Bolton Council

Managing Medicines

Adult Social Care

Contents

Introduction

The administration of medicines is a regulated activity under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is intended that this guidance is a statement of best practice within Bolton.

It is intended for use by all staff within Adult Social Care including agency staff, temporary, contracted staff, and commissioned organisations employed within the following CQC regulated services:

- Home Support Reablement
- Laburnum Lodge
- Wilfred Gere

The CQC website contains detailed guidance for each type of care setting and information on the requirements for specific medicines, conditions or circumstances: CQC: Medicines information for adult social care services

Guidance for Assessors
Consent and Capacity

Each person must be asked if they prefer the care staff to administer their medicines or whether they would like to be responsible for all or part of their medicines. If the assessment indicates that they need assistance from staff with medication, the person's consent will be needed before this can be given.

See Appendix 2, Medicines Administration Authorisation Form and Appendix 3, Pictorial Medicines Administration Authorisation Form.

A written consent form should fully record what was said and show how the person was helped to make an informed decision. Cultural requirements must be considered e.g. gelatine capsules are not suitable for vegetarians or people of some religious faiths. Some religious festivals may also include fasting and may mean that the person prefers to have their medicines at certain times. Advice from the community pharmacist should be sought.

If the person chooses not to give consent, staff must not administer medication. If the person has mental capacity but staff remain concerned about the person's ability to take medication without support, they should carefully explain any risks and with the person and their doctor, agree a plan to minimise the risks. The person's consent or

decision not to give consent must be noted in their care and support plan and reviewed regularly.

Only the person receiving the treatment can legally give consent. A family member or someone acting as next of kin cannot give such authorisation, sign for it to happen or make the decision.

Assessing Capacity and Best Interests Decisions

The Mental Capacity Act 2005 states all individuals are presumed to have capacity unless proven otherwise and everything possible must be done to help them decide. If there are doubts about whether a person has the mental capacity to give consent to receiving medication, a capacity assessment will need to be undertaken by a trained individual. The capacity assessment and best interest decision should be recorded in the person`s care and support plan. A copy should also be kept with the person's Medication Administration Record (MAR) chart.

If there is a legally appointed Deputy or Attorney with authority to make decisions about the person's health and welfare, they will need to make a best interest decision in consultation with the person's doctor and care providers.

The details of who was consulted in making the decision, how the decision was reached and what attempts were made to assist the person to make their own decision must be documented on the person's care and support plan by the assessor. The final responsibility for determining whether it is in the person's best interest lies with the assessor.

Assessment

It is the responsibility of the assessor to determine if help with medication is required and they (or the provider) should obtain the person's written authorisation for this assistance. The assessor is the person authorised by Bolton Council to undertake an assessment of the person's ability to manage their medicines. This should be undertaken when a person is first referred to a service, and again if things change. The authorisation will be confirmed using the Medication Administration Authorisation Form.
An assessment of the person's needs must 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.

- The person (and their family/carers with their agreement) should be actively involved in discussions and decisions about their medicines support. This includes focusing on how the person can be supported to manage their own medicines as much as possible, considering:
    - The person's needs and preferences, including their social, cultural, emotional, religious and spiritual needs.
    - The person's expectations for confidentiality
    - 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 e.g. the person themselves, if they choose to and are able to, or a family member, carer, care staff or care provider.
      The time and resources are likely to be needed to check that the correct medicines have been supplied in accordance with the MAR chart and to administer them safely.

All discussions and decisions about the person's medicines support must be recorded, including:

- The person's needs and preferences.
- The person's expectations for confidentiality.
- 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 this could be at an agreed time or when the person needs change.

The assessor must seek advice and support from the appropriate Health Professional as part of the assessment. This will help identify whether any changes or extra support may be able to either enable the person to maintain independence with their medication or reduce the support needed with medicines.
Advice and support that could be offered include a medication review of the person's medicines to check:

- If the person's medicines regimen can be simplified.
- If any medicines can be stopped.
- If any support can be provided for problems with medicines adherence (e.g. If the formulation of any medicines can be changed).
- Information about time-sensitive medicines should also be shared and plans put in place on how this can be managed.

During any assessment interview, the assessor should ask about the person's use of non-prescribed medication, recording the outcome on the Non-Prescribed Medicines (NPM) Form. Copies of the form should be filed with the signed Medication Authorisation Form and attached to the person's care and support plan.

Following an assessment

Any discussions and decisions about the person's medicine support needs should be recorded in their care and support plan, and if they need medicines support, the following should be recorded in their care and support plan:

- The person's needs and preferences
- The person's expectations for confidentiality
- How consent for decisions about medicines will be sought
- Details of who to contact about their medicines (the person or named contact)

- What support is needed for each medicine e.g. time specific medicine and when required medicines
- How the medicines support will be given
- How the medicine is collected
- Storage and ordering of medicines
- 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, e.g. after 6 weeks

A person who wishes to self-administer

A robust, objective assessment tool should be used to assess a person's ability to self - administer before they are allowed to take responsibility for any medication including inhalers and creams which people may have been able to use independently in the past. This must be included in the person's care plan. See Appendix 1 for Self-Medication of Medicines in Bed Based Care

The aim of the assessment is to determine the person's ability to self-administer safely, to ensure there are no unacceptable risks and to identify and resolve where possible any potential difficulties. This should include an assessment of the person's mental and physical abilities, level of knowledge of their medication and any support that may be needed to self-administer.

In bed-based services a person who wishes to take responsibility for administering their medication will be assessed over a number of days using the assisted medicine administration form before a decision is made.

When a person wishes to take over management of their own medicines

If a person wants to take over the administration of their medicines, a clear agreement should be recorded in a care plan and a risk assessment completed. There must also be a signed agreement from the person or their representative, accepting responsibility for taking their own medicine. If there is a refusal to sign an agreement, it must be recorded in the care plan. See Appendix 1 for Self-Medication of Medicines in Bed Based Care

Compliance Aids

People can retain their independence by using compliance aids or other available aids and these must be considered if packs and bottles are difficult to open, the person is unable to use their inhaler or other appliance, or they have difficulty remembering whether they have taken medicines.
The compliance aid will normally be filled and labelled by a community pharmacist. The person may qualify for a free service from a community pharmacy if they have been assessed by that community pharmacist as requiring 'reasonable adjustments' in order to comply with Disability Discrimination Act legislation. If they do not meet the criteria there may be a charge for filling the compliance aid payable to the pharmacy. If the compliance aid is not filled by a pharmacy, this should be included in the care plan, and a carer cannot administer from a self or family filled compliance aid.

Administration of medicine
Providing Medication Support

Category 1: General Support – (Person directs their support)

All category one tasks must be recorded in the communication charts in the person's home. Care staff should record in the communication chart any change in the person's ability to manage their medication and report any such change to the Manager.

Where a person needs a prompt or verbal reminder, care staff should only provide this support if the Service Provision Order or Medication Order Form clearly states why this support is necessary and outlines any risks associated with doing this.
A risk assessment must be completed by the Social Care or Healthcare Practitioner identifying why the prompt is required and the implications if the person being prompted persistently demonstrates confusion around whether or not they have taken their meds.

Care staff can collect medicines from the community pharmacy, as well as dispose of unwanted medicines safely by return to the supplying pharmacy (when requested by the person).

Tasks Care staff must not carry out under Category One support**:**

a) Undertake tasks that are not specified in the Service Provision Order or Medications Order Form. If it is not on the order form DON'T DO IT.

b) Pass to the person loose pills from non-original containers. N.B. this includes damaged containers/blister packs.

c) Pass to the person loose pills from containers or medication Compliance Aids filled by the person themselves or relatives rather than a Pharmacist, GP or medically qualified person.

d) Undertake any task for which they have not completed appropriate training.

e) Any Category 2 Administration of medicines tasks

f) Assist people who have been assessed as having a degree of mental frailty.

g) Such individuals may still be supported under Category 2 Administration.

Category 2: Administering Medication – (Person is unable to take responsibility for their medication)

If the assessment identifies that the person needs assistance, care staff can select and prepare medicines for immediate administration from the packaging/container, dispensed and labelled by a pharmacist.

Consent must be documented in the person's care plan. If they are unable to communicate informed consent, then it must be documented that the treatment is in their best interest.

There must be a written system in place to ensure that only competent and confident care staff are assigned to a person who requires Category 2 administration. A MAR chart entry must be completed for every administration of medication provided by care staff.

NOTE: care staff should only complete the MAR chart if they have actually seen the person take their medication.

Administration of medicines may include some or all of the following:

a) Selection from original packs and/or a Monitored Dosage System or Compliance Aid.

b) Selection and measuring a dose of liquid medicine for the person to take.

c) Application of a medicated cream/ointment- inserts drops to ear, nose or eye; and administers inhaled medicine including inhalers and nebulisers (further training may be required for an individual nebuliser)

d) Application of a transdermal patch

e) When the care staff selects the number of units required for an insulin pen as directed by the person, for the person to then administer themselves (the care staff cannot administer the insulin, this is a level 3 task)

Care Staff should not give medication**:**

a) If the person is unwell - they should contact their manager.
b) If there are no directions on the label; Support should not be given if the directions are unclear. Care staff should contact their manager for advice.

‘When required medications’ (PRN medications)

‘When required medications’ are those medicines which a doctor has prescribed to be given only when certain conditions or criteria are met, e.g. pain relief.

‘When required medication’ must be listed on the MAR chart with the maximum daily frequency and or the time lapse between any administrations and any special conditions to trigger a review.

All administration of ‘when required medication’ must be recorded on the MAR chart and all those supporting the person must be communicated with to ensure they are familiar with the requirement to complete the MAR chart if providing PRN medication to the person. Care staff are not expected to make judgements on medication, e.g. “take as required.”

The administration of ‘when required medications’ should be linked to the medication risk assessment and care staff instructed to contact the manager for advice and direction.

‘When required medicines’ must be listed on the Medicine Administration Record (MAR) chart with the maximum daily dose, frequency and/or the time lapse between any administrations, and any special conditions to trigger a review. All administration of ‘when required medicines’ must be recorded on the MAR chart.
If the medicine was offered to the person but was not needed at that time then an appropriate code should be included on the MAR chart. It is good practice for the directions to state what the medication is required for e.g. constipation.

A Pro re Nata (PRN) (Latin for “when required”) dose chart must be completed for all PRN medication. For each medicine this must include name, dose, strength, frequency, minimum time between doses and maximum dose in 24 hours. This must be reviewed regularly. (Appendix 19)

A person’s requirements for a PRN medicine must be reviewed on a regular basis.

Missed Doses

If a dose of medication was missed or omitted during the previous visit a double dose MUST NOT be given. Care staff must record on the MAR chart that a dose has been missed and report to their manager community who should immediately contact the community pharmacist or GP.

Category 3: Administering Medication by Specialised Techniques

In exceptional circumstances following an assessment by an appropriate Healthcare Professional, and after specific Category 3 training supported by clinical supervision from the Healthcare Professional, care staff may be required to administer medication by a specialist technique including:

a) Rectal administration, e.g. suppositories, diazepam (for epileptic seizure).

b) Insulin by injection including testing of blood sugars.

c) Administration through a Percutaneous Endoscopic Gastrostomy (PEG)

d) Buccal administration (when medicines are dissolved between the cheek and gum) e.g. midazolam

e) Administration of oxygen

If any of these tasks are delegated to care staff, then:

a) There must be a procedure in place that will ensure full risk assessments are completed and documented in the Service Provision Order and Service Delivery Plan.

The Healthcare Professional must provide any necessary training and confirm competency of care staff to carry out the task. Care staff can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to undertake the task.

