the GP or Pharmacist to see if the dosing schedule of the medications can be realigned, e.g. by use of a controlled release formulation. If the dosing intervals are an essential component of treatment, e.g. as in '4 times a day' regimen for antibiotic treatment, and the service provided does not cover these requirements, the Assessor should increase the care package accordingly. Where assistance with the administration of medication is required during the night, the Night Care Visiting Service might be appropriate to provide this assistance in some circumstances.
- 2.4.27 A review of a person's medicines support should be made to check whether it is meeting their needs and preferences. This should be carried out at the time specified in the provider's care plan or sooner if there are changes in the person's circumstances.

2.5 Use of a Compliance Aid

- 2.5.1 If the Assessor considers that the issue of a compliance aid may help a person to maintain independence they should discuss this with the Pharmacist. Such aids should be used in preference to providing assistance wherever practicable, as the promotion of independence is an underlying principle of the Policy.
- 2.5.2 A monitored dosage system (MDS) should not be necessary for a person who needs administration of medication. Not all medicines are suitable for dispensing into MDS, e.g. tablets affected by moisture or those that are sealed under inert gas (to protect from deterioration), liquids and inhalers.
- 2.5.3 Some people who usually have a MDS may need short-term assistance with their medication from a Care Worker until their condition improves; in these short term situations, it may be necessary for the Care Worker to assist with medication dispensed in the MDS, for the purpose of rehabilitation, and to enable the person to regain their independence.

2.6 Ordering and Collection

- 2.6.1 The arrangements for the ordering and collection and dispensing of prescriptions should be recorded on the Care/support Plan by the Assessor. Some Pharmacists will offer a prescription collection (from the GP practice) service and a delivery service for dispensed prescriptions to the person's home for 'house bound' persons – the Assessor should discuss options with the nominated pharmacy. There may be a charge for such services.
- 2.6.2 The Care Worker should be informed who is responsible for the ordering of repeat prescriptions. If the Care Worker is responsible they should ask for repeat prescriptions in good time in order to avoid the person running out of medication. A list of what medication has been requested should be kept by the person responsible for requesting the repeat prescription and this should be checked against what has been dispensed. Any difference should be reported to the Pharmacist before assisting with the administration of any medication.
- 2.6.3 When the care providers are responsible for ordering the persons medicines, they should not delegate this task to the supplying pharmacist (or another care provider).

2.7 Persons Discharged from Hospital

- 2.7.1 When a person is discharged from hospital there will be an attempt to resume the original package of care. The Hospital Pharmacy may provide a MAR chart with the discharge medication, provided that there is sufficient notice of the discharge and that nursing staff clearly indicate that support at home is to be provided. If there is

not sufficient time before discharge to prepare a MAR chart it may be possible to forward this to the person separately following discharge.

2.7.2 If the person did not receive assistance with their medication before admission but it is assessed that they will need this on discharge, their task will need to be part of the Care Plan and the person should be discharged with a MAR chart, providing as above, that there is time to arrange this.

2.7.3 All persons discharged with a package of care provided at home, which includes administration of medication, are to be reviewed in their home as soon as possible following discharge. An Authorisation form should be completed and provided to the patient's regular community pharmacy to ensure future supplies of MAR charts.

2.7.4 Where a MAR chart is not available, the medication administered should be recorded on the person's Communication Log/Communication Sheet.

3. CARE WORKER TRAINING

3.1 A training programme has been agreed and is arranged for all Care Workers by their employer.

3.2 Any training provided must give underpinning knowledge that will contribute towards the appropriate Health and Social Care Level 2 qualification or other recognised training as this becomes available.

3.3 Care providers must identify a competent person to deliver the training programme.

3.4 All trainers must attend the Sheffield Medication Policy Training for Trainers; only individuals who have attended the training may deliver the programme.

3.5 All Care Workers must have an annual review of their knowledge, skills and competencies which includes a refresher of the Sheffield Medication Training programme. This is the responsibility of each provider.

3.6 The Care Provider must ensure that the trainer attends a Medication Training Review session at least once in a two year period. These sessions are run annually and are open to all trainers.

3.7 Care Providers will be responsible for quality assuring their training and assessing the competence of their Care Workers, both before working in the field and subsequently. This will only be accomplished by direct observation at least annually.

- 3.8 It is the responsibility of the Care Provider to monitor all procedures and practices to do with medicines. This will help to ensure that any problems are resolved.
- 3.9 The Care Provider's Appropriate Contact should act as a representative for his/her Service Area in any training or other matters related to the Safe Custody and Administration of Medicines as and when appropriate. A record of the monitoring must be maintained on the Care Worker's file. This monitoring should take place at least annually. Additional monitoring can take place as and when the Appropriate Contact as a minimum feels it is appropriate or necessary.

4. THE ROLE OF THE CARE WORKER

4.1 Storage of Medicines

- 4.1.1 Care Workers should ensure that all medication is stored in the agreed designated area, out of sight and reach of children.
- 4.1.2 Some medication requires refrigerated storage. Where a provider is responsible for the transport of medicines, a risk assessment should be carried out to consider the needs of cold chain medicines and medicines which are liable to misuse (controlled drugs), especially if a Care Worker is not going straight from the supplying pharmacy to the person's home (if, for example, they have other support calls to make in between).
- 4.1.3 It is acceptable to store medicines requiring refrigerated storage in a domestic refrigerator. However, do NOT store medicines, in or immediately adjacent to, the icebox of a refrigerator or in the freezer compartment of a combined fridge freezer. Do not store medicines adjacent to food. Store medicines if possible in a door compartment that can be reserved for medicines.
- 4.1.4 The label on the medicine should indicate any special storage conditions e.g. the need to store in a refrigerator). Storage arrangements should be noted on the person's Care/Service Plan.
- 4.1.5 The assessor will note on the service procurement document if there is a need to make alternative arrangements to store medications in a locked container where this need has been identified by a risk assessment. This information will be transferred by the Care Coordinator/appropriate contact on to the Care/Service Plan which is kept in the person's home.
- 4.1.6 The storage of controlled drugs needs to reflect the risk of unauthorised access to the medicines.

4.2 Administering Medication

4.2.1 Care Workers may only administer medication when they have received appropriate training and where the person has given their authorisation. Care Providers have a duty to assess the competence of their Care Workers in assisting with medication. All administration must reflect the SIX Rights:

- Right person
- Right medicine
- Right route
- Right dose
- Right time
- Persons Right to refuse

4.2.2 The following descriptions define what administering medicines means and what assisting with medicines means:

- a. If the Care Worker gives any medicines or reminds the person to take their medicines **without** being requested (by the person) to do so, this activity must be interpreted as administering medicines which can be either:
 - Prompt and observe (**Level 1**), or
 - Administer (**Level 2**)
- b. If the person indicates to the Care Worker what actions they are to take on each occasion – this is not considered as administration.

For the greater majority of cases the above descriptions apply but it is recognised that there will always be the exception. An assessor may be required to review the care package with respect to the medication arrangements.

4.3 General

4.3.1 With the person's authorisation Care Workers may assist a person to take their medication which has been prescribed by the person's Doctor or other authorised prescriber responsible for aspects of the person's care. (Also see 4.11, Other Administration Techniques).

4.3.2 All Care Workers who have undertaken the appropriate training and demonstrated competence on the management of medicines may provide assistance with medication taken by mouth (oral preparations e.g. tablets, capsules and oral liquids) and medication applied externally to the skin e.g. ointments, creams and lotions.

4.3.3 Care Workers should make themselves aware of the exact arrangements for assisting the person with their medication, including whether another Care Worker or family carer is also involved in assisting with this task, and if there are any

arrangements for what medications might need to be taken 'as required' or in an emergency. This information will be provided by the Assessor and will be contained in the Care/Support Plan.

- 4.3.4 Care Workers must only administer prescribed medication from containers clearly labelled with the person's name, the name of the medication and dosage and which have been supplied by a pharmacy, hospital or dispensing doctor's practice.
- 4.3.5 Care Workers should follow carefully any special instructions on the label of the medication, such as ensuring the medication is taken as directed before or after a meal. This information should be on the MAR chart.
- 4.3.6 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 through their appropriate contact.
- 4.3.7 Care Workers **must not** administer medication from multi-compartment compliance aids or other compliance aids made up by family members or friends of the person.
- 4.3.8 The person has a right to refuse their medication. Please see Section 7 – Refused Medication.
- 4.3.9 The Care Worker should immediately inform their appropriate contact if they observe any possible adverse reaction to medication and should contact the GP, Pharmacist or the NHS111 service (if neither the prescriber or pharmacist are available). In case of emergency, the Care Worker should contact 999. Care Workers are in a good position to advocate on behalf of the person and feedback queries and concerns about the person's health to the GP or Pharmacist.
- 4.3.10 Care Workers should inform their appropriate contact if they have any concerns about the person's health regardless of whether or not they are involved in the administration of medicine.
- 4.3.11 Assessors and Care Workers must treat people with dignity and respect at all times. People must be involved in any discussions with regards to their medication and they must be enabled to make decisions. There must be respect for peoples' personal preferences and lifestyles. Where people are assisted with their medication this must be recorded in any relevant Care/Support Plans.

4.4 Oral Medicines

- 4.4.1 Administration of oral medication for the purposes of these guidelines means: removing medication from container and directly administering.
- 4.4.2 Medication should not be handled and solid dose forms e.g. tablets and capsules should be passed to the person in an appropriate container e.g. a medicine pot. Where the Care Worker has to place the dose in the person's mouth, the Care Worker should wear non-latex disposable gloves.
- 4.4.3 Sometimes it may be necessary to administer a half of a tablet. Tablets may only be cut using a recognised or approved tablet cutter. The pharmacy may be prepared to do this and so should be asked. Where the pharmacy is not willing to cut tablets in half, this task must be undertaken by trained staff, wearing non-latex gloves who will need to have had their practice checked. (This is to ensure they are using the cutter correctly and getting an accurate half tablet.) Staff are not permitted to return the unwanted half of a tablet to the pack as this is considered to be secondary dispensing. Instead this should be safely disposed of as per spoilt doses. In such cases the GP should be asked to provide sufficient quantities.
- 4.4.4 Tablets should never be crushed, no capsules opened, without the explicit instruction of the prescriber and/or the supplying pharmacist.
- 4.4.5 Some medication must be dissolved or dispersed in water before administration. This will be indicated on the label. (Note: The carer should use enough water to dissolve the dose but not use too much so that some is left.)
- 4.4.6 Tablets and capsules are best taken with a sufficient quantity of water to aid swallowing. This is especially important with capsules.
- 4.4.7 Bottles of liquid medicines must be shaken well before use. Doses of liquid oral medication must be measured using a 5ml medicine spoon, an oral syringe or a graduated medicine measure all of which are supplied by the pharmacy. Where the person experiences difficulty in taking liquid medicine from a medicine spoon or measure, an oral syringe may be required. Care Workers should contact their appropriate contact if the person is experiencing difficulties with liquid oral medicines.

4.5 External Preparations

- 4.5.1 Creams, ointments and lotions should only be applied by Care Workers where the skin area to be treated is unbroken. Care Workers must contact their appropriate contact if they have concerns regarding the application of external preparations. However, in the management of Moisture Associated Skin Damage

(MASD) where the skin may be broken, carers may apply prescribed external preparations as part of the MASD pathway. (See Appendix 17)

- 4.5.2 Care Workers must wear disposable, latex free gloves when applying external medication (e.g. ointments, creams, lotions or patches).
- 4.5.3 Where patches are prescribed, these should be accompanied with a Body Chart (Appendix 13) which will be kept with the MAR chart (Appendix 15). Note that the site used for patches must be rotated.
- 4.5.4 If the label becomes detached from the container, is illegible, or has been altered, medication must not be administered. Advice should be sought through the appropriate contact who should seek further advice where necessary. In the first instance this should be the supplying pharmacy. Out of normal working hours advice can be sought from the GP Collaborative (by ringing the patient's own GP) and also via the NHS111 service. Details should be recorded with the chart.
- 4.5.5 Medicines have an expiry (use-by) date. The expiry date must be checked to ensure that the medicine may still be used. In most cases where medication is supplied in the manufacturer's packaging the printed expiry date will apply. However, this is not always the case (e.g. eye drops and eye ointments – refer to pack label.). Care Workers should write the date of opening on the pack and note any labelled guidance on product expiry.
- 4.5.6 The Care Worker must inform their appropriate contact about any medication that has expired. The appropriate contact must contact the person's doctor to ascertain if the medication is still required, in which case the doctor will be requested to issue a new prescription. The Care Worker must enter the details on the person's chart and in the person's Communication Log/Communication Sheet, and the expired medication should be returned to the pharmacy.