Covert Administration

Covert administration is 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. There may be certain circumstances in which covert administration may need to be considered to prevent a person missing out on essential treatment. Covert administration is only likely to be necessary or appropriate where:

a) A person actively refuses their medicine, and

b) That person is assessed not to have the capacity to understand the consequences of their refusal, and
c) The medicine is deemed essential to the person's health and wellbeing

The principles of the Mental Capacity Act (2005) should be followed. If the person is found to be able to complete all four elements of the mental capacity assessment, then they should be assumed to have the mental capacity to make the decision themselves, even if their decision appears unwise. In these circumstances the decision must be respected, and covert medication cannot be given. It is important that this process is followed, as presumptions about a person's mental capacity cannot be based solely on their diagnosis (MCA, 2005.)

The use of covert administration must be recorded in person's care records. It should only be used after trying all other options. Care staff must be trained and assessed as competent to give the medicine covertly
Each medicine will need to be identified for covert administration, and each time a new medicine is prescribed or there are any changes. Medicines administration records should clearly record which medicines you administer covertly and when. The decision-making process must be easy to follow and clearly documented. This should include:

- Who is involved in and, responsible for decision making
- Assessment of a person's mental capacity to make a specific decision about their medicines
- Seeking advice from the prescriber about other options, for example, whether the medicine could be stopped
- Holding a best interest meeting to agree whether giving medicines covertly is in the person's best interests
- Recording any decisions made
- Agreeing where records of the decision are kept and who has access
- Planning how medicines will be given covertly, for example, by seeking advice from a pharmacist
- Providing authorisation and clear instructions for care staff in the provider's care plan including possible adverse effects
- When the decision to give medicines covertly will be reviewed

Care staff must be trained and assessed as competent to give the medicine covertly

Please note that crushing medication does not constitute covert administration if the person is aware that they are taking the medication, and it is only to aid swallowing.

This should not be undertaken without seeking advice from a pharmacist to confirm that medicine is suitable to be crushed.

Variable dose medicines

Where a variable dose is prescribed, for example “give one or two tablets”. The dose given must be recorded on the MAR.
A variable dose chart must be completed for all variable dose medication. For each medicine this must include name, dose, strength, frequency, minimum time between doses and maximum dose in 24 hours. This must be reviewed regularly. (Appendix 19)
When a medication is prescribed at a variable dose, the variable dose chart should include information on how a decision is made on the dose to administer e.g. one or two tablets.

Role of care staff

Care staff administering medicines can assume that any actions taken under the care plan are agreed to be in the person’s best interests. However, they have a key role in assessing the person at the time of administering the medicines. If there are variations in the circumstances covered by the care plan, then the care staff must not proceed with administering the medicines but must refer to their line manager for further advice.

The care staff must not undertake any duties which fall within the responsibility of a health care professional, e.g. sutures or catheter removal.
Care staff must not make any clinical decisions or judgments (e.g. increase or change of dosage) regarding the administration of medicines. If there is any change of circumstances relating to a person’s medicines, care staff must report it to the line manager or a healthcare professional or a nominated person (e.g. next of kin) and it must be recorded on the person’s file.

Any changes in medication should be recorded in the care plan and on the MAR chart. These changes must be handed over to staff coming on duty. Care staff may not administer medicines:

- Into the vein (intravenously)
- Vaginally
- Via a nasogastric tube (a tube directly into the stomach via the nose)

Care staff can obtain information on medicines from the prescriber, pharmacist or patient information leaflets. In addition, they can access a website such as the NHS

website. They must not offer medicines advice to the person without seeking advice from an appropriate health care professional.

A person discharged from hospital

A person discharged from hospital may have medicines that differ from that which they had before admission. An electronically produced list of medicines will be supplied by the hospital on discharge. If there are any queries, team leaders, supervisors or key staff must clarify with the hospital ward which medicines should be administered.

A person admitted to hospital

If a person is admitted to hospital all medicines must be sent with them and a photocopy of the MAR chart whenever possible. Information should be shared about a person's medicines when they are transferred between care settings.

A person leaving a bed-based service for a short time

In the event that a person is going to be away for a short time and will need to take medication during this time, for example visiting family or an outpatient appointment, the following information should be given to the person and/or their family members or carers who accompany them:

- The pharmacy labelled medicines that will be going with the person
- Storage
- Clear directions and advice on how, when and how much of the medicines the person should take
- Time of the last and next dose of each medicine
- A contact for queries about the person's medicines
- If any medicines are to be taken 'when required', there should be clear instructions provided on when to take the medicine.

Care staff should ensure:

- Risks have been identified, and any potential problems minimised
- The appropriate code is entered on the MAR chart
- Medication is checked on return to ensure medication has been taken by the person
- The remaining quantity is recorded on the MAR chart
- If a person attends an outpatient appointment, they should take a copy of their MAR chart with them if possible

A person attending day care

The service manager is responsible for making sure that medicines handed to staff are always stored, given, and disposed of safely. The service manager must carry out a risk assessment for each person to show how much help they need with their medication. This should be reviewed every year, or sooner if their situation changes or there are any concerns

Medicine Administration Record (MAR)

A MAR chart must be maintained by the care staff for each person who is receiving medication support. The MAR chart must be made available to any visiting clinician or others who are authorised to administer medication e.g. paramedic.
MAR charts must be used to record all medicines received, administered and disposed of. MAR can be paper based (pharmacy printed or handwritten) or electronic medicines administration records. A minimum of 2 information sources should be used to obtain a list of medicines for the person.
An example of a paper MAR chart is included in Appendix 4 and a Staff Signature chart in Appendix 5.

Pharmacy completed MAR charts are not essential, but they are preferable to handwritten ones as they reduce the risk of error.

Handwritten MAR charts should only be used in exceptional circumstances where it is not possible to obtain a MAR chart from the dispensing pharmacy. All handwritten entries should only be completed by a trained and competent care staff.
A handwritten MAR (including amendments and new items) must also include the following:

- Initials of person completing MAR
- Initials of checker to confirm MAR is correct before it is used
- It must be clearly written in black ink

It is the responsibility of care staff supporting with the medication to record medicines administration immediately after they are given.

Completing a MAR chart

The Medication Administration Records charts must document:

- The person's particulars including allergy status.
- The name, strength and form of each medication prescribed for the person.
- The dose of the medication.
- The route of administration.
- Any additional caution or advisory information
- The time the medicines are to be administered.
- Copies of emails, texts, faxes and transcriptions of phone messages must be kept and stored with the Care Plan.
- If more than one chart is in use reference to other charts e.g. "chart 1 of 2"
- When required "PRN medication" as a cross reference to the PRN medication
- Minimum interval between doses and maximum dose in 24 hours if appropriate
- An example of a MAR chart is included at Appendix 4

The care staff must confirm that a dose has been administered by entering their initials in the appropriate box on the paper or electronic MAR chart. This must be recorded at the time of administration after witnessing the person taking their medicine.

A new MAR chart should be provided where practicable whenever there is an alteration to the prescribed medication, including dose and timings of medication. 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 to still remain legible.

When a pharmacy printed MAR chart is used, occasionally some items may not be listed on the new MAR chart if the item is not prescribed due to the person having a sufficient supply e.g. creams or pain relief. These items must be handwritten on the new MAR chart, initialled and a second check completed and initialled so that it reflects all prescribed medicines.

When a paper MAR chart is full it must be transferred to the person's file in the care provider setting. Before using the new paper MAR chart, it must be compared with the completed MAR chart to ensure all medicines are included. If there are any discrepancies the line manager or community pharmacist must be contacted for further advice.

MAR charts in residential services

A MAR chart must be obtained and completed for each person assessed as Category 2. On admission to a residential service, a new person, their family and/or their care staff must be requested to bring with them all medicines. Staff must be satisfied with the general condition of the medicines before using, including that:

- The medicines are in date
- The medicines are in their original container
- There is a legible pharmacy label
- It has been dispensed within the last 6 months (check opening date and expiry date for eye drops/ointments)
- Storage conditions have been met

Staff must obtain a current list of medicines from the person's GP and confirm with the duty manager and/or GP any discrepancies. For a person arriving from Royal Bolton Hospital, an electronic medicines discharge summary will be provided. Staff should confirm with the person or their carer that they are taking their medicines as prescribed.

If, on admission, there are any doubts about what medicines are to be administered the GP or hospital ward must be contacted as soon as possible and the medicines reviewed. In the event of an admission out of surgery hours the advice of a pharmacist or out of hours provider must be sought and recorded.

For a person who is on an established system, all medicines received in a residential service must be checked against the MAR chart to confirm the name of the person for whom they were prescribed, the drug name, strength and quantity, date of receipt and signature of the receiver.

A visiting GP/Consultant/non-medical prescriber must be given the MAR chart to record any changes to medicines. Staff in residential services should keep a record of medicines administered by visiting health care professionals on the MAR chart.

MAR charts in domiciliary care services

A MAR chart must be obtained and completed for each person assessed as Category 2. The current MAR chart must be kept in the person's home. Completed MAR charts should be retained by the care provider. In exceptional circumstances where there are two care providers the main provider must take the chart for their own files and send a copy to the other provider.
If relatives, friends or other carers administer medicines then they must be asked to make an entry on the MAR chart to ensure that a double dose is not given. If they do not record

on the MAR chart, then it must be reported to the line manager for a risk assessment to be carried out.

Supply of medicine

Medicines must only be used for the person they are prescribed for. Bulk supplies of medicines for the use of more than one person must not be stored by staff unless covered by the section on Homely Remedies.

Ordering prescriptions

a) Care homes and bed based care

A named person will be nominated to make sure medicines are always available in the best and most efficient way. This person will assess each person's medicines on arrival and on a weekly basis to identify any items which have between 7 and 14 days' supply left. Repeat items will be ordered using the prescription request form from the persons GP or the Intermediate Care system as appropriate.
Prescription pads must be stored in the Controlled Drugs cabinet for the use of a visiting consultant or medical prescriber only. The consultant or medical prescriber will be responsible for ensuring that the serial number of each prescription used is recorded in the book provided. The intermediate tier pharmacist will take responsibility for monitoring serial numbers and the ordering of new prescription pads.
On admission to intermediate care, for those beds under the care of a GP, the nominated person will supply the temporary GP with a copy of the following information:

b) A person admitted from hospital

- Electronic discharge summary
- Letters as appropriate
- List of current medicines from the GP
- If there is any doubt about the person's medicines, the hospital ward must be contacted immediately for clarification.

c) A person admitted from home

- List of current medicines from the GP
- Letters as appropriate

d) Domiciliary Care

Assessors of medication support must document at the assessment stage who is responsible for ordering and/or collecting prescriptions. If it is identified that care staff are responsible, then this must be documented in the care and support plan. This must include details for reordering to ensure the person does not run out of medicines.

Storage of Medicines

All medicines should be kept in the original packaging in which they were obtained from the Community Pharmacy. The expiry of products should be checked before administration.

All prescribed medicines should contain the Community Pharmacy dispensing label detailing the person's name, date of dispensing, Community Pharmacy contact details, product name, strength, dose, formulation and route of administration.

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 plan. In residential services, medicines that require storage must be stored between a minimum of 2°C and a maximum of 8°C in a lockable medicines' refrigerator. The temperature must be monitored and recorded daily using the Fridge Monitoring Chart in Appendix 6.

The refrigerator must be defrosted regularly and cleaned no less than weekly. If the fridge temperature is out of the range of 2°C and 8°C then advice must be sought immediately from a manager. Out of date and discontinued medicines must be removed and disposed of. Medicines for internal and external use must be stored separately within the fridge. Only medicines requiring refrigeration should be stored in the fridge.

In residential services, all medicines must be stored in a locked cupboard or medicine trolley. If used, a trolley must be secured to a wall or immovable object when not in use. All keys are the responsibility of the designated person on duty. There must only be one duplicate key for medicine cupboards, trolleys and clinic areas and the original and duplicate keys must be kept separately from any other keys and separately from the master key. To keep medicines safe, the room temperature must be checked every day (ideally at the same time).

The supplies for each person must be kept segregated in a suitable reserved container (internal use and external use medicines must be stored separately). Residents in a care home who are self-medicating must be provided with a lockable cupboard in their own room to store medicines. The person will take responsibility for the key.
In domiciliary care services and Adult Placement medicines must be stored appropriately according to the individual circumstances. If there are special requirements, then these must be stated in the care and support plan.

Receipt of medicines procedure

Medications should be checked against the current and new MAR charts. Care staff should check the person's name, drug name, strength, formulation, dose, route and quantity are all correct and will last for the duration of the cycle / course. The new MAR

chart should also be checked to ensure the person's name, DOB, allergy status and medicines intolerances are all clearly documented.
Labels must not be altered. In the event of a discrepancy, advice must be sought immediately from the prescriber or a pharmacist.

Safe disposal of medicines

Unused, out of date medication, or medication no longer required, must be returned to any Community Pharmacy, with the person's authorisation. Where the medication to be returned is listed on the MAR, the MAR chart should reflect medicines for disposal.
Any out-of-date items must be re-ordered from the person's GP if still required.
Pharmacy labels must be anonymised before the containers are disposed of.
Medicines must be returned to a pharmacy when any of the following occur:

- A course of treatment has been completed and there is some residual medicine in the container
- The medicine has been discontinued
- The expiry date has been reached
- A person dies (these medicines must be retained for seven days before disposal) but in the event of sudden death medicines must be kept securely until it is known whether or not an inquest is to be held
- If the person is discharged home from residential care with a compliance aid the unwanted medicines in original packs must be returned to the pharmacy

Residential care

If a person leaves a service their medicines must be returned to them, or given to their relative or carer, or returned to the community pharmacy with the permission of the person or their relative. The action taken must be recorded in the person's on-going record.
Medicines given to a person when leaving a residential service must be counted, the amount recorded on the MAR chart, initialled and dated by the care staff.
All medicines no longer required must be returned to the community pharmacy. A duplicate book must be used to record:

- The person's name the medicine was prescribed for
- Name of the medicine
- Quantity
- Date
- Initial of person making the entry
- Reason for disposal

When returning medicines to the community pharmacy, the responsible duty person and the pharmacy driver collecting the returns must sign and print their names. A duplicate copy must be retained by the service.

Administration of Medicines

Managers are responsible for ensuring that only trained and competent members of staff are administering medication. When administering medication care staff should follow the 6 rights of medication administration at all times:

- The right person
- The right medicine
- The right dose
- Via the right route
- At the right time
- Person's right to refuse

Care staff administering medication should have completed an internal competency assessment and this should be reviewed annually with records kept.

Prescribed medicines must have clear and concise instructions, which include the maximum dose and when and how it must be taken. If it is a new prescription for the person, staff must ensure that they have the right information for safe administration according to the pharmacy label.

Some medicines may have variable doses, which will need to be checked with separate charts or booklets, e.g., warfarin and prednisolone. If this is the case, every time, before administration of the medicine the care staff must check the separate booklet for the correct dose and the dose administered must be fully completed on the MAR chart in addition to the care staff's initials.

Medicines must be given to one person at a time. They must be prepared according to the directions, taken directly to the person and given immediately. Staff and managers must do everything possible to allow the person administering medicine to do so uninterrupted. The person administering the medicines must not be distracted until the task is complete e.g. if a phone rings or assistance is required somewhere else the medicines procedure must be completed first.

In the event that medication cannot be administered, for example, the person is asleep or having a meal, if possible, offer again at a later time. Document what has occurred in the on-going record in the care plan and document the appropriate code on the MAR chart.

Refusal to take medication

It is the person's choice to take or not to take their medication. They cannot be forced to take their medication; however, some degree of encouragement can be given. If the person refuses help with medication this must be recorded on the MAR chart and reported to the Manager.

Medications must not be disguised or hidden in food in order to force a person to take them against their wishes. (See Covert Administration)

If the person refuses, the care staff must record the reason for refusal, with the appropriate code on the MAR chart. If the refusal continues then the manager of the service, the prescriber and/or the pharmacist must be contacted for further advice.

Refused medicines must not be returned to the original packaging but must be disposed of in the correct manner. Any medicine that is refused must be placed in a sealed envelope with the name of the medicine, the quantity and the name of the person the medicine is for and the envelope must be dated and signed by the care staff. This must then be returned to the pharmacy and entered in the Record of Disposed Medicine Book.

If it is stated in the care plan that a care staff must leave medicines for the person to take themselves at a later (prescribed) time to enable their independence, it must be left in a safe place and recorded on the MAR chart using the appropriate code. Care staff must check at the next visit that the medicine is no longer in the designated safe place. Any concerns must be reported to line manager.

Verbal Changes to Medication

Verbal changes to prescribed medicines can be accepted provided there is written authorisation of the changes supplied by the prescriber at the first opportunity.

A record must be made in the person's care plan detailing the nature of the request, the date and time of the request, the name of the prescriber and the name of the care staff receiving the request. The alteration must be confirmed in writing by the prescriber on the next normal working day, this may be in the form of a new prescription. Verbal alterations cannot be accepted for Controlled Drugs

Administration Procedures

Preparation

Before and after administering any medicines, the care staff carrying out the administration must wash and dry their hands, clean the medicine preparation area and gather the following:

- The persons Medicines Administration Record (MAR) chart
- A pen
- A jug of water and clean glass/glasses.
- Clean and dry medicines measure/s

The MAR chart must be checked for the following:

- The person's name.

- The dose has not already been administered.
- Any instructions, noting in particular recent changes.
- The time the medicine is due.
- The pharmacy label on the medicine container with the instruction on the MAR chart. If these differ, then the instructions must be clarified with the duty manager.
- Any special instructions to be followed, e.g. to be taken before or after food or to be dissolved in water.
- Expiry date

The care staff must methodically work their way down the MAR chart, selecting the appropriate medicines and offering them to the person whilst adhering to the ‘six rights’.

Types of medication

For each medication the directions and warnings on the MAR chart must be read carefully followed for each medication. If there are any queries about how to administer medicines, the prescriber or a pharmacist must be consulted for clarification e.g. “as directed”
All administration must be recorded on the MAR chart and cream chart or patch chart as appropriate**.** All medicines must be in date.

Liquid medicine

Liquid medicines must not be poured out in advance. Liquids must be administered using ‘liquid measures’ which are available from the community pharmacy**.** These include:

- Oral syringes
- Calibrated medicine pots
- Measuring spoons (teaspoons must not be used).

Creams, ointments and lotions

- Care staff administering the cream must wear disposable gloves.
- The affected skin area must be clean, and any residue of a previous application must be removed by gentle cleansing of the area
- The cream, ointment or lotion must be in the original container
- Any dressing and/or clothing must be replaced.
- Gauze, gloves or old dressings must be disposed of appropriately.
- Hands must be washed

The cream, ointment or lotion must be applied making sure that enough is taken from the container to complete the application. If too much is taken the remainder must not be returned to the container as this will contaminate the remaining medicine. It is good

practice for a cream chart to be used to show the area of application in addition to the MAR chart. See Appendix 8.

Eye Drops and Eye Ointments

- The person's head must be tilted back slightly
- The lower lid must be pulled down and one drop allowed to fall into the space between the lid and the eye
- Two drops must never be administered into the person's eye at the same time, or the second drop will run out
- If more than one drop is required in the same eye, there must be an interval before putting in the second drop. Check with a pharmacist if the order of administering and the timing are important
- If the directions on the label do not specify which eye or eyes the drops are to be administered to then the prescriber must be consulted for clarification and documented in the care plan.
- The procedure is the same for eye ointments; allow about 5 mm length of ointment.
- The person's eye must not be touched with the dropper or applicator.
- The container must be checked for the expiry date once opened; this is usually 28 days although some eye drops can be used for up to six months after opening

Nose Drops

- The person's head must be tilted well back and the correct number of drops allowed to flow down into the nose.
- The person's head must be kept tilted for a few minutes to allow the drops to be absorbed.

Ear Drops

- Lie the person down with the affected ear facing upwards
- Gently pull the outer ear backwards and upwards
- Use the drops at room temperature
- Fill the pipette with drops from the bottle and place 1 – 2 drops into the ear canal as prescribed
- Gently massage the area in front of the ear to ensure the drops are fully dispersed into the ear canal
- Keep the person on their side for 5 minutes
- Wipe away excess drops
- Do not put cotton wool into the ear

Transdermal Patches

Although these patches are applied to the skin, they do have a systemic, not a topical effect, i.e. they are absorbed through the skin and can affect the whole body. The patches are similar in appearance to a sticking plaster and they are applied in much the same way.

- To apply, the care staff must wear disposable gloves, the skin must be clean, dry and undamaged and the patch applied firmly to avoid creases
- The site must be varied for each new application, preferably a non-hairy site if possible, so that the skin does not get sore from repeated application in the same place.
- It is good practice to write the date applied on the patch
- Patches may be disposed of in general waste in a patient's home
- It is good practice for a patch chart to be used to show the area of application in addition to the MAR chart. See Appendix 9.

Inhalers

There are many different types of inhalers available and different techniques are required for different types of inhalers. Refer to manufacturer's instructions for each type of inhaler device and seek advice from a community pharmacy if needed.
If more than one inhaler is to be administered, there may be a requirement to administer in a particular order. If this is not indicated on the label seek advice from a community pharmacy

Setting the dose on an insulin pen

Care staff are not allowed to routinely carry out the administration of insulin or testing of blood sugars. This is a Category 3 task and requires specific training. They can set the dial on an insulin pen according to the number of units specified in the written record from the diabetic clinic or GP. The care staff must then give the pen to the person to self-administer. This is a Category 2 task.

Swallowing difficulties

If a person is experiencing difficulty in swallowing medication, then the prescriber or a pharmacist must be contacted (via the manager for domiciliary care) as a review of the medication will be required. This may result in the medication either being

- Discontinued
- Given in a different form e.g. patch or liquid form
- Alternative medication being prescribed
- Crushing

Sometimes care staff may be required to give the medication in a way not advised in the product information leaflet e.g. by crushing or dissolving the medication. This is known as

giving medication in an “unlicensed” way. This must only be done following a risk assessment and under the direction of the prescriber and/or a pharmacist and recorded in the care plan.

The prescriber and/or pharmacist should specify the directions to crush etc. on the MAR chart. Information from the pharmacist detailing exact instructions on how to administer the medication should be kept with the MAR chart. An example of a letter that may be completed by a GP and/or pharmacist to authorise administration in an unlicensed way and to give detailed instructions for administration can be found in Appendix 10.
If a person has general swallowing difficulties e.g. delayed swallow, coughing when drinking liquids etc. then a referral should be made to the Speech and Language Team.

Thickeners and oral nutrition supplements

Thickeners are indicated for dysphagia, to thicken liquids and foods to various consistencies, depending on a person’s need. They prevent foods and fluids from entering the lungs leading to serious complications. When a person is prescribed thickeners, care plans for dysphagia should include:

- Current consistency recommendations
- Directions and risk assessments
- Documentation of use and monitoring of thickeners
- Hydration levels

Thickeners need to be stored securely, and staff need to be trained on the use of thickeners and any food modifications required by individuals.

Oxygen

Oxygen is prescribed on a Home Oxygen Order Form (HOOF) written by either the GP or hospital consultant. The HOOF contains details of how the oxygen should be used. The HOOF is sent directly to the oxygen supplier who will then arrange for the delivery of the oxygen. If more oxygen cylinders are required, the supplier should be contacted directly. Changes in the person’s clinical condition must be referred to the doctor who can organise a new HOOF if required. The supplier can only deliver oxygen in accordance with the direction on the HOOF.

Documentation must be in place at the service covering the ordering, receipt, storage, administration and removal of the oxygen. A procedure should be in place for informing the emergency services of the location of oxygen if they are required to attend in the event of a fire or fire alarm.