4.6 Administering 'when required' Medicines

- 4.6.1 Most medication will be prescribed for administration on a regular basis. Some treatments may be prescribed on a PRN or an 'as required' basis. It is essential that the Care Worker has sufficient information in order to determine if a dose being requested by the person is appropriate. If in doubt the Care Worker must contact their appropriate contact who must contact the GP practice for clarification. Any such 'as required' dose should have information about the reason for the medication, the recommended dose, the recommended frequency and the maximum doses in 24 hours. The reason for assisting with a dose of 'as required' medication should be recorded on the person's Communication Log/Communication

Sheet. (See Appendix 10 – CQC Frequently Asked Questions: When require (PRN) medicines.)

4.7 Administering Variable Doses

4.7.1 Some medication is prescribed on a reducing or variable dosage regime and the Care Worker must always refer to any accompanying information. (Information may not always be on the MAR chart but may be documented elsewhere such as warfarin dosing letter.)

4.8 Administering Controlled Drugs

4.8.1 Although the assistance with the administration of controlled drugs follows the steps for the administration of any other medication, care should be taken with storage to minimise any risk of inappropriate access to the medicines.

4.9 Prescriber Directions to Amend Dose

4.9.1 Any change in the dose of previously supplied medication should be communicated to the care provider by the prescriber. If this is initially verbally, the verbal instruction should be confirmed by another person and a written confirmation should be faxed at the earliest possible time.

4.9.2 Following an instruction from an authorised source (e.g. GP/prescriber) all changes should be documented by the provider on the existing MAR chart by means of a new entry with the original being crossed through with a single line so as to still remain legible. The label on the medicine container will need to indicate that there has been a change in dose and to refer to the MAR chart. Where possible, these alterations should be signed and dated by the clinician or alternatively written authorisation should be provided.

4.10 Emergency Supplies

4.10.1 Although staff should ensure there is sufficient medication for the service user, there may be occasions where the patient's supply has run out. There is a provision under the NHS to obtain an 'Emergency Supply'. The Appropriate Contact or other member of staff should contact '111' who will send a request to a convenient pharmacy able to make a supply. In such cases, a copy of the current MAR or an empty container (bearing a label) should be presented to the supplying pharmacist to ensure that the correct medication is provided.

4.11 Other Administration Techniques

4.11.1 Assistance with the administration of creams/ointments/drops for instillation into the eye, ear or nose, and medication in patches to be applied to the skin (transdermal patches) may only be given after specific written instructions from the Care Worker's appropriate

contact. Where necessary and appropriate, the Care Worker will receive training in the administration of unusual medications or preparations.

4.11.2 Assistance with nebulisers and inhaler devices (including spacers) must only be given by Care Workers who have received instructions on the use of the particular device and have written authorisation from their appropriate contact.

4.11.3 The following medications must NOT be administered by Care Workers:

- Injections
- Suppositories
- Pessaries
- Enemas
- Internal rectal creams
- Internal vaginal creams
- The application of dressings involving wound care
- The application of medication to broken skin except where this applies to the application of barrier products (i.e. MASD Pathway and the Medi Derma-S Products) See Appendix 17

4.11.4 The administration of these medicines is the responsibility of a health care professional (e.g. a District Nurse). In some circumstances Care Workers will have undertaken advanced training to enable them to undertake some of the above tasks under the guidance of nursing staff. The health care professional remains responsible for the monitoring of such assistance with health care tasks and in some circumstances the appropriate health authority would need to fund such assistance.

4.12 Administration of Medicines via Enteral Feeding Tubes (PEG/PEJ) (Appendix 9 – Administration of Drugs Via Enteral Feeding Tubes)

4.12.1 When specific skills are needed to give a medicine via a PEG or PEJ tube, this task should only be delegated to a Care Worker when:

- There is local agreement between health and social care that this support will be provided by a Care Worker
- The person (or their family member or carer if they have lasting power of attorney) has given their consent
- The responsibilities of each person are agreed and recorded
- The Care Worker is trained and assessed as competent (see also the section on training and competency).

4.12.2 A care plan should be in place to cover medicines administration via an enteral tube covering the relevant issues. The directions on the label/MAR Chart/Care Plan should clearly identify how and when

the medication should be administered via the PEG tube. This includes all activities e.g. crushing and flushing.

- 4.12.3 Staff should have received appropriate training to prepare and administer medicines via enteral feeding tubes if they are undertaking this task. This should include a regular competency assessment.

4.13 Non Prescribed Medicines (NPM) (Appendix 3 – Non-prescribed Medications Form)

- 4.13.1 During any Assessment interview, the Assessor should enquire about the person's use of non-prescribed medication, recording the outcome on the Non Prescribed Medicines (NPM) form. Copies of the NPM form should be filed with the signed Medication Authorisation Form and also attached to the person's Care Support Plan.
- 4.13.2 Care Workers are permitted to assist persons with the administration of non-prescribed medication in addition to prescribed medicines, providing that advice has been sought from the person's Doctor or Pharmacist in order to check for drug interactions or contra-indications.
- 4.13.3 When Care Workers are asked by the person to administer non-prescribed medication and the medicine has not been listed on the NPM form, they must refer to their appropriate contact, who will take further advice from the person's GP or Pharmacist. (The appropriate contact should record any advice received on the Reviews/Amendments section of the NPM form and feed back to the Care Worker).
- 4.13.4 Before referring to the appropriate contact, the Care Worker **MUST** ask the person what other medicines they are taking. This course of action must be followed in all cases, even if the person manages their own medication.
- 4.13.5 Details (including the time and the dose) of any non-prescribed medication that is administered to the person must be recorded on the person's MAR chart. Note that it is the responsibility of the Care Provider to ensure that such items are accurately transcribed onto the MAR chart. (see appendix 6, Transcribing)
- 4.13.6 Before assisting with non-prescribed medications the person's MAR chart, Communication Log or Communication Sheet must be checked to see if anyone else has administered non-prescribed medications and that the recommended dose will not be exceeded. If in any doubt the appropriate contact should be contacted for advice.

4.13.7 The use of non-prescribed medication should be checked at each Review of the Care Package, or whenever there is a change of prescribed medication. Any changes should be noted on the Reviews/Amendments section of the NPM form.

4.13.8 Care Workers must not offer advice on non-prescribed medicines and remedies as it may be **DANGEROUS** to do so.

5. DISPOSAL OF UNWANTED MEDICINES

5.1 Out of date/Unused

5.1.1 Unused, out of date medication, or medication no longer required, must be returned to any community pharmacy, with the person's authorisation. Where there is no informal carer (e.g. a family member) who can be responsible for the return of medicines no longer required, the Care Worker must obtain approval of their appropriate contact to return the medicines to the pharmacy. Where the medication to be returned is listed on the MAR, the MAR chart should reflect medicines for disposal. Furthermore, it is good practice to receive a receipt of returned medication from the pharmacy. Details should also be entered in the person's Communication Log/Communication Sheet.

5.2 Disposal of Spoilt Doses

5.2.1 Where a single dose of medication has been removed from the container but is not used, it should be disposed of by placing in a suitable container, envelope or disposable glove and taking to the community pharmacy. Details of medication destroyed must be recorded in the person's Communication Log/Communication Sheet.

5.2.2 If the person requests that a spoilt dose is not destroyed (e.g. after having been dropped on the floor) and that the dose be administered, the details must be recorded on the person's MAR chart and the Care Worker should report the administration of the spoilt doses to their appropriate contact immediately. This situation may occur if the spoilt dose is the only dose remaining.

5.2.3 Where the person lacks capacity to decide the safety of taking a spoilt dose, the Care Worker should follow the guidance, dispose of the dose appropriately and report any problems to their appropriate contact.

5.3 Disposal of Sharps

5.3.1 Care Workers are not responsible for the disposal of sharps (syringes or needles). This applies to unused as well as used sharps.

6. PROBLEMS WITH ADMINISTERED MEDICINES

6.1 Drug Interactions

6.1.1 There is a possibility that two medicines taken at the same time may interact with each other. Both the GP and the dispensing pharmacist should be aware of this risk with prescribed medicines. However, there is also a risk of an interaction with non-prescribed medicines, certain foods (e.g. grapefruit) and alcohol. Therefore, Care Workers should remind the person of the potential for adverse effects of alcohol consumption whilst taking some medication. Where a known interaction exists between a medicine and alcohol, a warning should appear on the label of the medicine container.

6.2 Side Effects

6.2.1 Some medication causes side effects and the Care Worker should be alert to this possibility and report any concerns to their appropriate contact.

6.3 Adverse Drug Reactions – Yellow Card Reporting

6.3.1 An Adverse Drug Reaction (ADR) is an injury caused by taking a medication. ADRs may occur following a single dose or prolonged administration of a drug or can result from the combination of two or more drugs. The **Yellow Card Scheme** is the UK system for collection information on suspected ADRs to medicines. The scheme is intended to improve the safety of the medicines.

6.3.2 When necessary, the appropriate contact of the Care Worker or the Assessor/Care Manager should discuss any concerns relating to a person's medication with the supplying Pharmacist or the GP.

7. REFUSED MEDICATION

7.1 If a person refuses their medication, the Care Worker should consider waiting a short while before offering it again. They should ask about other factors that may cause the person to refuse their medicine. This must be reported to the Care Worker's appropriate contact immediately and should also be noted on the MAR chart and in the person's Communication Log/Communication Sheet. The person may need to have a further assessment and guidance should then be added to the Service Plan about what to do in this situation (if guidance has not already been given). The reason for ongoing or repeated refusal needs to be understood by discussion with the person in the first instance.

8. COVERT ADMINISTRATION (Appendix 11 – CQC Frequently Asked Questions: Covert Administration)

- 8.1 Covert administration is the term used when medicines are administered in a disguised format, e.g. in food, drink or via a feeding tube without the knowledge or consent of the person receiving them. As a result, the person is unknowingly taking a medicine. Every person has the right to refuse their medicine, even if that refusal appears ill-judged to staff who are caring for them.
- 8.2 Covert administration is only likely to be necessary or appropriate where a person actively refuses their medicine but is judged not to have the capacity (as determined by the Mental Capacity Act 2005 – see Glossary) to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing.
- 8.3 Covert administration of medicines should be a last resort and reasonable effort must be made to give medicines in the normal manner. Alternative methods of administration may be considered following discussion with prescriber. For example, liquid rather than solid dose forms may be considered.
- 8.4 Administering medicines in food or drink can significantly alter their therapeutic properties and effects so that they become unsuitable or ineffective. Pharmacist advice is always necessary.
- 8.5 Covert administration of medication should only be undertaken following an appropriate assessment to establish the person's capacity to make decisions. Decisions taken on the person's behalf should only be done in their best interest.

9. MAR CHARTS AND OTHER RECORDS

9.1 MAR Chart Service

- 9.1.1 Sheffield City Council commission a Medication Administration Record (MAR) Service from Sheffield community pharmacies.
- 9.1.2 Participating pharmacies will supply a MAR Chart for adults aged 18 and over in receipt of home care funded by the Council (including both in-house services and any organisation delivering services on behalf of the Council) who is assessed as requiring support at Level 2, i.e. where the Care Worker is responsible for 'removing medication from the container and directly administering' the medication.
- 9.1.3 A MAR Chart will not be required for individuals assessed as requiring support at Level 1 i.e. where the role of the Care Worker is to 'prompt and observe (the) person' taking medication (although the Care Worker is required to record the prompting and observation within the care log books).

9.1.4 It should be noted that some people may be independent with some medications, for example oral medications, but may need assistance with others, for example to apply (administer creams). A MAR Chart should be provided for any aspect of medication administration for which the person requires assistance at Level 2 from a Care Worker.