Documentation must be in place covering the administration details for the oxygen. This must include the flow rate and length of time the oxygen should be used for and the

prescriber's details. Oxygen equipment must be checked at each administration to ensure the correct flow rate is selected.

the prescriber. All changes must be documented. A documented robust risk assessment must be in place for both the use and storage of the oxygen. See Appendix 18.

If the person is self-administering the oxygen, then a documented robust risk assessment must be in place and regularly reviewed to assess their ability to do so correctly and safely. Oxygen and associated equipment (for example, masks/nasal cannula and tubing) must only be used for the person for whom it was supplied.

Anaphylaxis

People with potentially serious allergies will often be given an adrenaline auto-injector to carry at all times. This should be used as soon as a serious reaction is suspected, either by the person experiencing anaphylaxis or someone helping them.

Homely Remedies

There may be a need to be treat minor ailments without necessarily consulting with the person's GP. A homely remedy is a treatment for mild to moderate symptoms that need immediate relief e.g. toothache or indigestion. See Appendix 11

Any administration of a homely remedy must be recorded and use of homely remedy must not extend beyond 48 hours without medical advice being sought. In the case of olive oil eardrops these can only be administered under audiology recommendation, and audiology will authorise the use of olive oil ear drops for a maximum of 10 days via a referral letter.

Self-Care

When a person or their family request the care staff to support them with non-prescribed medicines the care staff must refer the request to their duty manager for discussion with the person's pharmacist or GP to ensure that this medication is safe to take or apply with their other prescribed medication.
If for any reason this cannot be done staff must not administer the medication. Medication ca only be administered from the original pack as purchased or supplied.
If it is agreed that it is safe to administer a record must be made in the care plan (Appendix 12) including:

- The name, strength, form (i.e. tablets, liquids, patches) and dose of the medication
- The indication (what is it for)
- The name of the GP/pharmacist giving this advice

- That the person or their family understands and accepts any risk associated with taking or applying the medicine

All OTC products purchased on behalf of the person or brought into a care setting should be:

- checked, to make sure they are suitable for use
- in date
- stored according to the manufacturer guidance
- recorded

Care staff must not offer advice to a person or their family/carers about over the counter medication or complementary treatments nor should they purchase any such medicines based on symptoms described by the person or family.
Emollients and barrier creams can be applied as requested by the person, their family/carers or appropriate health care professional as part of the personal care as long as this is written into the support plan. However, if the person has severe dry skin or a rash they should be referred to their GP.

Controlled Drugs

There are strict criteria for prescribing, administering, safe custody, record keeping and disposal of controlled drugs (The Misuse of Drugs Regulations 2001). A standard operating procedure must be displayed and followed in residential services. See an example at Appendix 13
Any concerns about the management of controlled drugs must be reported to the Local Information Network for controlled drugs where they will be reviewed via the incident reporting system on www.cdreporting.co.uk.

Administration

Before administering a controlled drug, the care staff must measure and check the dose with another level two medication trained member of staff whenever possible. If a trained member of staff is not available to check the dose another competent member of staff must carry out the check. To do this they must understand they are reading the information, checking it against the documentation on the MAR chart, and agreeing that the dosage dispensed is correct. By signing they are committing that they have done this check.

The person's name, plus time and dose given, must be recorded in the controlled drugs register after carefully checking the MAR chart. Once the care staff has witnessed the person taking the medicines, the care staff must initial the MAR chart.

The care staff and the witness must then also initial the controlled drugs register, after verifying that the remaining balance is correct.

The administration process must be fully completed for each person, before moving on to the next person.

Receipt, recording storage and audit

Care staff collecting controlled drug prescriptions from the pharmacy will need to provide identification.

A controlled drugs register must be a bound book with numbered pages. Electronic controlled drugs registers are permitted as an alternative. It must be used to record the receipt, administration and disposal of controlled drugs held in the service. Each drug, for each person, must be recorded on a separate page, with the name, dose and strength of the drug written clearly at the top of the page

If a District Nurse administers a controlled drug in a residential service, they must complete their own documentation and the controlled drugs registers belonging to the service.

On receipt of the controlled drug from the pharmacy, the date and quantity must be entered in the controlled drugs register and initialled by an authorised member of staff, with a second person as a witness. The correct balance must be verified each time.

Electronic controlled drugs registers are permitted as an alternative. Legislation requires that computerised entries must be:

- Attributable to the person who created the record
- Secure
- Cannot be altered at a later time
- Capable of being audited
- Compliant with best practice
- Accessible from the care home and capable of being printed.

When transferring the drug record to a new page in the controlled drugs register, the amount remaining must be identified with ‘brought forward from page x’ written clearly on the new page.

Controlled Drugs must be stored in a locked metal cabinet which fulfils the requirements of the Misuse of Drugs Act 1971. Completed registers must be archived for a minimum of two

years from the last entry. Good practice would be to retain the controlled drugs register for longer as cases can take several years to come to light or before they go to court.
Routine checks of all controlled drugs held and the recorded running balances should be carried out by two designated members of staff on a weekly basis and a record kept. See Appendix 14.

Where a discrepancy is found it should be reported to the registered manager who should investigate promptly. If the discrepancy cannot be resolved, the advice of the community pharmacist should be sought and the CQC local officer informed. An audit form for Controlled Drugs in Residential Services is included in Appendix 15 This audit should be completed monthly.

Disposal

Controlled drugs that are no longer required must be returned to the community pharmacy for disposal. This must be discussed with the pharmacist in advance and the returned medicines recorded in the controlled drugs register and the balance verified.
Care homes providing nursing care must make arrangements for the collection of waste medication with a licensed waste disposal company. Controlled drugs must be denatured before handed to the waste disposal company in a specially designed denaturing kit.

Medication error

A medication error can occur in the process of prescribing, dispensing, preparing, administrating, monitoring, or providing medicine advice, regardless of whether any harm has occurred. Examples of medication errors can include the following:

- Omissions - any prescribed dose not given.
- Wrong dose administered, too much or too little.
- Extra dose given.
- Wrong medication - the administration to a person of any medicine not authorised for them.
- Wrong dose interval.
- Wrong administration route - administration of a medicine by a different route or in a different form from that prescribed.
- Administration of a drug to which the person has a known allergy.
- Administration of a drug past its expiry date.
- If staff are aware or become aware of an error and the person is unwell, medical assistance must be sought immediately. In all situations, staff must contact the

manager immediately, ensure they make a record on the person's MAR chart and in their daily records.

Incident Reporting

If a medicines error occurs it must be reported immediately to an appropriate manager. The advice of a GP or a pharmacist must also be sought immediately.

It must be considered whether a safeguarding referral should be made to the appropriate body such as the Care Quality Commission (CQC) or the ICB.
Incidents concerning Controlled Drugs must be reported via the Controlled Drugs Accountable Officers website and a safeguarding referral should be made.

Audit

Provider managers must carry out an audit of a 25% sample of persons in residential care and 10% of persons in domiciliary care each month to ensure compliance with this policy. If compliance is less than 90% a re-audit should take place on a weekly basis until compliant.

Training

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014as amended, requires that individuals in key roles within the care service are fit and proper persons, possessing the necessary qualifications, competence, and good character to effectively oversee and support medication related activities.

The registered manager is responsible for arrangements for training staff and assessing competency. Bolton Council offers training for staff, and independent providers who provide care for people who live in Bolton. Training sourced elsewhere must incorporate the requirements of this policy.

All care staff must have an annual review of their knowledge, skills and competencies which includes refresher training. Any training undertaken should be recorded the member of staff's training file. Any workplace assessment must include direct observation of their practice by a suitably trained line manager or relevant health care. See Appendix 17 for an example of what needs to be assessed.

All Staff:

There are three levels of training for care staff.

Level 1 must be received by all care staff.

Level 1 forms part of induction training. The importance of this level is that it must raise awareness of the management of medicines. It must also identify what the care staff is **not** able to do before completing level 2 training.

Level 2 is essential before any care staff administers medicines and must be completed every 2 years.

Level 2 may be described as basic training and must be carried out by a registered nurse, pharmacist or pharmacy technician. This must provide the care staff with knowledge and practical skills to safely select, prepare and give different types of medicines, a process that is referred to as 'medicine administration'

Basic training is necessary for the following:

- Understand and comply with Bolton Adult Social Care Services Medicine policy and relevant CQC guidance
- Administer medicines safely and effectively
- Use safe procedures for handling medications
- Use and maintain Medication Administration Records (MAR charts)
- Seek appropriate advice on queries concerning medications

Level 3 - To be completed annually

This relates to those circumstances following an assessment by a healthcare professional, when a care staff is asked to administer medicines by a specialist technique including:

- Rectal administration, e.g. suppositories, (diazepam for epileptic seizures)
- Buccal administration (e.g. Midazolam)
- Insulin by injection
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Administration of oxygen

Glossary and References

Administer Medicine given to an individual for immediate consumption.

Assessment Identifying and recording the needs and risks of an individual so that appropriate action can be planned.

Blister pack Medication in individually sealed compartments as supplied by a manufacturer.

Carer An informal carer, e.g. family member, providing some level of unpaid care support to the individual. Formal (i.e. paid) carers are referred to in this policy as Care Staff.

Care and support plan An agreed record which sets out the outcomes for any help required, with details of services to be provided, who will be responsible for arranging them and a review date.

Case manager / case staff The staff responsible for carrying out the assessment, care planning and review of an individual's care needs – usually a social staff, care coordinator or community care officer.

Care package The combination of services agreed in order to meet the individual's assessed needs.

Care Provider A registered body who provides care to meet identified needs and is regulated by the Care Quality Commission.

Compliance Aid A device used to aid compliance e.g. special bottle tops, reminder charts. They also include reusable plastic containers for taking medicines that are divided into days/time of day usually known as 'multicompartmental compliance aids' (MCAs) or dosette boxes.

Covert Administration The administration of medicines in a disguising format without the knowledge or consent of the individual receiving them, e.g. in food or a drink Daily Diary Log The daily record chart care practitioners complete during their visit to an individual. Fixed.

Dosage When the dose of a drug has a fixed pattern with no end date.

Health/healthcare Professional Healthcare staff that are registered with a professional body e, g. a doctor, pharmacist, nurse, pharmacist technician. GP General Practitioner Homecare or Community Support Manager Senior Manager employed by the care provider, for example the Registered Manager or Care Manager.

Individual The person receiving support that may also referred to as the person.

MAR Chart Medication Administration Record Chart - the chart used for care practitioners to record all administration or refusal of medicines.

Medication/Medicines The terms drug, medicine and medication are used interchangeably.

Monitored dosage system A system or device which separates medicine doses to help an individual manage their medication. It must be prepared and sealed by a pharmacist and is only suitable for certain drugs. This may also be known as a pharmacy filled compliance aid.

Over-the-counter medicine Medication that an individual may choose to buy or be advised to purchase by a healthcare professional. Sometimes referred to as non-prescribed medication.

Prescribing Act of recommending or ordering, or the use of a medicine or a remedy by an individual.

Prescriber GP/Doctor/Consultant and Non-Medical Prescribers who prescribed medication

PRN Pro re nata is a Latin phrase meaning in the circumstances or ‘as required’ in reference to dosage of prescribed medication that is not scheduled.

Risk assessment A systematic process used on individuals for checking risks and hazards and how best to manage these safely.