9.2 Recording Administration

9.2.1 When social care providers have responsibilities for medicines support, they should have robust processes for recording a person's current medicines. These should ensure that records are:

- Accurate and up to date
- Accessible, in line with the person's expectations for confidentiality

9.2.2 A MAR chart must be maintained by the Care Worker for each person who is receiving administration of their medication from a Care Worker.

9.2.3 The MAR chart must be made available to any visiting clinician or others who are authorised to administer medication e.g. paramedic.

9.2.4 The MAR chart and the person's Communication Log/Communication Sheet must be kept in the person's home in an agreed location. Both must be examined on each occasion the Care Worker attends the person's home, prior to administration. This is in order to note any changes in medication and to ensure that the medication has not already been administered.

9.2.5 The Care Worker must confirm that a dose has been administered by entering their initials or signature in the appropriate administration record box on the chart. Medication administered to a person must be recorded at the time of the administration. For time specific medication, the time of administration must be recorded on the MAR chart (where room permits) or on the Communication Log.

9.2.6 Where a MAR chart is not available, the medication administered should be recorded on the person's Communication Log/Communication Sheet. The Care Worker should inform their appropriate contact where this is happening so that arrangements can be made to provide a MAR chart.

9.2.7 A new MAR chart should be provided where practicable whenever there is an alteration to the medication prescribed. When this is not possible, the changes should be documented on the existing MAR chart by means of a new entry with the original being crossed through with a single line so as to still remain legible. The label on

the medicine container will need to indicate that there has been a change in dose and to refer to the MAR chart. These alterations should be signed and dated by the clinician or alternatively written authorisation should be provided. Any alterations to the MAR chart that cannot be shown as coming from an authorised source will not be administered without clarification as above.

- 9.2.8 There may be items prescribed for the person but dispensed by a different supplier e.g. stoma products. These will not be listed on the MAR chart but their application will need to be recorded on the communication records.
- 9.2.9 Similarly with Food supplements. These are not addressed by the Medication Policy but they should be treated as any other special diet, that is, the instructions would be clearly noted in the Care/Service Plan and should be followed by the Care Worker. Compliance with the instructions must be recorded in the person's Communication Log/Communication Sheet and/or MAR chart as applicable.
- 9.2.10 Although the Pharmacist should be asked for a new MAR chart when the repeat prescription is submitted for dispensing, there may be other medicines, such as 'when required' items, that are not on the prescription but still need to be on the MAR chart. The Pharmacist should be requested to put these on the new MAR chart for continuity.

10. STORAGE OF MEDICATION RECORDS

- 10.1 The current MAR chart should be kept in a safe place in the person's home. Where there are concerns about the safekeeping of the MAR charts or Care/Service plans, this should be reported to the Assessor, who will assess the risks and plan to minimise those risks. The arrangements for the safekeeping of papers and charts would be noted in the Care/Service Plan. The Care Worker or other appropriate person must send completed MAR charts to the Service Provider's branch or team office for storage on the person's file. In exceptional circumstances where there are two Service Providers, the main Provider shall with the consent of the person, take the chart for their own files and send a copy to the other Provider. If the person is assessed not to have capacity to consent, a best interests decision as to the sharing of information should be taken by the Assessor.

11. REPORTING ERRORS AND DISCREPANCIES

- 11.1 Errors occur when medication is not administered according to the instructions given. This may include:
- **Administering the wrong medicine**
 - **Administering the wrong dose**
 - **Omitting to administer the medication**
 - **Omitting to record**
- 11.2 Errors can occur and Service Providers should have clear incident reporting systems. However, the safety of the person is paramount and this should be the initial priority of the Care Worker and the care provider organisation. Staff must report all errors so that the Care Workers and the organisation learn from mistakes and prevent errors in the future.
- 11.3 Care Workers must not make a judgement on the impact that the error may have on the person. All facts must be clarified before action is taken. They should seek advice from the appropriate contact within their organisation. Advice should be sought from the appropriate clinician, e.g. the person's dispensing pharmacy, a late night pharmacy or the patient's GP.
- 11.4 Discrepancies must be investigated appropriately and a conclusion drawn as to the underlying cause. This may be an omission to record/administer. The discrepancy may also involve the loss of medication which may be due to theft and which must be reported to the police.
- 11.5 Drug errors must be reported regardless of who made the error or who it is perceived made the error where this has affected the person in their care.
- 11.6 There must be a proportionate response to errors that addresses the issue but it must be considered whether the reasons warrant the reporting to Adult Access as a safeguarding concern, i.e. whether or not the incident reported constitutes neglect.

12. TRANSFER OF CARE (SHORT OR LONG TERM)

- 12.1 When the person is transferred between services, the responsibility for the administration of medication is also transferred. Thus all medications and relating records must be transferred with them allowing the receiving administering Care Worker to continue safe practice. This includes transfer to secondary care.

13. DEATH OF THE PERSON

- 13.1 In the event of an unexpected death of the person, the coroner may request an examination of the person's medication. Therefore every attempt should be made to retain the person's medication which should be stored securely until a decision has been reached regarding inquest proceedings or a death certificate has been issued.

14. ADVICE TO PEOPLE ON MEDICAL ISSUES

- 14.1 It is the responsibility of the prescriber to explain the reason for the treatment and the likely effects (including side effects) of any medication prescribed to the person.
- 14.2 The prescriber makes a judgement on whether to explain to a person the nature of an illness and the implications of any treatment. This judgement must be respected by Care Workers.
- 14.3 Care Workers **MUST NOT** discuss or disclose a person's medical history or treatment to a relative or lay person. Any questions must be re-directed to the person, the person's Medical Practitioner, or the Care Worker's appropriate contact.
- 14.4 Care Workers should seek advice about medicines from people with specialist experience such as the prescriber, the Pharmacist (preferably at the person's regular pharmacy) or another health professional, when it is needed.

15. REVIEW OF THE MEDICATION POLICY

- 15.1 No policy or guide will cover every eventuality. In the event of uncertainty, staff will need to use common sense and seek appropriate advice and guidance. Such advice and guidance can be sought from an appropriate contact, the person's GP, the Pharmacist. Staff are requested to submit any comments on current procedure to their appropriate contacts.

There may be occasions where situations are not covered in this guidance. Please bring concerns you have to the attention of your appropriate contact.

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MEDICATION CHECKLIST FOR CARERS

1. You must **NEVER** involve yourself with the person's medication unless you have been asked to do so by the appropriate contact and the person has given authorisation. If the person is unable to give authorisation then the Assessor will arrange for a 'best interests' decision to be made and this will be noted in the Care/Service Plan
2. You must not fill Monitored Dose System cassettes, or put out medicines in advance in egg cups, saucers etc.
3. You must always administer medication in line with the correct procedure:
 - i. The MAR Chart and the Service Plan will be set up and kept in the person's home and should be examined on each occasion for any changes in medication;
 - ii. Check the MAR chart and the person's Log/Communication Sheet to ensure that the medication has not already been administered
 - iii. Select the medication required
 - iv. Check the name of the person, name and dose of the drug on the label
 - v. For medicines in MDS check the descriptions of the tablets or capsules and count doses (Count and Colours)
 - vi. Administer the medication
 - vii. Record the administration of medication by entering your initials in the correct date and time box on the MAR Chart (or record in the SU's Log/Communication Sheet if appropriate e.g. medicines administered from Monitored Dosage Systems.)
 - viii. Record on the MAR chart if medication is not taken, indicating the reason using the appropriate code on the MAR Chart
4. Under no circumstances should staff alter the labels on medication.
5. Medication should not be handled. Tablets and capsules should be shaken or tapped onto a spoon to prevent handling. Liquid medication should be measured using a 5ml medicine spoon or graduated medicine measure showing specific measurements to ensure the correct dosage is given.
6. The use of an oral syringe to measure and administer a dose of liquid may be advisable if a person has difficulty taking a liquid medicine from a spoon or medicine measure. Oral syringes are available from the Pharmacist on request (see paragraph 5.3.7).
7. Carers are not authorised to assist with the administration of certain types of medication (see paragraph 5.9.3).

Medication Authorisation Form

Appendix 2

Before completing the Medication Authorisation Form, the Provider must consider if the person (service user) is able to sign the form themselves and has the capacity to make the decision to do so, taking into account the following guidance:

Scenario	Considerations & Actions
A: Person has the capacity to make the decision and is able to sign the form.	Person decides if they wish to sign the form.
B: Person has the capacity to make the decision, but is unable to sign due to physical impairment.	The person is asked for verbal consent; a representative of the person's choosing (this may include the provider's assessor) may then sign the form on the person's behalf, documenting the reason for taking this action.
C: Person is deemed to lack capacity to make the decision (regardless of ability to sign).	<p>The provider's assessor should consider their own knowledge of the person, their circumstances, and any other relevant information, to determine if the person lacks the mental capacity to make the decision to consent to support with the administration of medication and the issuing of a MAR chart. A decision may be made by the assessor on behalf of the person where it is in their best interests to do so.</p> <p>Assuming support with the administration of medication and the issuing of a MAR chart is deemed in the person's best interest, the representative (this may include the provider's assessor) should sign the form on the person's behalf, documenting the reasons they have made this decision.</p>

Medication Authorisation Form

It was agreed at an assessment with a social worker or care manager that a home care provider will help to administer your medication.

To be read and completed by the service user or their authorised representative¹:

I give authorisation for care workers from my home care provider to assist with the administration of medication as prescribed by my GP or other authorised prescriber.

If applicable, I also give authorisation for my care workers to administer non-prescribed medication in accordance with the agreed non-prescribed list².

I understand that:

- Care workers can only administer medication recorded on the Medication Administration Record (MAR chart) at the prescribed level.
- Anyone who administers my medication, including, for example, my carer or a family member, will record the details on the MAR chart. Administration of any non-prescribed medication will be recorded in the home care provider's log book.
- My care workers will follow the guidance set out in the Sheffield Medication Policy.

I agree that:

- I will make available to my care workers / home care provider the MAR chart and any other records relating to my medication.
- I authorise my care workers / home care provider to communicate with my GP, pharmacy or any other prescriber about my medication and issues that arise.

¹ The form should only be completed by a representative of the service user by exception, for instance due to a physical or cognitive impairment.

² <http://www.sheffield.gov.uk/content/sheffield/home/disability-mental-health/medication-policy.htmlv>

- My details can be shared with my pharmacy to enable them to produce a MAR chart for use within my home.
- Where necessary I will give as full information as possible to my care workers / home care provider about my medication including what I have and have not taken.
- I will cooperate with my care workers / home care provider to enable them to safely administer my medication, ensuring that my medication is appropriately stored. I will also enable them to appropriately dispose of medication that is no longer prescribed, out of date or is spoilt and cannot be used safely.
- My home care provider will keep my MAR chart when it is completed for audit purposes.

NAME	
SIGNATURE	
DATE	

Please refer to pages 3 and 4 to see the information your home care provider will share with your pharmacy.

A Medication Authorisation Form is to be completed in full on the first occasion an individual requires support with medication administration as part of a home care package.

In the event a service user transfers to a new provider, the original Form remains valid. In the event of any changes, the pharmacy must be informed (see page 5).

All providers will adhere to the Sheffield Medication Policy when administering medication:
<http://www.sheffield.gov.uk/content/sheffield/home/disability-mental-health/medication-policy.html>

SERVICE USER NAME	
LAS ³ ID	
DATE OF BIRTH	
ADDRESS	
CONTACT TELEPHONE NUMBER	
If there is another individual(s) i.e. carer or family member who it is more appropriate to contact, please detail below:	
NAME	
RELATIONSHIP TO SERVICE USER	
CONTACT TELEPHONE NUMBER	
NAME	
RELATIONSHIP TO SERVICE USER	
CONTACT TELEPHONE NUMBER	
GP	
SURGERY	
NOMINATED PHARMACY	
HOME CARE PROVIDER	
CONTACT TELEPHONE	
DATE SERVICE TO COMMENCE	

³ Previously known as CareFirst number until Sheffield City Council IT system change on 08/10/18.

MEDICATION LEVEL ⁴ (as per support plan)	
MDS (NOMAD) TO BE USED ⁵ (please ✓)	
THE SERVICE USER REQUIRES SUPPORT WITH (please ✓ applicable boxes):	
	ALL MEDICATIONS
	CREAMS
	PATCHES
OTHER (please state):	

NAME OF STAFF MEMBER COMPLETING FORM	
ROLE	
SIGNATURE	
DATE	

The Form must be completed by the home care provider at the point of undertaking the initial assessment with the service user and sent to the specified pharmacy and the service user's GP by one of the following methods:

- In person
- Fax
- Post

The pharmacy will only supply MAR charts upon receipt of a fully completed Form.

The home care provider will ensure a copy of the Form is retained in the following locations:

- The service user's file in their property
- The service user's file at the provider's local office

To be completed by the Pharmacy:

NAME	
ROLE	
SIGNATURE	
DATE OF RECIEPT	

⁴ Pharmacies will supply a MAR chart for adults aged 18 and over in receipt of home care funded by the Council (including both in-house services and any organisation delivering services on behalf of the Council) who is assessed as requiring support at Level 2, i.e. where the Care Worker is responsible for 'removing medication from the container and directly administering' the medication.

⁵ Monitored Dosage Systems (known as a NOMAD) should only be used by exception where an individual requires support at Level 1. The pharmacist will supply a separate, standardised MAR chart for the care worker to record administration of medication from the MDS.

REVIEWING & UPDATING THE AUTHORISATION FORM

In the event that any of the details on the form change, the home care provider will inform the pharmacy at the earliest opportunity, recording the details in the box below:

DESCRIPTION OF CHANGE	DATE PHARMACY INFORMED	METHOD	SIGNATURE

The home care provider will review the content of the form at least annually, as part of their formal review of the individual's care package, informing pharmacy as described.

	DATE	SIGNATURE
Review 1		
Review 2		
Review 3		
Review 4		

ENDING THE SERVICE

The home care provider must inform the pharmacy when they no longer require a MAR chart for this service user by completing the following table and returning the form to the pharmacy via one of the methods described on page 4:

SERVICE USER NAME	
LAS ID	
DATE OF BIRTH	
POSTCODE	
Please ✓ the reason that a MAR chart is no longer required for this service user:	
INDEPENDENT WITH MEDICATION	
HOSPITALISATION (LONG TERM)	
ADMISSION TO CARE HOME	
DECEASED	
OTHER (PLEASE STATE):	

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Non-Prescribed Medication

Copy and keep with all copies of the Service User's Authorisation Form

To be completed by Assessor or Care Worker's Line Manager

The Good Practice Guide permits carers to assist persons with the administration of non-prescribed medication providing that advice has been taken from the person's Doctor or Pharmacist checking that it is suitable and does not affect any medication the person is already taking. Where the person lacks capacity, information should be sought from their family, carer, LPA, advocate or whoever has the required information.

The person should be asked the following questions in relation to non-prescribed medication:

- Do you take any medicines that are not prescribed for you by your doctor?
(or dentist/nurse prescriber/pharmacist prescriber) Yes No

- If Yes: Do you take non-prescribed medicines Regularly? Yes No
- Occasionally? Yes No

- What non-prescribed medicines do you take **regularly**, (e.g. vitamins, herbal products)

Regular Medicine	Recommended dose	Dosage interval	Maximum dose in 24 hours	Authorised Yes / No	Authorised by GP or Pharm

- What non-prescribed medicines do you take **occasionally** (e.g. Paracetamol for pain relief, dioralyte for diarrhoea, E45 Cream / Aqueous Cream for dry / itchy skin)?

Occasional Medicine	Recommended dose	Dosage interval	Maximum dose in 24 hours	Authorised Yes / No	Authorised by GP or Pharm

N.B: Indicate against each medicine listed if the continued use of the non-prescribed medicine has been approved by the Service User's GP or Pharmacist. The doctor should be requested to prescribe all medicines taken on a regular basis (if available on an NHS prescription)

Name of Assessor/Line Manager

Name of GP

Name of PharmacistDate

If you have concerns about any aspect of the person's medication you must speak first to the Pharmacist.

Any changes should be noted on the continuation sheet by Appropriate Contact

Reviews / Amendments of Non Prescribed Medication

Details	Entered By	Signature	Date

Getting Help with Your Medication at Home



Information for you and for other people who are helping you to take your medicines

If you need help to take your medicines an assessment will be made of your existing medication capabilities and your needs. Following your assessment the Assessor may arrange for care workers to help you as part of a care/service plan. Your Assessor will also need to record anyone else such as relatives, friends or others who might also be helping you to take your medicines. Everybody who is helping you needs to read this leaflet to make sure you are given your medicines safely.

Your Assessor will ask you for your permission for the care workers to give you your medicines. If it is difficult for you to give your permission or make decisions about your medicines you can ask someone else to help you decide. If you don't have anyone to do this or anyone to act on your behalf your assessor will make sure the arrangements made are best for you.

Your Assessor will need the name and address of your regular pharmacy (chemist shop) and doctor's surgery so that both the pharmacist and GP know you are receiving help. Your chosen pharmacy may provide you with a Medication Administration Record (MAR). This record must be kept with all of the medicines you are taking. Everybody who is helping you, including friends or family, must check this record before they give you any medicines and they must record any medicines that you have taken. This is to make sure you are given the correct medicine at the correct time.

All of your medicines must be kept in their original containers; it is not safe to transfer them into dosette boxes or similar appliances.

It's safer if you get all your prescriptions and non-prescription medicines from the same pharmacy. (Non-prescription medicines include herbal remedies or medicines you can buy over the counter, e.g. cough syrup.) If a relative, friend or anyone else gives you any medicines that are not prescribed for you, they should make sure it is safe for you to take by asking your G.P. and/or Pharmacist. You should inform the carer as well as recording these kinds of medicines on your communication records so others who are helping you know what medicines you are taking.

If you or anyone who is helping you has any concerns about your medication, or any side effects, your G.P. and/or pharmacist should be contacted.

If you have any questions about your care speak to your Assessor or Care Worker in the first instance. They will help you to contact the most appropriate person or service to help you.

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GUIDANCE FOR DAY SERVICES

1. All medication brought into Day Service or short stay establishments by or for the use of persons must be in original or dispensed containers labelled with the name of the person and administration details.
2. Persons who self-administer their medication must provide the Manager with details of the medication that they bring into the building; this will be shared with the appropriate worker and recorded in the person's notes and care/support plan.
3. **Persons transported to the facility by an escort**
 - i. Where the person is transported to the Day Service or short stay service accompanied by an escort the escort should advise the person to bring all necessary medication with them.
 - ii. All medicines must be in appropriately labelled containers (original packs or dispensed containers labelled with dosage instructions and person's name).
 - iii. The escort will make a note of all persons bringing medication into the service by recording this on the register. On arrival at the service this information will be passed onto the staff member so that they can ensure that the medication is present and made secure.
 - iv. Escorts will ensure that any medication transported is kept in a safe place i.e. in the person's bag, not in the persons hand or pocket.
4. **Independent travel by a person – unescorted**
 - i. The person should be requested at the initial assessment, to bring all necessary medicines that they will require during the day to the service on each occasion that they attend.
 - ii. All medicines must be in appropriately labelled containers. (Original packs or dispensed containers labelled with dosage instructions and person's name).
5. The administration of medication in day services should be recorded in the person's daily record and on the Day Services medication administration record, which will have a photograph of the person.
6. The safe keeping of medicines in day service should be considered, if a person self-administers then a lockable room or cupboard should be allocated for them to store their medication to safeguard from others. If the person is unable to self-administer their medication will be stored in a lockable facility by the staff on duty.

7. Day Service staff accredited to administer person's medication will be familiar with all sections of this guidance and comply with the guidance outlined in it.
8. The assessment for self-administration will be undertaken by the accommodation service or carer and will be communicated to day services, who will place in the person's day service file. However monitoring of this will still take place and any concerns communicated to the relevant service/carer.
9. On arrival at the day service you should check with the escort on signing the register which person has brought in medication. Where the person travels independently this should be checked with them on arrival.
10. The medication should be checked with details in the person's plan of care and Day Services medication administration record, any discrepancies should be checked with the person's carer.

GUIDANCE ON TRANSCRIBING MEDICATION DETAILS ONTO MAR CHARTS FOR PROVIDERS⁶

INTRODUCTION

Care workers must record the medicines support given to a person for each individual medicine on every occasion, in line with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This includes details of all support for prescribed and over-the-counter medicines, such as:

- Reminding a person to take their medicine
- Giving the person their medicine
- Recording whether the person has taken or declined their medicine.

Care workers should use a Medication Administration Record (MAR Chart) to record any medicines support that they give to a person. This should ideally be a printed record provided by the supplying pharmacist; however, there may be occasions when the MAR Chart will need to be produced by the provider.

The MAR Chart must be accurate and up to date and the provider should have robust processes to ensure this. Any new records, additions or changes should only be made and checked by people who are trained and assessed as competent to do so. Such transcribing should only be undertaken by a person who has been deemed competent by appropriate person.

Circumstances when transcribing is required include:

- The person's pharmacy does not supply a MAR Chart;
- There has been a planned discharge from hospital and the medication has changed (current MAR Chart does not reflect changes);
- Medication has been prescribed during an interim visit e.g. the service user has been prescribed antibiotics.

Medical advice must be sought before medicines are transcribed or administered if there are concerns about the safety of transcribing:

- Due to the quality of the information available
- A discrepancy between the information and the medication provided
- Any additional medicines (e.g. bought over the counter or herbal medications) not listed in the medication source⁷

This should be documented in the person's notes.

⁶ Managing medicines for adults receiving social care in the community
(<https://www.nice.org.uk/guidance/ng67>)

⁷ Non-prescribed medicines must be recorded on the 'Non-prescribed Medication Form':
<http://www.sheffield.gov.uk/content/sheffield/home/disability-mental-health/medication-policy.html>

TRANSCRIBING PROCESS

The appropriate, competent member of staff should carefully transcribe the details onto the MAR Chart using one of the following, listed sources:

- An original prescription signed by a prescriber from primary care, which may be the right hand side/counterfoil of the current prescription;
- A secondary care discharge prescription or outpatient prescription.
- A printed or written record obtained from the service user's GP detailing current prescribed medication;
- The pharmacy label on the current medicine container/box;
- A copy of the current MAR Chart from the previous care setting.

Where the pharmacy label on the medicine container/box is used there must be a check to ensure that the medicines are current and 'fit for purpose'. The label on the packaging must be clear and unambiguous and includes all of the following:

- The service user's name (checking that this is the correct person);
- The name of the medicine inside the packaging (also checking that it matches the medicine named on the label);
- The expiry date of the medicine (checking that this has not been exceeded);
- All directions are clear and legible.

The above medication details must be transcribed onto the MAR Chart. All information must be printed or handwritten legibly in ink and must meet the following requirements:

- The person's full name and date of birth should be clearly written on all MAR Charts.
- All medicine names and instructions must be written in full as printed on the label or from other source. Any ambiguity in the instructions must be checked.
- The following medication details must be stated:
 - Name of the medicine
 - Form e.g. tablets, capsules
 - Strength (NB pay attention to **milligrams/ micrograms**)
 - Dose and frequency
 - Route of administration
 - Time of administration
 - Duration of treatment (if known or applicable)
- Any special instructions and advice labels e.g. take with or after food, disperse in water, may cause drowsiness, should be included
- Any advice label or warnings, that cannot fit on the MAR Chart should be highlighted, for example, by adding ****see advice on the pharmacy label****

- The transcriber must sign and date against each item and print their name along with their signature on the back of the MAR Chart
- If a service user needs more than one MAR Chart, each Chart should be clearly marked sequentially on the front 1 of 2, 2 of 2 etc.
- Details of any allergies or intolerances must be stated in the space indicated. If none are known record 'Not known'.
- The quantity of each medication received should be recorded.

Attach the medication source, where applicable, to the MAR Chart to allow the GP or others to check. The person's care plan must be documented identifying that the MAR Chart has been transcribed, listing the medicine sources used and the date of the source. Alternatively, document the source, for the GP to check, saving a hard copy in the patient's file.

If informed verbally by the prescriber of any dose change or if a medication is stopped, then the MAR Chart must be altered accordingly and checked by another member of staff. The changes must be recorded as a new entry. The original entry must not be altered, instead it should be crossed through (with a single line) stating "See new entry" and include the date of the change. Furthermore, the pharmacy label will need to be marked "See new directions on MAR".