Variable Dose When the dose of a drug may increase or reduce over a defined period of time but is still scheduled (as opposed to PRN medication). Additional information about this should always be shown on the label or provided through additional instruction

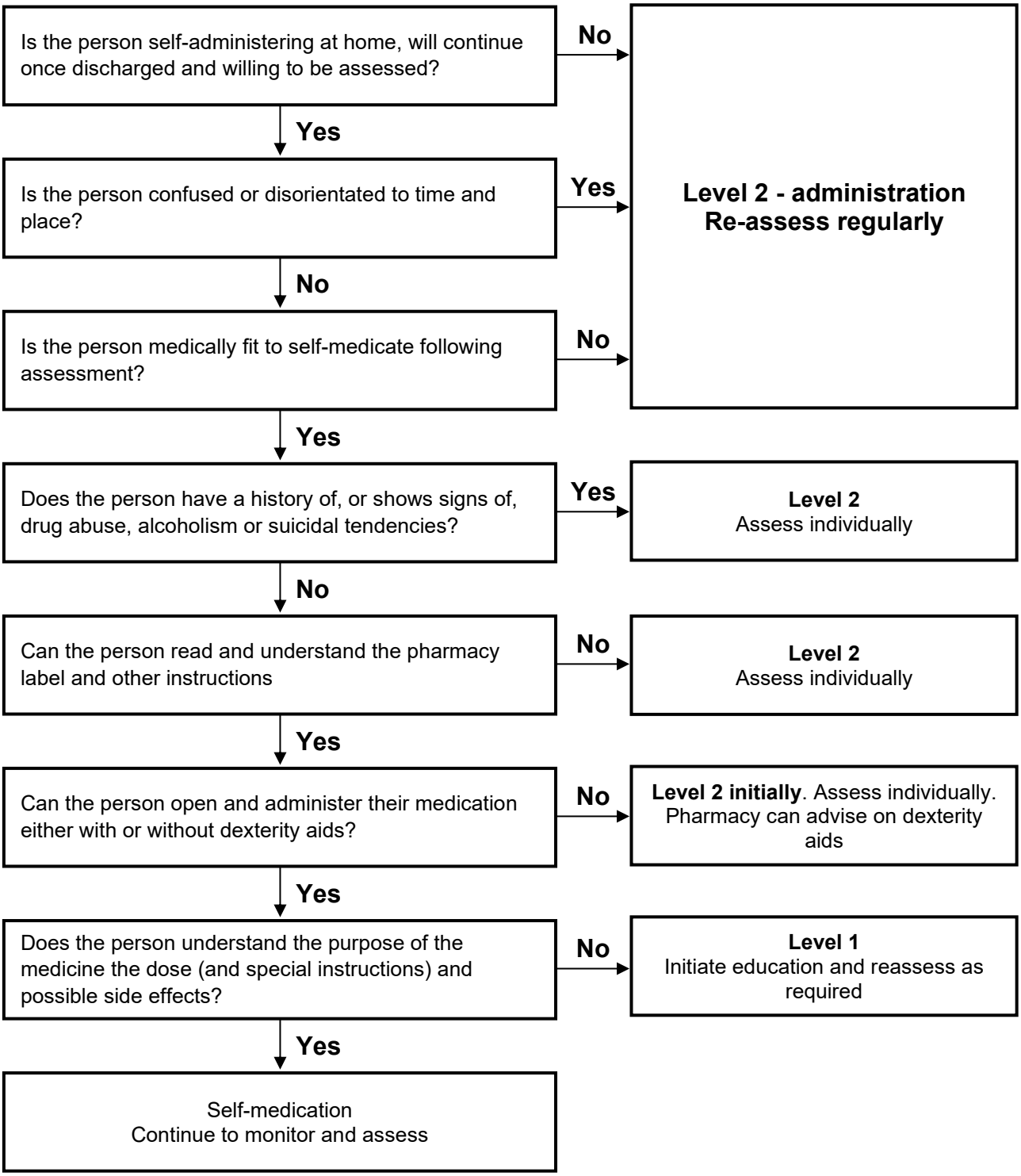
Advice on medicines

Advice on medicines can be obtained from

- Any community pharmacist
- The Community Services Medicines Management Team: 01204 337693
- The pharmacy department at The Royal Bolton Hospital: 01204 390390
- Medicines Information The Royal Bolton Hospital: 01204 390748
- The person's GP

Appendix 1 – Self Administration of medicines risk assessment – bed based services

Person's Name:	D.O.B:	Base:



For further advice or support contact the community services pharmacy team

Self-Medication of Medicines Assessment Record

Person's Name:	**D.O.B:**	**Base:**

Admission Date:		Review on a weekly basis or sooner if condition changes			
Initial assessment level		Assessed by		Date	
Review of assessment level		Assessed by		Date	
Review of assessment level		Assessed by		Date	
Review of assessment level		Assessed by		Date	
Review of assessment level		Assessed by		Date	

Levels of self-medication	
	Full self-medication following documented assessment
Level 1	Patient needs supervision with their medicines. The bedside table key is in possession of the care supervisor. As a minimum, the care supervisor and patient must together check the medicines to be taken. The pharmacy team will, if appropriate, educate the patient on how the medicines are to be taken and why they are prescribed
Level 2	Full care supervisor administration of all types of medication
Level 3	Nurse administration for certain specific medicines or carers after specialist training (e.g. injections, pessaries or suppositories)

Assisted medication form

Person's Name:			**D.O.B:**	**Base:**
Room No:			**Compliance aid being used:** Yes/No	
Date:	**Time:**	**Interventions/comments:**		**Signature:**

Self-Medication of Medicines in Intermediate Care

Consent Form

Name of person.....

Address .....

.....

Date of birth.....

I agree to be responsible for my medicines, as detailed below, whilst in Intermediate Care.

Medicines for self-medication include:

.....

.....

.....

A pharmacy technician or pharmacist has explained what my medicines are for and any other important information.

I will:

Ensure my medicines are either on my person or locked up securely in the bedside table provided. I will not leave them unattended anywhere in the building

Tell the care supervisors looking after me when I have taken my medicines

Ask the pharmacy staff or care supervisors if I am unsure about anything

Only take medicines that are prescribed for me

Tell the care supervisors if I am running out of a medicine.

I understand that I can change my mind at any time and ask the care supervisors to resume administering my medicines to me.

Signature of patient .....

To be completed by the assessor:

Signature of assessor .....

Name of assessor .....

Date of assessment .....

Appendix 2 – Medicines Administration Authorisation Form

Name of person: .....

Address: .....

.....

I give authorisation for Bolton Council to arrange for a care staff to administer my medicines as prescribed by a GP, dentist or non-medical prescriber. I also give authorisation for a care staff to administer non-prescribed medicines in accordance with the list of homely remedies and self-care guidance.

I give permission for appropriate health care professionals to access my health records while I am under this service

The type of assistance I might need has been explained to me and is written on my care plan. I understand that the person administering my medicines will always check that I give my permission before administration. I also understand that I am free to refuse the medicines at any time.

Signature of person: ……

NB. The person must only sign this form if they have the capacity to consent to a care staff administering their medicines.

To be completed by the assessor:

Name of assessor: .....

Tel No:.....

Date of assessment: .....

Either:

1. I have explained the support to be offered and believe that the person understands and consents to this at the time of completing this form.

Signature of assessor: .....

Or:

2. I do not believe that the person understands and can consent to the support that is being offered at the time of completing this form.

It has been decided that **it is / it is not** (delete as appropriate) in the person's best interest for medicines to be administered. The following people have contributed in making this decision.

(Include contact details and relationship to person)

.....

.....

Signature of assessor: .....

If the person lacks capacity to consent, is there a personal welfare attorney (Lasting Power of Attorney) or a deputy* in place? **Yes/No**

If yes, please give details:

Name:.....

Contact Details: .....

Does the attorney or deputy consent to administration of medicines on behalf of the person?

Yes/No

Signature of attorney/deputy:.....

Date:.....

This authorisation must be kept on the person's file and a copy in their home (if domiciliary care)

Appendix 3 – Pictorial Medicines Authorisation Form

Bolton Adult Services

Medicines Administration Authorisation

I will let a care staff help me with my medicines.

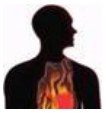
Medicines from my Doctor, or some of these:

Simple Linctus

Senna

E-45 or Sudocrem

Paracetamol



Gaviscon

Olive oil ear drops

If my medicines change, I will have to sign another form.

Name of person.....

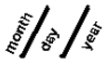
Address of person .....

Signature of person .....

Name of assessor .....

Signature of assessor.....

Contact number .....



Date of assessment.....

Name of GP .....

Appendix 4 – Sample MAR chart

MEDICATION ADMINISTRATION RECORD

NAME		D.O.B.	
ADDRESS (Room Number)		ALLERGIES	
GP	TEMP GP	START DATE	END DATE / START DAY

MEDICATION PROFILE	COMMENCING Date / Time	Week 1	Week 2	Week 3	Week 4

			date recd.	quant.	by	date recd.	quant.	by	
Commenced		route	date recd.	quant.	by	date returned:destroyed	quant.	by	
GP Sig.			date recd.	quant.	by	date recd.	quant.	by	
Commenced		route	date recd.	quant.	by	date returned:destroyed	quant.	by	
GP Sig.			date recd.	quant.	by	date recd.	quant.	by	
Commenced		route	date recd.	quant.	by	date returned:destroyed	quant.	by	
GP Sig.			date recd.	quant.	by	date recd.	quant.	by	
Commenced		route	date recd.	quant.	by	date returned:destroyed	quant.	by	
GP Sig.			date recd.	quant.	by	date recd.	quant.	by	
Commenced		route	date recd.	quant.	by	date returned:destroyed	quant.	by	

A = Patient away from unit **D**= Drug not available **N**=Nurse administration **R**=Refused **S**= Self medicate **V**= Vomiting or nausea

O= Other (define)..... Page.....of.....

Appendix 5 – Signature chart (Bolton adult services signature record chart)

BOLTON ADULT SERVICES SIGNATURE RECORD CHART

To be completed by any member of staff who administers medicines or is involved with the completion of a MAR chart.

DATE	NAME	SIGN NAME	INITIALS

Appendix 6 – Example of Fridge and room temperature monitoring chart

Daily temperature checks							
Service		**Fridge Location**		**Month**		**Year**	

All drug fridge temperatures and ambient clinical room temperatures MUST be recorded daily.
When checking the temperature, you must ensure the reading is between 2°C and 8°C for fridges and <25°C for ambient temperature. If the reading falls outside the parameters:
Refrigerator- Ensure the door is closed. Wait 10 minutes and re-check. If the temperature remains out of range quarantine stock and contact appropriate manager/ Pharmacy for advice
Ambient- if the room temperature is greater than 25 °C or temperature excursions occur over more than one day or on multiple days in a given week contact appropriate manager/Pharmacy for advice
Move medicines to an alternative monitored fridge until the problem has been solved
Contact the prescriber to order replacement medicines if required

Date	**Time**	**Fridge temperature**			**Check (initial)**	**Reset (initial)**	**Ambient temp (<25°C)**			**Check (initial)**	**Reset (initial)**
		Actual Between 2-8°C	**Min** More than 2°c	**Max** less than 8°c			**Actual**	**Min**	**Max**		
1st											
2nd											
3rd											
4th											
5th											
6th											
7th											
8th											
9th											
10th											
11th											
12th											
13th											
14th											
15th											
16th											
17th											
18th											
19th											
20th											
21st											
22nd											
23rd											
24th											

25th											
26th											
27th											
28th											
29th											
30th											
31st											

Please note Drug Fridges should be cleaned weekly - Date and sign below when this has been completed

Week 1		**Week 2**		**Week 3**		**Week 4**		**Week 5**	
Date	Sign	Date	Sign	Date	Sign	Date	Sign	Date	Sign

Appendix 7 – General guidance for assessors and care staff for the timing of medicines administration

Cautionary and advisory labels for dispensed medicines

If there is a specific instruction for administering a particular medicine it must be followed. It will be included on the label e.g. ‘take with or after food’ or ‘dissolve or mix with water before taking’.