Written confirmation of the change must be requested from the prescriber to verify this and retained with the person's records.

TRANSCRIBING VARIABLE DOSES (E.G. PARACETAMOL)

Most MAR Charts provide insufficient space to record the administering information for variable doses. For this reason the carer's notes or a dedicated "Pain Relief Record Book" should be used by the carer to record all details of administration. These details should include the following:

- Quantity administered
- The time of administration
- Reason for administration (e.g. back pain)

TRANSCRIBING WARFARIN (ANTICOAGULANT)

The MAR Chart must contain the following information:

- Person's name and date of birth
- Date the warfarin commenced
- Current dose, in milligrams (**not** number of tablets) stating planned daily dose regime until next INR test
- Time of day the dose is to be given
- Date of next INR test
- Two signatures which confirm that the current daily dose regime has been checked against the clinicians instruction

CHECKING

The transcription **must** be checked by a second competent member of staff as soon as possible. The 'checker' must ensure that the original source of information matches the transcription. The 'checker' must sign and date against each item and print their name along with their signature on the back of the MAR Chart.

Medical advice must be sought if any discrepancy cannot be resolved between the transcriber and checker.

REMOTE CHECKING

It may not always be possible for a member of staff to witness 'live' the transcribing such as when the MAR Chart is being amended in the person's home by a care worker working alone. In such cases the carer can use a work mobile phone or tablet device to photograph the amendments and the listed source. The consent of the person should be obtained. This evidence can be transmitted to the person witnessing the accuracy of the transcribing, and who may be based at the office.

Note that any information stored on a mobile device must be deleted as soon as possible.

CARER ADMINISTERING TRANSCRIBED MEDICINES

If there is any uncertainty regarding accuracy or appropriateness of transcribed medicines then clarification should be sought immediately. The carer must seek clarification from the transcriber. If there is still uncertainty, advice must be sought from the GP or the dispensing pharmacy. If none are available the carer should contact 111 for advice

Warfarin - Information for Carers of Persons on Warfarin

Background

Warfarin is being used in the management of increasing numbers of patients and conditions including patients with atrial fibrillation (irregular and often abnormally fast heart rate), Deep Vein Thrombosis (a blood clot that develops within a deep vein in the body, usually in the leg) and other disorders. While it is a very effective drug in these conditions, it can also have serious side effects, e.g. severe haemorrhage (bleeding). These side effects are related to the International Normalised Ratio (INR) level, which measures the delay in the clotting of the blood caused by the warfarin. While the 'normal' INR is 1, the specific range of INR values depends on the disease and the clinical conditions. Warfarin monitoring aims to stabilise the INR within set limits to help prevent serious side-effects while maximising effective treatment.

Notes for Carers

People can have their blood tested at the hospital, their surgery or at one of four participating community pharmacies.

- All persons taking warfarin are provided with a letter detailing their daily dosing schedule which is valid until the next INR blood test is taken and reviewed by the clinician. This letter is usually faxed to the care provider managing the person's care though it may be given to the person. In some cases, though not common, the dosing schedule is entered in a 'yellow' anticoagulation booklet.

- In readiness for the INR blood test the person or carer should fill in the questions at the bottom of the last dosing letter and give the slip to whoever is taking the blood sample. This information is extremely important for determining persons' warfarin doses and includes the following:
 - Has the person experienced any signs of bleeding or bruising?
 - Is the person planning any dental or other surgery?
 - Has the person followed their advised dosage instructions?
 - Has there been a change in the person's other medications or dietary habits since their last test?

- If there is an unexpectedly high or low INR and no information provided to explain it, then the clinician performing the test will need to contact the care provider to find out more before deciding the dose of warfarin.

- **Dose instructions will normally be faxed to the care provider before 5pm on the day of the INR blood test.** Please do not panic if you haven't received a fax before this time. There are some occasions when anticoagulation clinic staff work beyond 5pm. (For persons who has their dosing performed by the Royal Hallamshire Hospital.)
- **If the dosing instruction has not been received by 5pm you should give the same dose as was on the previous dosing instructions** for the appropriate day and follow the new instructions when they are received.
 - If a fax is not received the next day, you should telephone the Anticoagulation Clinic, Surgery or testing pharmacy on the next working day.
 - Over the weekend, the GP Out-of-hours Collaborative can use the "ICE" system to see what dose has been specified by the Anticoagulation Clinic.
- Please look out for boost/miss(omit) instructions ["Take xxmg for xx day(s)" or "Miss xx days"] above the main box of weekly dose instructions. These are one-off doses to correct a low or high INR more quickly, and should be taken on the day the dosing instruction is received, unless a date is specified.
- People who take warfarin are likely to bruise or bleed more easily. Bleeding from minor injuries (e.g. cuts, scrapes & nosebleeds) should stop within 15 minutes.
- Please complete an incident report/concern form if any person is discharged from hospital without written instructions for their warfarin dosing.
- If the person is discharged to another care provider or starts to manage their own Warfarin please advise the Anticoagulation Clinic on the numbers below in order that we can amend our records.
- Should you receive a fax for patients who you are no longer involved with again please advise the service (**STH Anticoagulation Clinic, surgery or pharmacy**).

STH Anticoagulation clinic phone lines are open Monday to Friday 9am to 3.30pm – 0114 2713820. The clinic staff work until 5pm and urgent calls between 3.30pm and 5pm can be made through the switchboard on 0114 2711900. Non-urgent queries should wait until the next working day.

Tallulah Test 13
D.O.B: 10/02/2016

ACCT13
Date of INR: 10/11/2016


INR: 2.5

Your Warfarin dose instructions (DOSE IN MILLIGRAMS PER DAY) FOR EACH DAY OF EVERY WEEK ARE AS FOLLOWS:

Warfarin	Mon	Tue	Wed	Thu	Fri	Sat	Sun
mg	5	5	5	5	5	6	6

Continue on this dose until you receive your next set of dosing instructions.

Previous Instructions

Date	INR	Dose	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Anticoagulant:	Warfarin
21/10/2016	2.5		5	5	5	5	5	6	6	Diagnosis:	Atrial Fibrillation
11/10/2016	2.5		5	5	5	5	5	4	4	Target INR Range:	2.0 - 3.0 (2.5 Target)
										Start Date:	08/06/2015

Tallulah Test 13 ACCT13

Your next appointment date is on **17/11/2016**. If you think you will have difficulties getting to this appointment please contact us on 0114 271 3820.

Example Dosing Letter

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Administration of Midazolam Oral Liquid (Epistatus^{®8} or Buccolam^{®9})

INTRODUCTION

Midazolam is a short-acting benzodiazepine. Buccal midazolam is used as an alternative to rectal administration of diazepam in the treatment of potentially life threatening tonic-clonic seizures, which are likely to progress to status epilepticus.

There are two products, Epistatus[®] and Buccolam[®]. Both are midazolam oral liquid supplied in an oral syringe to be administered by the buccal route. They are usually prescribed as “as required” (PRN) medication for emergency treatment. As neither product is licensed for adults (only for children) they must be prescribed on a ‘named patient only’ basis.

What is the buccal route?

The buccal route is where a medicine is placed against the sides of the gums and cheeks. The medicine is absorbed directly into the bloodstream. The medicine does not need to be swallowed, but if swallowed accidentally will cause no harm.

Staff may only administer the liquid form of this medication which is administered through a syringe (*without a needle*) after training by a competent epilepsy liaison nurse or epilepsy nurse consultant.

GUIDANCE FOR THE USE OF BUCCAL MIDAZOLAM

(Adapted from Learning Disability Service 2015)

The following guidance MUST be followed when using Buccal Midazolam.

1. A copy of the individual seizure management plan, signed by the consultant neurologist has been completed and attached to the care/service plan.
2. As the product is not licensed the person must be allowed to make an informed choice around the use of Buccal Midazolam. An assessment must have been done using the Mental Capacity Act key principles.
3. All staff who will potentially administer Buccal midazolam must have received training from the epilepsy liaison nurse or epilepsy nurse consultant. The staff members competent to administer buccal midazolam must receive an annual update of the training by epilepsy liaison nurse or epilepsy nurse consultant.
4. This training must include:
 - a. Epilepsy awareness
 - b. Knowledge of midazolam including contra indications, drug interactions and side effects
 - c. How to deal with problems in the use of this drug
 - d. Administration technique to include both Epistatus[®] and Buccolam[®] since pharmacy may have supplied either preparation
5. The staff member must be deemed competent to administer buccal midazolam by the specialist delivering the training and certified to administer.

⁸ Epistatus[®] Patient Information Leaflet: <https://www.medicines.org.uk/emc/files/pil.2679.pdf>

⁹ Buccolam[®] Patient Information Leaflet: <https://www.medicines.org.uk/emc/files/pil.2768.pdf>

6. The staff will be trained to administer buccal midazolam to a named person following an individual management plan*; it is not transferable to another person. If they are to administer to more than one person training must be given around each individual.
7. All staff administering the Buccal Midazolam must have Basic Life Support training annually

***INDIVIDUAL MANAGEMENT PLAN**

The individual management plan must include the following:

- Name of individual
- Seizure classification / description
- Possible seizure triggers
- Possible seizure warning signs
- Usual duration of seizure
- Usual recovery from seizure
- When buccal midazolam should be administered
- How much is to be given
- What the usual reaction is (If not known to be documented clearly after first use)
- Whether a repeated dose can be given or NOT
- Time interval for a repeat administration
- Maximum amount of buccal midazolam in a 24-hour period
- When buccal midazolam should not be administered
- Emergency services **MUST** be called on the very **FIRST** administration of Buccal midazolam
- After first administration the carer must document tenants reaction to the medication and when the emergency services would need to be called.
- Other people to be contacted (if appropriate)
- Signed by the prescribing Consultant Neurologist
- The seizure management plan should have an expiry date of no longer than six months, to ensure it is reviewed
- Each administration of buccal midazolam must be recorded with details of the seizure, its duration, the time of administration of the medication and the effects of the medication following administration.

Administration of Drugs via Enteral Feeding Tubes

Adapted from Sheffield Teaching Hospitals Nutrition Handbook

DRUG FORMULATIONS

Preferred Formulations:

- Liquids or soluble tablets are the preferred formulations to be administered via an enteral feeding tube.
- Crushing tablets or opening capsules should only be considered as a last resort and should be discussed with a pharmacist first.

Crushing tablets or opening capsules is generally an off-license activity. Therefore, the prescriber and pharmacist may be professionally accountable for any adverse effects resulting from such administration.

It is safe and reasonable for tablets to be crushed or capsules opened providing that a licensed alternative is not available and the formulation remains effective.

The NEWT Guidelines for administration of medication to patients with enteral feeding tubes or swallowing difficulties provides a useful resource and should be accessed. Another useful resource is the Handbook of Drug Administration Via Enteral Feeding Tubes by Rebecca White and Vicky Bradnam.