If a medicine has specific requirements these will be on the label - examples of medicines with specific instructions are some diabetic medicines, anti-coagulants such as warfarin or medicines containing ‘nitrates’ such as ‘Isosorbide Mononitrate’

As a **general** rule if a medicines is labelled as follows:

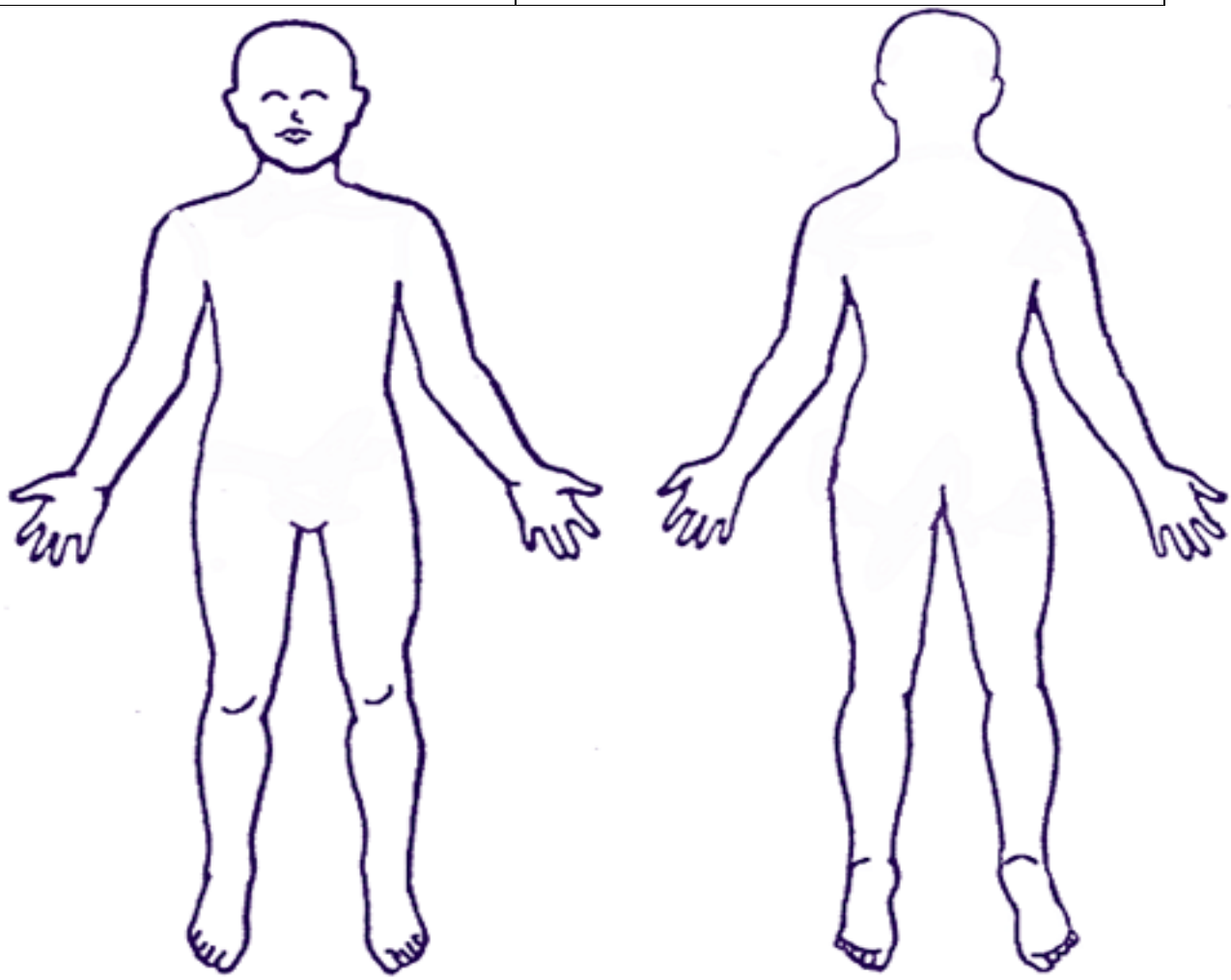
Direction	Time of administration
Daily	Administer once a day at the same time each day
Twice daily	Administer either: morning and teatime or morning and bedtime This depends on the care package. Medicines which must be administered at **teatime** rather than bedtime include **diabetic** medicines (this will be identified in the care plan if a patient is diabetic) and the label will specify ‘take with of after food’, anticoagulants such as **warfarin** and medicines containing ‘**nitrates**’ such as ‘Isosorbide Mononitrate’
Three times a day	Administer either: morning, lunch and bedtime or morning, teatime and bedtime Depending on the care package See below for advice on taking with foods
Four times daily	Administer morning, lunch, teatime and bedtime
Night	Administer at bedtime
Take with or after food	Does not necessarily have to be a full meal, a light snack such as a piece of toast or a glass of milk is adequate

Take 30 minutes before the first food, drink or medicines of the day with a full glass of plain water. Do not lie down for 30 minutes after taking	Administer in the morning on arrival at a patient's home. Keep the patient upright (sitting or standing) and carry out any other necessary tasks before breakfast

Appendix 8 – Cream and ointment application chart

Service Users Name:	Date of birth:	Liquid logic Number / NHS number:

Prescribed cream / ointment	Directions for use



This form should be placed in the person's room & completed on each application

Date	Time	Area cream applied	Staff signature	**Comments** – including name of cream/ointment if more than one prescribed

Cream and ointment application chart – Page 2

Service Users Name:	**Date of Birth:**	**Liquid Logic Number/NHS number:**

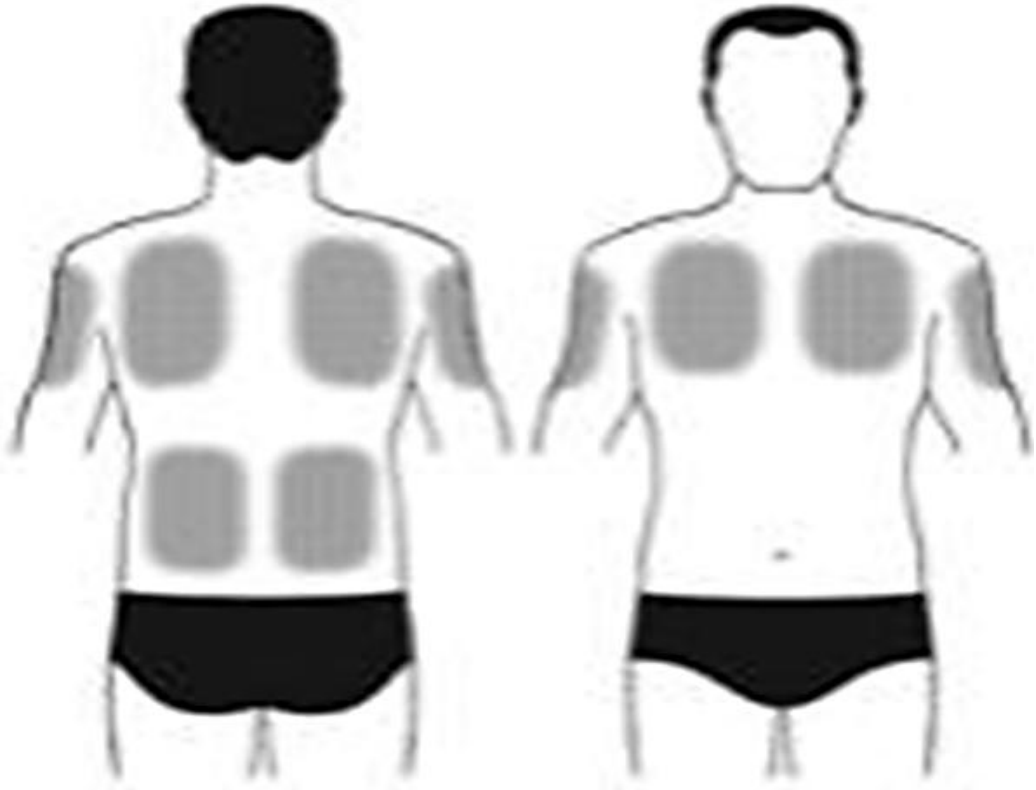
Date	**Time**	**Area cream applied**	**Staff signature**	**Comments** – including name of cream/ointment if more than one prescribed

Appendix 9 – Patch application chart

Service Users Name:	Date of birth:	Liquid logic Number/NHS number:

Prescribed Patch	Directions for use

Apply patch to ONE of the following possible sites.
The diagram represents areas on the body where the patch may be applied.
Please rotate the patch leaving several days between using same site.
Application of patch must also be recorded on the MAR chart



Patch Number	Date Applied	Time	Comments - including name of patch if more than one prescribed

Patch application chart – Page 2

Service Users Name:	**Date of birth:**	**Liquid logic Number/NHS number:**

Prescribed Patch	**Directions for use**

Patch Number	**Date Applied**	**Time**	**Comments – including name of patch if more than one prescribed**
Patch Number	**Date Applied**	**Time**	**Comments**
Patch Number	**Date Applied**	**Time**	**Comments**

Appendix 10 – Example letter/form for administering medication in an unlicensed manner (GP/Pharmacist authorisation for administration of unlicensed medicines)

Practice stamp/Unit Name

Patient
Name:

D.O.B

NHS No:

Address:

Authorisation for care staff to give medication in an unlicensed way (i.e. not advised in product information leaflet)

Crushing/dispersing tablets in water or opening capsules is often an unlicensed use of a product and this **must only** be done under the direction of a prescriber and/or a pharmacist.

This letter/form authorises care staff to give the following medication as advised in the table below:

Medication	**Administration directions** **(Include method e.g. crush in a tablet crusher, disperse in 15-30mls of water etc.)**	**Information source consulted (e.g. NEWT Guidelines/SPC/drug manufacturer)**

General advice: Only crush medicines one tablet at a time; preferably in a tablet crusher. Crushing or dispersal in liquid should be performed immediately before administration. Medication should be placed in a small amount of food e.g. a teaspoon of cold food (if stable to do so – see above) or 15-30ml of liquid, to ensure that the entire dose is given and there is no danger of it being given to other residents.

Do not mix dispersed medicines with milk or carbonated water. Diluted blackcurrant cordial can be used to mask taste.

These directions apply to the above patient only. If any new medication is started or any circumstances surrounding drug administration for this patient change, then advice must be sought from the prescriber and/or pharmacist.

Authorising Prescriber Name:		Reg No:
Signature:		Date:
Authorising Pharmacist Name:		GPhC No:
Signature:		Date:

Appendix 11 – Homely remedies

HOMELY REMEDIES GUIDANCE

DEFINITION: A homely remedy is a product that can be obtained and administered to a resident/service user without a prescription, for the immediate relief of mild to moderate symptoms e.g. toothache, indigestion etc.

Administration

Ensure service user has no potentially serious symptoms
Check past medical history and drug history
Check allergies
Service users consent
Max 48 hours

Storage

Store separately from prescribed medication
Clearly indicate they are homely remedies
Date check every month
Record date opened for liquid medication and check when should be used by

Record keeping

Record details of assessment, homely remedy administered and outcome in care plan
Record administration on homely remedy chart

Adverse reactions

Report any adverse reactions to GP

Paracetamol

Indication: Relief of occasional mild to moderate pain

Maximum Duration of Treatment: 48 hours

Possible side effects: Rare but may include rash

Has the service user been given any medication containing paracetamol in the last 24 hours?

- This includes preparations such as co-codamol (brand names Kapake, Solpadol, Zapain and Remedeine), co-dydramol, co-proxamol and products purchased over the counter such as cough and cold remedies.
- Labels of current medication should be checked carefully for paracetamol content
- Paracetamol may still be given with other paracetamol containing products provided that the **maximum dose in 24 hours is not exceeded** (see below) and that it is at least **four hours** since the last dose

Are there any medical reasons why paracetamol may be inappropriate for the service user?

- Paracetamol is not suitable if the resident has a history of **severe liver disease** or **alcohol abuse**

Can the service user swallow tablets?

- If it is decided that the service user can safely have paracetamol, they can be given either tablets or liquid as follows:
- 500mg tablets/capsules/caplets: **TWO tablets up to FOUR times a day**. Maximum of TWO tablets (1g) in any FOUR hours, maximum daily dose = 8 tablets (4g).
- 250mg/5ml suspension: **20ml* up to FOUR times a day**. Maximum of 20ml in any FOUR hours, maximum daily dose = 80ml* (4g)

*20ml = FOUR x 5ml spoonful's

SENNA

Indication: Occasional or non-persistent constipation

Maximum duration of treatment: 48 hours

Possible side effects: Temporary mild griping pain/abdominal cramps

Is it possible to rectify the constipation without drug treatment?

- Aim to encourage fluid intake (little and often) and increase dietary fibre intake with fruit juice, dried apricots and prunes
- Increase mobility of service user if possible

Are there any medical reasons why senna may be inappropriate for the service user?

- Senna should not be usd if the service user is already taking a laxative e.g. Macrogols (Movicol), Ispaghula Husk (Fybogel), Docusate (Dioctyl), Lactulose etc.
- Avoid in nausea, vomiting, intestinal obstruction or abdominal pain
- **Refer to doctor immediately** if symptoms such as constipation alternating with diarrhoea, rectal bleeding, passing mucous, anorexia or weight loss are present or if symptoms are persistent
- Do not give senna to any service users who may be pregnant/breastfeeding

Can the service user swallow tablets?

- If it is decided that the service user can safely take senna, they can be given either tablets or liquid as follows:
- 7.5mg tablets: **TWO tablets at NIGHT**. Max. daily dose = TWO tablets (15mg)
- Senna 7.5mg/5ml syrup: **10mls* at NIGHT**. Max. daily dose = 10mls (15mg)

*10mls = TWO x 5ml spoonful's

Additional Information

- Senna usually takes 6-12 hours to work
- Drink plenty of fluids whilst taking senna and aim to increase dietary fibre
- PRN medicines that can commonly constipation: codeine, morphine, tramadol, indigestion remedies, antihistamines (e.g. chlorphenamine), antidiarrheals (e.g. loperamide)

Simple Linctus

Indication: Dry, irritating cough

Maximum duration of treatment: 48 hours

Possible side effects: None known.

Will the service user benefit from taking simple linctus?

- Simple linctus is indicated for **dry (i.e. non-productive), irritating coughs**
- If the service user is bringing up phlegm that is clear white or pale yellow in colour then simple linctus may not be beneficial. Instead, plenty of fluids should be given and the patient should be monitored for any signs of deterioration.

Are there any medical reasons why simple linctus may be inappropriate for the service user?

- If the service user has symptoms such as shortness of breath, chest pain, wheeziness, copious/dark/blood stained phlegm, seems generally unwell or suffers from asthma/COPD then they should be referred to the GP.

What dose should be given to the service user?

- If it is decided that the service user can safely take simple linctus, they can be given:
- Simple Linctus: **5 - 10ml* up to FOUR times a day**. Max. daily dose = 40ml.

*5-10ml = ONE to TWO 5ml spoonful's

Additional Information

- Contains alcohol – care with religious beliefs
- May be more soothing if taken with warm water
- Ensure resident has access to plenty of fluids throughout the day

Gaviscon Advance

Indication: Relief of heartburn/indigestion

Maximum duration of treatment: 48 hours

Possible side effects: Very rarely allergic reaction – rash, itch, dizziness, difficulty breathing

Could Gaviscon affect any of the service users other medication?

- **Gaviscon should not be given at the same time as other medication as it may affect absorption**

Are there any medical reasons why Gaviscon may be inappropriate for the service user?

- If the service user is suffering from severe gastric pain then they should be referred to the GP

What dose should be given to the service user?

- If it is decided that the patient can safely take Gaviscon Advance, they can be given:
- Gaviscon Advance Suspension: **5-10ml* AFTER meals and at BEDTIME**. Max. daily dose = 40ml (in divided doses). **Shake well before use.**
- Note: Lifestyle measures such as eating small regular meals, chewing food well, avoiding spicy food and avoiding clothing which is tight around the waist may also help to ease symptoms

*5-10ml = ONE to TWO 5ml spoonful's

ADDITIONAL INFORMATION

- Gaviscon Advance is sugar free and therefore suitable for diabetics
- PRN medicines that commonly cause indigestion include NSAIDs e.g. aspirin, ibuprofen, naproxen, diclofenac
- **Caution: chest pain due to angina or heart attack can be mistaken for indigestion/heartburn**

E45 & SUDOCREM

Indication: Mild skin conditions

Maximum duration of treatment: 48 hours

Possible side effects: Local hypersensitivity reactions

What conditions can E45 and Sudocrem be used for?

- Sudocrem can be used for the treatment of incontinence rash where the skin is intact. It is a "barrier cream" and its main purpose is to protect the skin.
- E45 is used to soothe and reduce the irritation of dry skin

Are there any reasons why these creams may be inappropriate for service users?

- Any signs of development of a pressure area, refer to nurses
- Sudocrem is not appropriate for service users who wear pads, as the pad becomes ineffective
- If the service user is suffering from a rash accompanied by systemic symptoms (e.g fever, vomiting, diarrhoea) then they should be referred to the GP

How should I apply these creams?

- Use **gloves** when applying and ensure that a **separate tube** is used for each resident - **never share creams**
- Ensure skin is dry and clean before application
- E45: **apply to affected areas AS OFTEN AS REQUIRED**
- Sudocrem: **apply a thin layer TWICE DAILY to the affected area**. Max daily dose = two applications

ADDITIONAL INFORMATION

- Since both products contain paraffin, residents should not smoke after use and should be kept away from fire/flames
- Do not decant

Olive Oil Ear Drops

Indication: Ear wax

Maximum duration of treatment: 10-14 days before ear syringing

Possible side effect: Pain

What condition can olive oil ear drops be used to treat?

- Some people produce more ear wax than others and a build up of wax is more likely to occur in: older adults, patients with learning difficulties, hearing aid users, people with a narrow ear canal or those using cotton buds

What problems can excessive wax lead to?

- Tinnitus, hearing loss, vetigo, pain and discharge
- It can also prevent an audiologist from being able to assess hearing ability or take impressions for hearing aids

What dose should be given to the service user

- 1 - 2 drops into the ear canal 2-4 times a day
- Keep the person on their side for 5 minutes after administering
- Do not put cotton wool in the person's ear
- If at any stage the person complains of any pain then the drops should be stopped and advice sought from person's GP

Additional Information:

- Only to be used on the advice of audiology

To be administered for a maximum of 48 Hours before contacting the person's G.P.

Name:				**D.O.B.**	
Address:					
				Allergies:	
G.P.					
Date:	**Time:**	**Initials:**	**Medicines:**	**Dose:**	**Reason:**

Appendix 12 – Self care

Self-Care Form

Care staff/support staff cannot administer any product to manage self-care without checking that these are suitable for a service user. The purpose of this form is to document the advice of a health care professional on the use of a self-care product. The health care professional advising should check suitability of the product for the service user as well as checking it does not affect any medicine the person is already taking.

Name of Service user and family member requesting self-care			
Date of Birth			
Date of request			
Reason for request			
Medication name, form and strength			
Dose/Frequency			
Duration			
Review Date			
Consult GP if			
Name of person giving advise			
Role	Nurse	Pharmacist	GP

Signature of service user or their family to show they understand and accept any risk associated with taking the medicine	

Appendix 13 - Standard Operating Procedure (SOP) for Controlled Drugs in Care Homes

The Misuse of Drugs Act 1971 controls the availability of drugs that are considered sufficiently ‘dangerous or harmful’ with a potential for misuse. These drugs are termed Controlled Drugs (CDs) and it is a criminal offence to possess, possess with intent to supply or administer these drugs without authorisation.

Controlled drugs are likely to cause dependence or misuse in varying degrees. They are classed according to the extent of harm they may cause when misused.

Advice about controlled drugs may be sought from a community pharmacist.

There must be strict controls for the prescribing, administering, safe custody, dispensing, record keeping and disposal of controlled drugs.

Any concerns about the management of controlled drugs must be reported using an incident reporting procedure. These concerns must be shared with the Local Information Network for controlled drugs where they will be reviewed via the incident reporting system on www.cdreporting.co.uk.

Administration

Before administering a CD, the care staff must measure and check the dose with another level two medication trained member of staff whenever possible. If a trained member of staff is not available to check the dose another competent member of staff must carry out the check.

The person’s name, plus time and dose given, should be recorded in the CD register after carefully checking the administration chart. Once the trained care staff has witnessed the resident taking the medication, the service user’s MAR chart must be initialled by the care staff.

The care staff and the witness should then initial the CD register, after verifying that the remaining balance is correct.

The administration process should be fully completed for each service user, before moving on to the next service user.

Receipt, storage, recording and audit

Care staff collecting controlled drugs prescriptions from a pharmacy will need to provide identification.

A CD register (a bound book or register with numbered pages) must be used to record the receipt, administration and disposal of CDs held in the service. Each drug, for each service user, should be recorded on a separate page, with the name, dose and strength of the drug written clearly at the top of the page.

If a District Nurse administers a CD in a residential service, they must complete their own documentation and the CD registers belonging to the service.

On receipt of the CD from the pharmacist, the date and quantity must be entered into the CD register and initialled by an authorised member of staff, with a second person as a witness. The correct balance should be verified each time.

When transferring the drug record to a new page in the CD register, the amount remaining must be identified with ‘brought forward from page x’ written clearly on the new page. It is good practice to keep CD registers for longer than the mandatory two years.

Controlled Drugs must be stored in a locked metal cabinet which fulfils the requirements of the Misuse of Drugs Act 1971.

Completed registers must be archived for a minimum of 2 years and according to Bolton Council Records Retention policy.

Routine checks of all CDs held and the recorded running balances should be carried out by designated members of staff on a weekly basis and a record kept. Where a discrepancy is found it should be reported to the registered manager who should investigate promptly. If the discrepancy cannot be resolved, the advice of a pharmacist should be sought and the CQC local officer informed. An audit form for Controlled Drugs in Residential Services is included in Appendix 13. This audit should be completed every six months in addition to weekly stock checks.

Disposal

Controlled drugs that are no longer required should be returned to the community pharmacy for disposal. This should be discussed with the pharmacist in advance and the returned medication recorded as returned in the CD register.

Care homes providing nursing care must make arrangements for the collection of waste medication with a licensed waste disposal company. CDs must be denatured before handed to the waste disposal company in a specially designed denaturing kit.

This should be used as a Standard Operating Procedure for residential services. It should be printed and displayed within the service

Appendix 14 – Weekly count of CD's

Base.....

Weekly Count of Controlled Drugs						
Date:	Drug count correct: Yes/No (if incorrect give details)	Signature – CS	Signature of witness	Discrepancy reported to	Discrepancy resolved by	Date discrepancy resolved

N.B. If weekly drug count is not completed; you must state the reason why.

Appendix 15 – Residential Services Controlled Drug Audit

Instructions:

1. Complete the audit every six months.
2. Collect CD register and a MAR chart for a service user who has been administered a CD.
3. Complete audit.
4. Complete the "Action required" column including realistic target dates.
5. Re-audit as necessary.
6. Store the completed audits for a period of 2 years and ensure that they are available for review by relevant personnel e.g. pharmacy staff, CQC, local authority staff, etc.

Any incidents involving CDs should be reported to the CD Accountable Officer by the individual who has discovered the issue via the following website: www.cdreporting.co.uk. A safeguarding referral should be made and any relevant in-house/external incident forms or procedures completed. Any loss of CDs should be reported to the police.