GUIDANCE FOR CARER

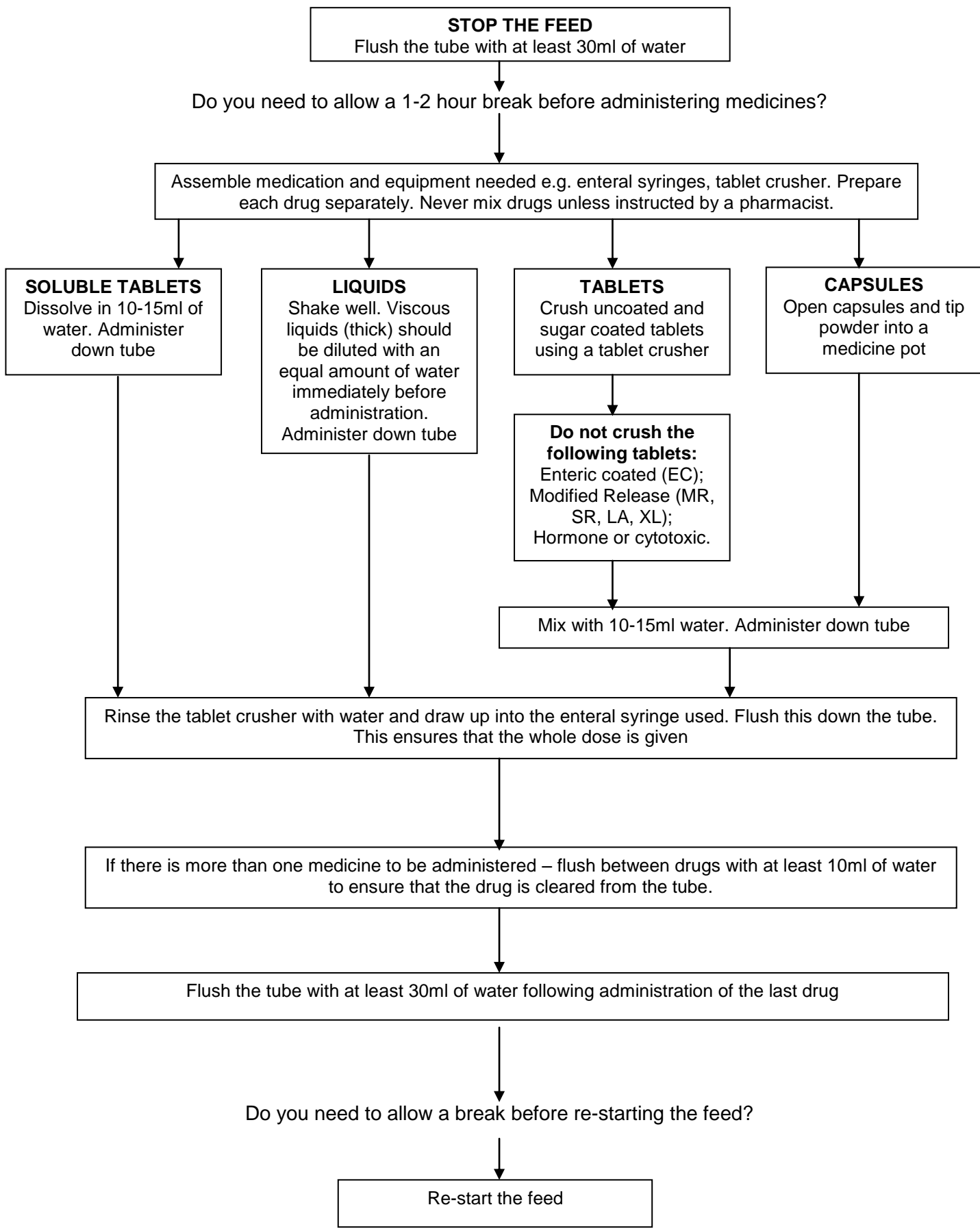
- Do not add medication directly to the feed
- Seek further advice for fluid-restricted patients as flushing volumes may need to be reduced
- Only use enteral syringes intended for enteral use which cannot be connected to any parenteral lines (Injections)

DRUG AND FEED INTERACTIONS

Interactions between feeds and drugs can cause complications. Where possible administer the dose during a break in the feeding regime to minimise complications.

Examples of Problem Drugs

- **Phenytoin and carbamazepine:** Feed should be stopped for 2 hours before and after administration of the medication. The patient's drug levels will need to be monitored regularly.
- **Digoxin:** Blood levels may be affected by feeds with high fibre content. Feed should be stopped for 2 hours before and after administration of the medication. The patient's drug levels will need to be monitored regularly.
- **Warfarin:** Vitamin K in some feeds can reduce the effect of warfarin and other anti-coagulants. Feed should be stopped for 1-2 hours before and after administration of the medication. Changes in the formulation of the feed should be avoided. The patient will need their INR to be monitored whenever there is any change with feeds such as enteral feeding is started, changed or discontinued.
- **Antacids:** The metal ions (Calcium, aluminium, sodium) in the antacids bind to the proteins in the feed and can block the tube.
- **Penicillins:** Feed may reduce the absorption. If possible feeds should be stopped for 1-2 hours before and after administration of the medication.
- **Other antibiotics:** Levels of antibiotics such as ciprofloxacin, tetracycline and rifampicin can be significantly reduced by feed.



Care Quality Commission – Resources for Adult Social Care

Frequently Asked Questions: When required (PRN) medicines

Background

Medicines with a 'when required' dose (PRN) can be prescribed to treat short term medical conditions (such as nausea and vomiting) or long term conditions when people experience "flare-ups" such as reliever medicines for people with asthma. Other common examples include medicines for pain, indigestion, anxiety and insomnia.

Care plans and medicines rounds

A care plan should contain enough information to support staff to administer PRN medicines as the prescriber intended. This should include:

- details about what the medicine is for
- symptoms to look out for and when to offer the medicine
- whether the person is able to ask for the medicine or if they need prompting or observing for signs of need, for example non-verbal cues.
- When the medicine should be reviewed and how long the person is expected to take the medicine
- Where there is more than one option available, for example multiple painkillers, the order in which they should be tried should be made clear. For example, paracetamol first, then codeine if pain not resolved.

This information should ideally be kept with the Medicines Administration Record (MAR). When required care plans should be person centred and detail how the medicine is to be offered, including outside the normal medicine round and what record will be made. For example, GTN spray which is used occasionally for chest pain in angina may be recorded just when it is needed. Pain relief which is assessed at each medicine round may be recorded each time it is assessed or only when given, depending on the requirements laid out in the care plan.

Administration

There should be a care home policy for when required medicines which includes:

- the reasons for giving the 'when required' medicine,
- how much to give if a variable dose has been prescribed,
- what the medicine is expected to do,
- the minimum time between doses if the first dose has not worked
- offering the medicine when needed and not just during 'medication rounds',
- when to check with the prescriber if there is any confusion about which medicines or doses are to be given,
- recording 'when required' medicines in the resident's care plan.

When required medicines would normally be kept in their original packaging.

People should be offered medicines in a person centred manner, at the times they are experiencing the symptoms, not just at medicines rounds or times printed on MAR charts. The exact time the medication was given and the amount given should be recorded.

If PRN medicine is given regularly then a referral to the prescriber should be considered for a medicines review, as their treatment may need to be altered.

If medicines do not have the expected effects (such as effective pain relief) the prescriber should be contacted.

Responses from prescribers about queries to medicines should be clearly recorded.

Important points to consider

- Does the medication policy and procedure cover the administration of PRN medicine?
- Do care plans provide detailed information on medicines prescribed PRN?
- Do staff understand what the medicines are for?
- Do staff know when to give the medicine or ask the person if they need it? Do they know what symptoms to look out for? Is the maximum amount to be given in a day or the time to leave between doses recorded?
- Are PRN medicines given regularly? If so, has a medicines review taken place?
- Are accurate records of administration made?
- Are PRN medicines held in suitable quantities and within their expiry dates?
- Is a person centred approach undertaken - offered the medicine at times other than the usual medication rounds?

Quality Assurance

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Date Prepared:	Date of check:
March 2017	03 May 2017

Sheffield Guidance on Covert Medication and Deprivation of Liberty

Introduction

Following a recent Court of Protection judgement: (AG v BMBC & Anor [2016] <http://www.bailii.org/ew/cases/EWCOP/2016/37.html>) (the “BMBC case”) concerning covert medication, Deprivation of Liberty and the Mental Capacity Act, NHS Sheffield CCG has adapted this guidance from one issued by the Calderdale Safeguarding Adults Board. The case will be of interest to all professionals who work in the provision of care, particularly health professionals, care home and homecare staff and social workers.

This guidance should be read in conjunction with the Mental Capacity Act 2005, the Care Act 2014, Care and Support Statutory guidance, Human Rights Act 1998, your agency’s covert medication policy, Advance Decisions policy, the court judgement above, and the NICE Guidance on covert administration:

<https://www.nice.org.uk/guidance/qs85/chapter/Quality-statement-6-Covert-medicines-administration>).

What is Covert administration?

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. (NICE guidance).

Patients with swallowing difficulties may need medication administered with soft food. Administering medication in this way would not be considered as covert if the patient is fully aware and has consented to having their medication administered in this way.

When can covert medication be used?

Covert medication should only be used in exceptional circumstances and when deemed necessary and in accordance with the Mental Capacity Act. This means that only those people who have been subject to an assessment of their capacity to consent to taking medication and have been deemed to lack capacity. Medication should not be administered covertly until after a best interest meeting has been held, unless in urgent circumstances.

A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life. Therefore, care staff must respect a competent adult’s refusal as much as they would his or her consent. Failure to do so may amount not only to criminal offence, but also to a breach of their human rights.

Who is responsible for carrying out the capacity assessment?

MCA Code of Practice states *“If a doctor or healthcare professional proposes treatment or an examination, they must assess the person’s capacity to consent... But ultimately, it is up to the professional responsible for the person’s treatment to make sure that capacity has been assessed.”* Other practitioners and carers retain a responsibility to participate in discussions about this assessment.

The process of assessment

For the purposes of assessing capacity to consent to taking or refusing medication there is a need to firstly establish that a person is unable to make a decision because of an impairment of or disturbance in the functioning of the mind or the diagnostic test. This clinical diagnosis provides the justification for proceeding. The second stage of assessment can only proceed if the answer to the first stage is “yes”.

The Functional Test:

The elements of the functional test are found in s.3(1) MCA 2005, which states that the person is unable to make a decision for himself if he or she is unable:

- To understand the information relevant to the decision; or
- To retain that information; or
- To use or weigh that information as part of the process of making the decision; or
- To communicate his decision (whether by talking, using sign language or any other means).

Note that if the person cannot do one or more of the above they will lack capacity for the decision to be made.

What are the specific issues in a mental capacity assessment regarding consent to medication?

The Mental Capacity Act states that a person is presumed to have capacity to make a decision unless it is demonstrated otherwise (by means of a mental capacity assessment).

For a decision relating to consent to take medication this means the person must:

- Understand in simple language what the treatment is, its purpose and why it is being prescribed,
- Understand and weigh up its principle benefits, risks (such as side effects) and alternatives,
- Understand and weigh up in broad terms what will be the consequences of not receiving the proposed treatment,
- Retain the information for long enough to make an effective decision, or communicate their decision in any form.

Where an individual cannot demonstrate an understanding of one or more parts of this test, then they do not have the relevant capacity at this time.

Advanced Decision to Refuse Treatment

In some cases the person may have indicated refusal at an earlier stage, while still competent, in the form of an Advanced Decision to Refuse Treatment. Where the person’s wishes are known, staff should respect them, provided that the decision in the Advanced Decision to Refuse Treatment is clearly applicable to the present circumstances and there is no reason to believe that the person has changed their mind. This is an important and complex issue and you should follow your agency policy on Advance Decisions. **Note this must not conflict with an authority given to an attorney under lasting power of attorney for personal welfare.**

Best Interest Decisions

In circumstances where there is evidence to rebut the presumption of capacity to make decisions regarding the refusing of medication, a capacity assessment should be undertaken in respect of the individual. If the individual has been assessed to lack capacity to understand the consequences of refusing their medication then a decision to give medication covertly must not be made prior to a best interest meeting.

The Best Interests meeting should involve all relevant people and must include the persons' attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney. Where the individual has no legally appointed representative, then regard must be given to the MCA Code of Practice and Care and Support Statutory guidance in respect of ensuring the individual has independent support with the decision making process.

'Best interests' is a method for making decisions which aims to be objective. It requires the decision makers to think what the 'best course of action' is for the person. It should not be the personal views of the decision-makers. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them. Decisions made by the person in the past when they were more insightful should also be considered where relevant to the decision.

Nice Guidance states that ***“The purpose of this meeting is to agree whether administering medicines without the person knowing (covertly) is in the person's best interests. A best interests meeting should be attended by care staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the person (this could be a family member, friend or independent mental capacity advocate depending on the person's previously stated wishes and individual circumstances). If the person has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.”***

The Mental Capacity Act 2005 provides a checklist which must be followed when making a decision for someone.