Completed by:

Name: Signature: Job title: Date:

The CD Cabinet	Findings	Action required
Does the metal cabinet used to store the CDs fulfil the requirements of The Misuse of Drugs (Safe Custody) Regulations 1973.		
Are all medicines clearly segregated?		
If CDs are packed in a Monitored Dosage System (MDS), is the whole container stored in the CD cupboard when not in use?		
Is the stock level appropriate? i.e. no more than approx. a month's supply in stock?		
Are there any out-of-date medicines in the CD cupboard?		
Is there anything else stored in the cupboard that should not be there (e.g. money or valuables)?		
Are drugs awaiting destruction clearly segregated from other stock in the cupboard (e.g. expired drugs or drugs no longer required by the patient)?		
Are the CD cupboard keys kept separately from general keys?		
CD Register	**Findings**	**Action required**

Is there a separate page in the CD register for each drug, each formulation, each strength and each patient?		
Are all entries complete, clear and legible? This should include name and form of drug, quantity of stock, date received, patient name, date, time, quantity supplied, signature of person administering drug, signature of witness and remaining balance.		
Are all entries supported by two signatories?		
Are all stock balances correct?		
Are balances checked on at least a weekly basis?		
Is there a record of all CDs that have been destroyed (nursing) or returned to pharmacy (residential care)?		
If applicable, are any amendments in the CD register annotated with footnotes (initialled and dated) rather than crossed out? If crossing out is found, has follow up action taken been taken?		

Administration	Findings	Action required
At administration has the MAR chart been signed by the member of staff administering the medication?		
Do the instructions on the MAR chart agree with the dosage administered according to the CD register?		

Appendix 16 – Example Medicines Administration Record (MAR) Audit Form

Registered service: ……Date completed: ……Completed by: ……

Room number/ID										
Name of person										
Date of birth										
Address/Room No										
GP/surgery										
Allergies										
MAR dated for current period										
MAR pages numbered										
Name of medicine										
Strength of medicine										
Form of medicine										
Dose of medication (including frequency and time)										
Day of administration recorded for once weekly medication or 72hrs/96hrs										
Course duration or stop date (antibiotics, steroids etc)										
Maximum daily dose stated for “as required” medication										
Total number of tablets administered e.g. 1 or 2 tablets										
MAR charts initialled to confirm correct										
Strength and number of warfarin tablets given, recorded on MAR										
Carers signed for doses given										

Appropriate use of codes if medication not given										

Registered service: ……Date completed: ……Completed by: ……

Room number/ID										
"Other" reason codes if medication not given										
Quantity of medicines received, recorded and signed in by care staff										
Two signatures to confirm amendments										
Two signatures on handwritten/carers own MAR										
Special storage requirements adhered to e.g. fridge items										
Fridge and room temperature daily monitoring										
Medication stocked in safe manner										
Date of opening recorded e.g. eye drops										
All medicines in date										
Homely remedies medication supplied for maximum 2 days										
Homely remedies medication chart completed correctly										
Consent form signed										
No out of date MAR charts left in folder										
Support to self-medicate available										
Relevant risk assessments completed										
Covert administration form completed (if applicable)										
Disposal (record of returned medicines)										

Not all of the criteria will be applicable to all services. For further advice contact the pharmacy team on 01204 337693/337071

Appendix 17 – Medication Administration Competency Assessment

A thorough assessment should be undertaken before staff members begin administering medication unsupervised. The assessment should be repeated at intervals of not less than one year or sooner if circumstances indicate, for example, if there has been a medication error.

Questions have a "yes/no/not applicable" response. Where a "no" response has been selected this must be resolved before the person can undertake medication administration unsupervised.

It may not be possible to witness the administration of all the different forms of medication if no one that you visit has this type of medication.

Name of staff member:	**Date:**

Training and policy

Has the member of staff completed administration of medicines training and/or refresher training? Date completed:	Yes/No
Does the member of staff know how to access the medication policy if they wish to check any information?	Yes/No

Administration of Medicines

Preparation and hygiene	
Staff member identified person	Yes/No
Did the member of staff check the documentation available to establish where the medication is kept for that person?	Yes/No
Did the member of staff make sure that everything was properly prepared before starting to administer the medication, e.g. prepare a drink for the person	Yes/No
Did the member of staff wash their hands before starting to administer any medication and follow appropriate hygiene measures whilst administering the medication? E.g. wear gloves when applying creams.	Yes/No
Consent	
Before preparing or administering the medication where applicable, did the member of staff obtain the person's consent to administer?	Yes/No
Selection and preparation of medication	
Before selecting, preparing or administering any medication did the member of staff read the MAR chart accurately?	Yes/No

Did the member of staff check whether a dose had already been administered/taken by the person or if the medication had been cancelled?	Yes/No/NA
If any directions are unclear or illegible on the MAR did the member of staff take appropriate steps to clarify the directions?	Yes/No/NA
Was the medication selected checked against the correct MAR chart including checking the person's name on the label and MAR?	Yes/No
If the directions on the MAR chart differed from those on the label did the member of staff take the appropriate steps to satisfy themselves as to the correct dose to be given	Yes/No/NA
Was the correct medication and dose selected at the correct time? Was consideration given to timing in terms of food or other directions on the label?	Yes/No
Was the medication prepared according to the directions and information on the MAR chart or any accompanying protocol?	Yes/No
Administration	
Did the member of staff check the records to see how the individual prefers to take their medication or demonstrate that they knew this information and administer the medication accordingly?	Yes/No
Did the member of staff offer information, support and reassurance throughout to the person, in a manner which encourages their co-operation, promotes dignity and which is appropriate to their needs and concerns?	Yes/No

NA – not applicable

Was the medicine administered correctly and a glass of water offered where appropriate? Please tick the items you have witnessed being administered.	Yes/No

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

Did the member of staff visually witness the person taking all their medicines	Yes/No
If the medication was left for the person to take later was this done in accordance with a documented agreed plan and was this recorded on the MAR chart correctly?	Yes/No/not applicable

If the medication was not taken was the appropriate advice sought and documented?	Yes/No/not applicable

Record keeping

Did the member of staff sign the MAR chart immediately after administration or enter appropriate code if not given?	Yes/No

Stock control

Did the staff member check that there is sufficient prescribed medication for at least one week?	Yes/No/ NA
If there are shortages in medication, did the member of staff take appropriate action (as per care plan) to ensure the stock was replaced?	Yes/No/NA
Was all medication stored appropriately? E.g. fridge, not near a radiator, locked box if needed	Yes/no

Ordering, receipt and disposal of Medication

Where staff are responsible, did the member of staff record any medication received into the person's home/care setting using the correct documentation?	Yes/No/NA
Was any out of date medicine or discontinued medicine dealt with in accordance with the care plan/medicines policy?	Yes/No/NA

Assessing advice and information

Does the member of staff know who to contact if they need advice on medication?	Yes/No

Dealing with errors

Can the member of staff describe the correct process for dealing with a medication error?	Yes/No

Outcome of assessment	✓
Demonstrates competence to administer medication unsupervised	
Demonstrates competence to administer medication unsupervised with the exceptions identified below:	
Requires further supervision or training in order to administer medication unsupervised	

Name of member of staff being assessed.....

Signature .....

Job title .....

Name of assessor.....

Signature .....

Job title .....

Date of assessment.....

This assessment must be reviewed by……or sooner if circumstances change

Appendix 18 – Example Risk assessment

Bolton Council	Risk Assessment	

Task/Activity:	Date assessment completed:	Review Date:
Brief Details of Task/Activity:	Assessment completed by:	Signature:

What are the hazards?	Who might be harmed and how?	What are you already doing to control the hazard?	What further action or additional controls are required	Risk rating	Action by who	Action by when	Date completed

CATEGORIES OF LIKELIHOOD	
Highly Likely	Expected to happen/reoccur, possibly frequently.
Possible	Might happen/reoccur at some time depends on circumstances.
Unlikely	Not expected to happen/reoccur but possible in certain circumstances.
Very Unlikely	Would only occur in very exceptional circumstances.

CATEGORIES OF CONSEQUENCE SEVERITY	
Catastrophic	Incident could result in one or more fatalities
Major	Major injury resulting in incapacity, hospitalisation >24 hours
Significant	Injury requires attention of a Doctor or Hospital treatment or hospitalisation <24 hours
Minor	Small cut, bruise, abrasion, basic first aid treatment provided
Negligible	Some discomfort, self-help. No treatment required

RISK RATING				
	Highly Likely	Possible	Unlikely	Very Unlikely
Catastrophic	A	A	B	E
Major	A	B	C	E
Significant	B	C	D	E

RISK CLASSIFICATIONS	
A	**Unacceptable risk** requires immediate attention. Work *should not be started or continued* until the level of risk has been reduced.
B	**High risk** requires immediate attention. Control measures must be identified and put into place as soon as possible.
C	**Medium risk** requires attention as soon as possible. The risk should only be tolerated in the short term and only when further control measures are being planned and introduced, Timescales must be short.
D	**Low risks,** confirm that there are no low/no cost solutions which may eliminate/ reduce the risk further.

Minor	C	D	E	E
Negligible	E	E	E	E

E	**Trivial risks,** no further action required but review at regular intervals to ensure controls remain effective.

Appendix 19 – 'When required' (PRN)/variable dose template

The following information must be referred to when offering and administering prescribed PRN and variable dose medication. This chart must be kept with the resident's MAR chart for reference. Response to therapy for PRN medication should be recorded in the resident's care plan or on the back of the MAR chart.

<table>
<tr><td>Person's name:</td><td colspan="2">Date of birth:</td></tr>
<tr><td>Name of medication:</td><td colspan="2">Form:</td></tr>
<tr><td>Strength:</td><td colspan="2">Route of administration:</td></tr>
<tr><td>Dose and frequency:</td><td>Minimum interval between doses:</td><td>Maximum dose in 24 hours:</td></tr>
<tr><td colspan="3">Reason for administration (why the medication should be given): Describe in as much detail as possible the condition being treated i.e. signs & symptoms, behaviours, type of pain, expected outcome.</td></tr>
<tr><td>Can the resident judge if they require their medication?

Yes No Only if prompted</td><td colspan="2">Variable doses
How is the patient assessed for variable dose medication? i.e. if the prescription says one or two, under what circumstances should one tablet be given and under what circumstances should the dose be two?</td></tr>
<tr><td>Any special instructions e.g. before or after food, on an empty stomach, given covertly</td><td colspan="2">Most common side effects Use current BNF or product information leaflet to list these</td></tr>
<tr><td colspan="3">Any additional comments/information?</td></tr>
<tr><td colspan="2">Name of person information obtained from (if needed) e.g. GP</td><td>Date contacted:</td></tr>
<tr><td>Prepared by (name & signature):</td><td colspan="2">Job title:</td></tr>
<tr><td>Approved by (name & signature):</td><td colspan="2">Job title:</td></tr>
</table>

Start date:	Review date:

Key Information and Version History

Title	Managing Medicines
Prepared by	Head of Service - Integration
Approved by	Legal Services / ALT
Date effective from	August 2026
Review frequency	Every 2 Years
Next review date	August 2008
Distribution	Internal

Revision History

Version	Date	Summary of changes	Author
8.0	July 2017	Fridge monitoring chart updated Medicines policy put on new template Definitions section added Homely remedies updated Patch chart added New references added Medicines Administration Record (MAR) Audit Form – updated to reflect new adult services audit Criteria Assisted meds form Medication Administration Competency Assessment Unlicensed medication letter updated Direction of prescriptions added	S Cook
9.0	June 2018	Policy approved for publication by Quality Governance Board	PPP Team
10.0	July 2021	Fridge monitoring chart updated With ambient room temp References updated Self-care added Covert administration updated CD's updated Electronic MAR's included	S Cook

		Thickeners and oral supplements updated Section 21, 23, 24 Best interest and capacity Some appendices removed	
11.0	August 2024	Variable dose section added PRN medicines updated Training section updated Appendix 19 – PRN/variable dose chart added Level 3 administration of medicines updated References updated	S Cook
12.0	September 2025	New template used. Updates to headings.	M Woods

Approval

Approving Groups/ Body	Approval Date
Quality Governance Board	June 2018
Adult Leadership Team	August 2026