Summary of best interests checklist (see Mental Capacity Code of Practice)

- Consider all the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision - **and**
- Consider a delay until the person regains capacity - **and**
- Involve the person as much as possible - **and**
- Not to be motivated to bring about death - **and**
- Consider the individual's own past and present wishes and feelings - **and**
- Consider any advance statements made - **and**
- Consider the beliefs and values of the individual - **and**
- Take into account views of family and informal carers - **and**
- Take into account views of Independent Mental Capacity Advocate (IMCA) or other key people - **and**
- Show it is the least restrictive alternative or intervention

If it is agreed that the administration of covert medication is in the person's best interests, this must be included within their medical records and their care/service plan. There must be a

clear management plan, including details of how the covert medication plan will be reviewed. This documentation must be easily accessible on viewing the person's records.

If the medication relates to serious medical treatment or chemical restraint and the best interests meeting does not reach agreement, then legal advice should be sought as a last resort in relation to placing the matter before the Court of Protection (COP) for the Court to make the decision. In cases where restraint is an issue consideration may be given to an application for a DoLS authorisation.

Following a Best Interests decision to give covert medication

Following or as part of the best interests meeting NICE suggests ensuring *“that need for continued covert administration is regularly reviewed”* To achieve this NICE suggests the creation of a covert medication management plan, that would include the following:

- Medication review by the GP.
- Medication review by the pharmacist to advise the care provider how the medication can be covertly administered safely.
- Clear documentation of the decision of the best interests meeting.
- A plan to review the need for continued covert administration of medicines on a regular basis. (Important note: If a person regains capacity, medication should not continue to be given covertly. Person should be assessed prior to each administration to ascertain if they have the requisite capacity to consent.)

It is essential that the decision process is fully documented. The medicine administration chart must also be annotated with the necessary instructions for administering the medicine.

It must be clearly documented and highlighted that the patient has their medications covertly administered when transferring between care settings, for example on admission to hospital. It is recommended that GP practices flag the patient record to ensure the information is included in any admission documents.

The effects of the decision must be reviewed especially for patient deterioration or declining food and drink. Review must also be carried out a regular basis as to the need for continued covert administration of medicines. A plan for review should be included in the documentation and the outcome of each review recorded.

How does covert medication link to a deprivation of liberty?

Treatment without consent is potentially a restriction contributing to the objective factors creating a deprivation of liberty. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DoL and must be subject to the principle of least restrictive alternative. The existence of such treatment must be clearly identified within any application for a DoLS authorisation, either for a urgent/standard authorisation or when informing a Local Authority or Clinical Commissioning Group of a potential DoL in domiciliary care or supported living services.

The use of covert medication must always call for close scrutiny, especially in cases where the medication impacts on the person's behaviour/mental health or has a sedative effect. Covert medication in this case is a serious interference with the right to respect for private life under human rights legislation and there must accordingly be proper safeguards against arbitrariness.

The use of covert medication within a care plan must be clearly identified within the Deprivation of Liberty Safeguards (DoLS) assessments and authorisation. The DoLS authorisation should reflect a requirement to keep the use of covert medication regularly under review.

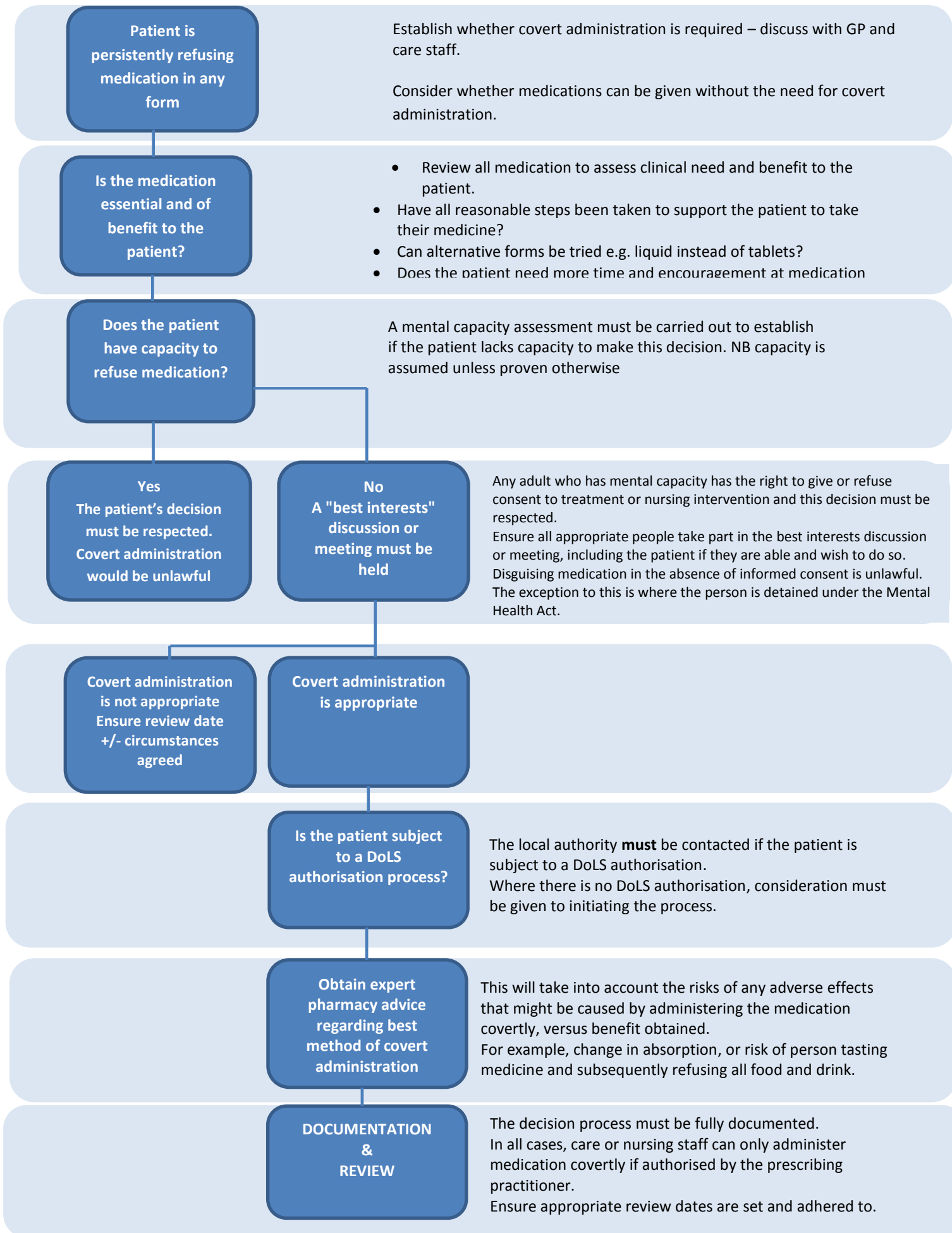
The managing authority (care provider) must notify the supervisory body of changes to the covert medication regime, including changes to the nature, strength or dosage of medications being administered covertly. Such changes should always trigger a review of the DoLS authorisation. The Managing Authority should also inform the Relevant Person's Representative of this in order to give them an opportunity to request a review of the DoLS authorisation.

If a standard authorisation is granted for a period longer than 6 months, there should be a clear provision for regular reviews of the care plan involving family and health professionals. The period of time between reviews should be determined by the circumstances of the individual case. It is not an absolute policy that standard authorisations should be limited to 6 months in all covert medication cases, but the more regular the reviews, the more likely justification there would be for a longer period of authorisation. One way of achieving this would be for the DoLS authorisation to be made subject to conditions about the need to keep the medication regime under regular review.

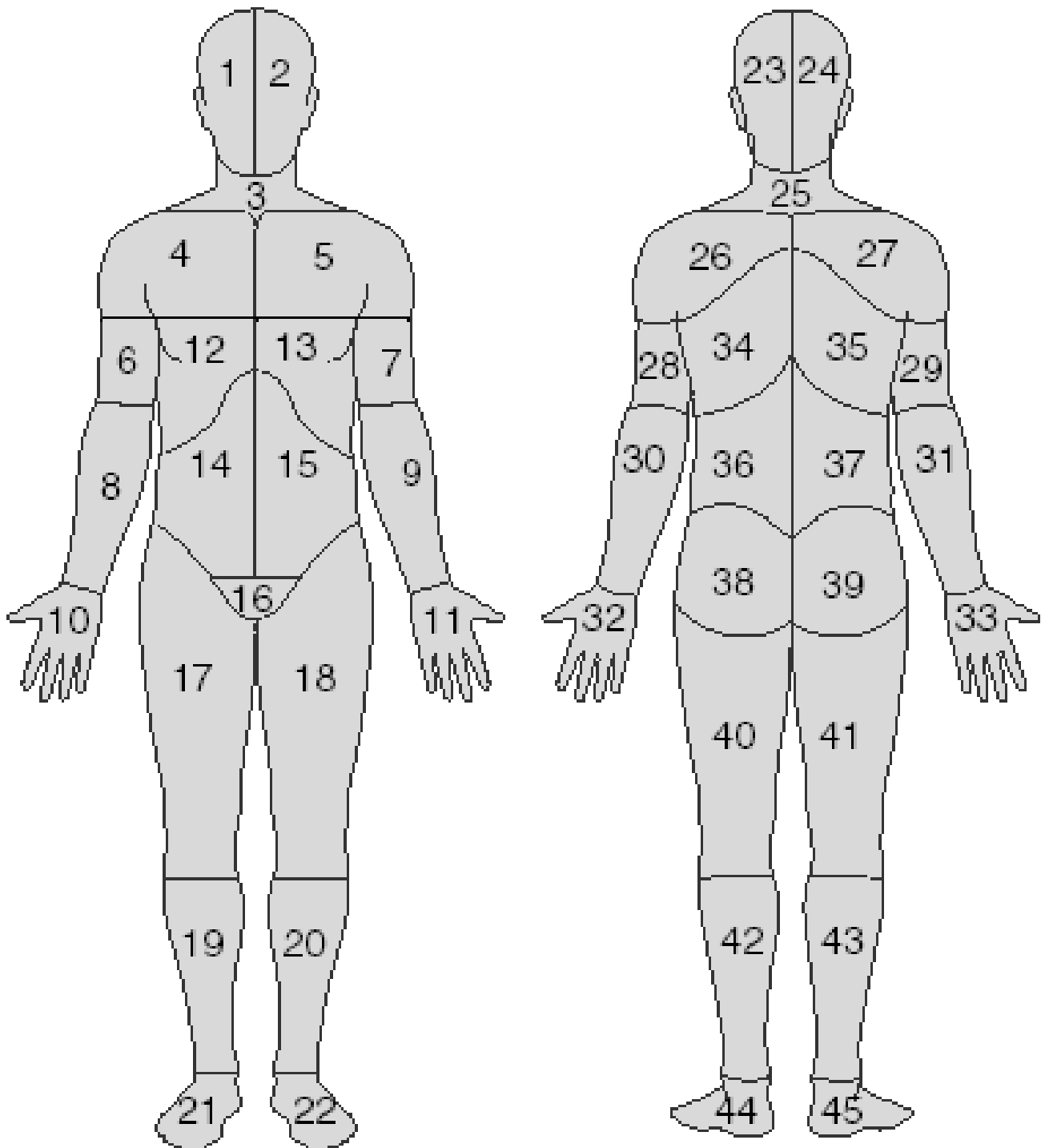
Expert pharmacy advice

A pharmacist will be able to consider the best method that meets patient's needs and preferences taking into account which will cause the least distress. A Pharmacist must be consulted in all covert medication decisions to ensure any medication given covertly is done safely.

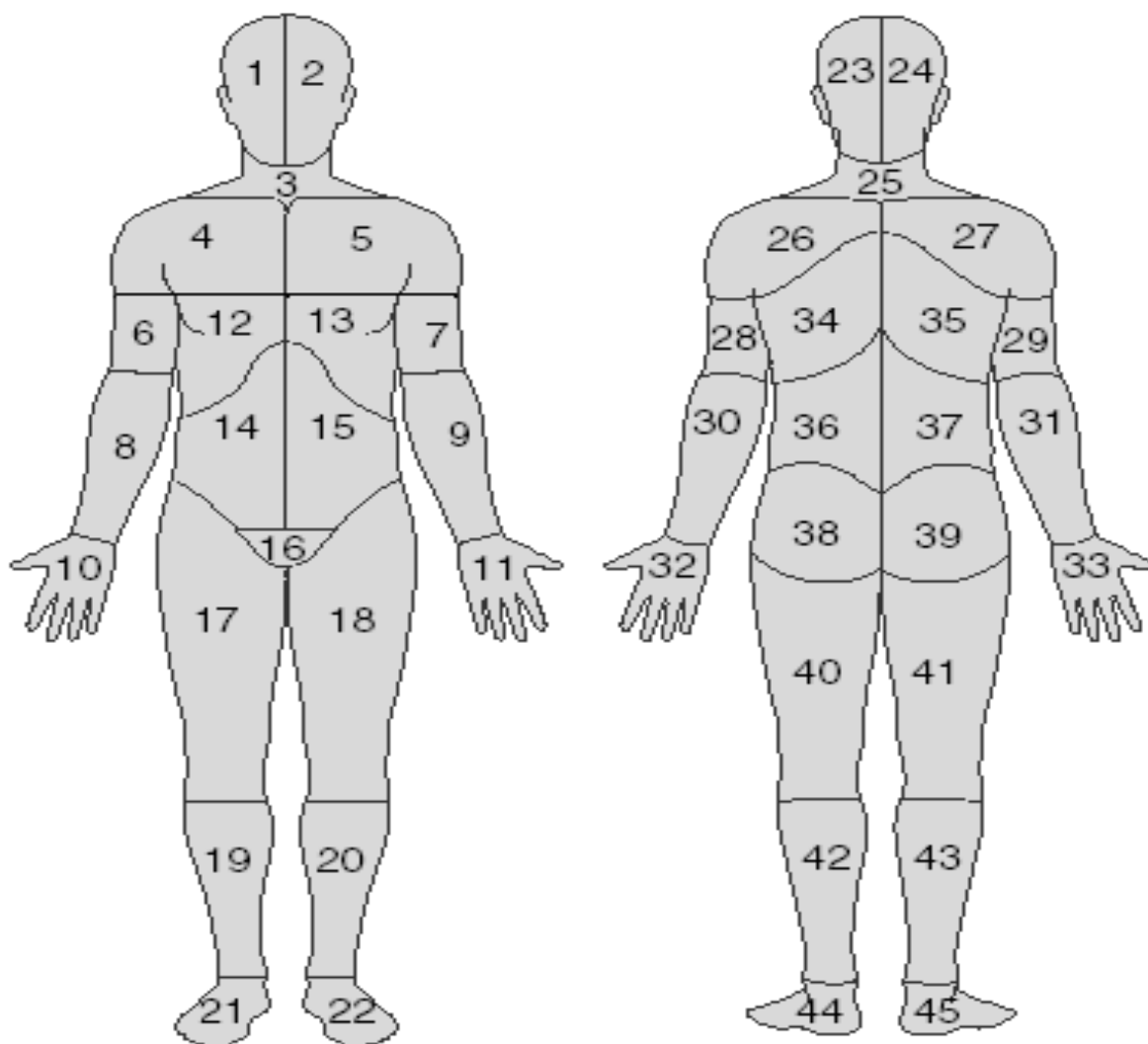
Covert Administration of Medication - Aide Memoire



BODY CHART



TRANSDERMAL PATCH APPLICATION BODY CHART



Drug Name _____		Strength _____		Intended duration of patch _____ days		
Date	Old patch removed	Time of application	Area of application (state number)	Applied by	Date/time patch still insitu check	Checked by

FIRE RISK WITH PARAFFIN BASED EMOLLIENTS¹⁰

All patients/carers and their families should be warned regarding the following risks

- Persons treated with skin ointments and other skin products containing paraffin must be made aware of the potential fire risks associated with these products.
- The risk of fire should be considered when using large quantities of any paraffin-based emollient (e.g. application of 100g or more at once or over a short period of time).
- Change patient clothing and bedding regularly—preferably daily—because emollients soak into fabric and can become a fire hazard
- Persons should be told to keep away from open or gas fires or hobs and naked flames, including candles, etc. and not to smoke when using these paraffin containing preparations.
- The risk is increased when these products are applied to large areas of the body and when clothing, bedding or bandages become soaked with these skin products. These products may cause clothing, bedding or bandages to catch fire.
- The person's contacts (family and friends) should be made aware of the risk since these apply if the person is near to others who are smoking or using a naked flame.

The following commonly prescribed products contain white soft paraffin (WSP) at concentrations of 50% or more	The guidance also applies to these other high risk products
Diprobase Ointment	Dithranol Ointment
Emulsifying Ointment	Epaderm Liquid
Paraffin 50% / White Soft Paraffin 50% Ointment incl. brands e.g. Emmolin Emollient Aerosol Spray	Hydromol Ointment
White Soft Paraffin	Imuderm Liquid
Zinc And Salicylic Acid Paste BP	Infaderm Therapeutic Oil
Zinc Ointment BP	Paraffin may be a constituent in 'specials'

NB: These lists are not exhaustive and carers should check the ingredients listed on the product and contact the pharmacy if required.

¹⁰ <https://www.gov.uk/drug-safety-update/paraffin-based-skin-emollients-on-dressings-or-clothing-fire-risk>

ADDITIONAL REQUIREMENTS FOR SERVICES PROVIDING SHORT BREAKS

ADMISSION

In respite/short stay services a pre-admission telephone conversation will take place at which point confirmation of medication will be taken. On admission this will be cross-referenced with the medication sent in and the transcription onto the MAR sheet. In short stay service there may not be a second staff member to check the entry. In this case the pre admission details should be checked again by the staff member on the next shift during handover and initialed as checked. Any concerns should be checked with the service user's GP. In addition to this the prescriber / GP will be contacted on a bi-annual basis as part of the support plan review to get an up-date on medication alongside new diagnosis etc.

THE SAFE CUSTODY OF MEDICINES

All medicines must be safeguarded against loss or possible misappropriation, and should be stored in a secure lockable receptacle in a designated room or in the person's own room.

Advice must be sought from the Dispensing Pharmacist about the Safe Custody of any medicines requiring refrigeration.

MONITORING

A record must be made of the date and quantity of each medicine received. (Provision to record medicines received will usually be made on the Medication Administration Record chart issued by the pharmacist)

ALL medicines entering the home must be checked against each person MAR chart and current list of medication, to ensure correct medication has been supplied.

All medication should be stock checked on a weekly basis and cross checked against records of administration

In addition all medications including: Monitored Dosage Systems, when required medicines, non-prescribed medicines, original packs and external preparations must be stock checked at least once per week and recorded. This stock check must also include monitoring of use of medication especially around when required medicines and non-prescribed medicines to prevent incorrect use or over reliance of that medication.

In addition to all the above regular stock checks, random monitoring of medication is also recommended, this should be undertaken by the most senior manager on duty, at least six weekly. Choosing 5 person's medication at random and completing the monitoring medication form.

MEDICINES MANAGED ON BEHALF OF PERSONS

All medicines must be kept either in a locked medicine cupboard in a designated room or lockable facility in the person's own room.

The keys and access codes to all medicine storage cupboards must be kept safe at all times and secured in a locked cabinet accessible by staff on duty competent to administer medication.

KEYS MUST NEVER BE LEFT IN A LOCK OR KEY CODES LEFT OUT ON DISPLAY.

There must be a written Key Holding Policy, which identifies staff responsible for the custody of keys/access codes for medicine storage facilities.

CONTROLLED DRUGS

The term 'Controlled Drug' is used in the legal classification of medicines to identify medicines that are addictive or have serious abuse/misuse potential.

The prescribing, supply, storage, administration, and disposal of controlled drugs are regulated under The Misuse of Drugs Act (and Regulations). In practice where a medicine is identified as a Controlled Drug either on the medication label or MAR chart, the following must be applied unless the person is self-administering.

- The medicine must be stored in a designated controlled drugs cupboard that meets Home Office approval
- The receipt, administration and disposal of controlled drugs must be recorded in the Controlled Drugs Register.
- The administration must be witnessed
- Both the person administering and the person witnessing must sign the MAR sheet
- The staff administering the controlled drugs must be deemed capable and competent to do so.



Additional Monitoring Form for Checking Medication

Check completed by:

Designation:

Date/Time:

Site:

Chose 5 service users at random

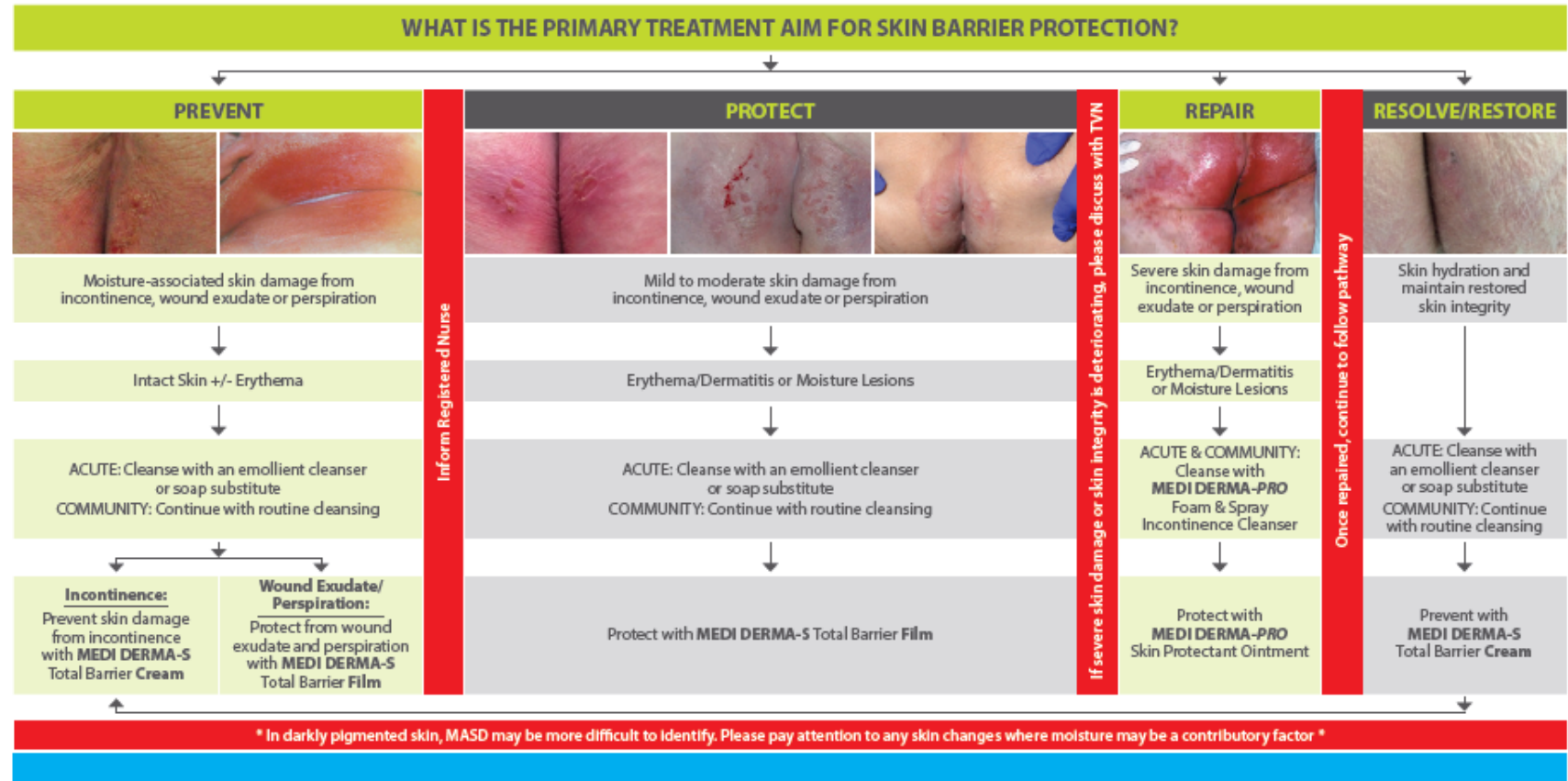
Service users checked	Quantity checked	Label matches MAR sheets	MAR sheet completed correctly	Correct procedure followed for changes in dose (If Required)	Comments Action	Tick, date and initial once completed
1)						
2)						
3)						
4)						
5)						

Comments/Actions _____

Signed:.....

Date:.....

Prevention & Management of Moisture Associated Skin Damage (MASD) Pathway



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