



MEDICATION MANAGEMENT PRACTICE GUIDELINES

OLDER PERSONS RESIDENTIAL CARE

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Hampshire County Council

Medications Management Practice Guidelines for Residential Care

PART ONE

General information

1. How to use these guidelines

These guidelines, together with the overarching Medication Management Policy 2014, describe how residents may be supported by staff, within a residential care home, to use their medication effectively. Other services have specific procedural guidance and these residential care guidelines must never be applied to other care services.

These guidelines should be read and acted upon in conjunction with information provided at training.

2. Responsibility of the staff

The Registered Manager:

- Is responsible, with the support of the Service Manager, for ensuring that all staff are aware of the systems for medications management in residential care homes
- May appoint a 'designated person/s' to look after the medication for those residents who are unable to manage their own. The designated person must be appropriately trained and competent to carry out this duty. The designated person must know and be known to the prescriber and dispensing pharmacist
- Must ensure that all medication, including controlled drugs are administered only by designated and appropriately trained staff
- Must ensure that all residents have a current care and support plan around medications in place. This may also include risk assessments around medications management

The Designated Staff

- Must know the limitations of their role in relation to medication
- Must follow the policies and procedures within the home
- Must have undergone suitable training for their role. (see section 3 below)
- Must immediately report medication incidents and errors including any discrepancies in the records, errors with medication or changes in a resident's condition to the Duty Manager

- Must not administer any level 3 medication (by specialist techniques) unless they have had specific training from an appropriately qualified professional, and have been signed off as competent to do so.

3. Training and resources for staff

All staff must have access to the current overarching Medications Management policy and these Practice Guidelines for Residential Care.

All HCC social care staff must attend medications training to Common Induction Standards level as a minimum and must attend HCC medications basic awareness course.

All staff administering medicines (Level 2 and above) will attend the 'Safe Use of Medicines' course initially and then every two years as a refresher.

In addition to attending training, staff competency to administer medications will be assessed annually. (Or more frequently based on the judgement of their line manager).

A Deputy Manager, Registered Manager or a Practice Development Nurse will assess competence.

Staff who fail the competency assessment or make medication errors will re-attend the training and this will be followed by further assessment of competence as well as supervised practice.

After attending training, each designated member of staff will have their own copy of the training material book 'Support the use of medication in social care setting version 4 (2015) by John Green.

Each home must have a copy of 'Handling Medicines in Social Care' from the Royal Pharmaceutical Society of Great Britain'. <http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf>

Each home should have access to a drug reference source, for example BMA New Guide to Medicines and Drugs or a recent British National Formulary (BNF), so that staff may look up medications and see uses, side effects etc.

4. Levels of support

The Care Quality Commission described three levels of support with medications that service users might require.

- **Level 1.** 'General Support Tasks'. The service user takes responsibility for self-medication (with minimal assistance from care staff)
- **Level 2.** 'Administration by care staff' Care staff take responsibility for administering medication.
- **Level 3.** 'Administration by specialist technique' Qualified health professionals or social care staff administer medication by specialist technique.

A resident's needs may change and it is essential that these needs are monitored and assessed regularly and an on-going risk assessment is in place.

Risk assessment

A risk assessment must be carried out for all new residents on entering the residential care home, to establish the level of support they require with medication. For those residents who self-medicate, there must be an ongoing assessment of their continuing ability to do so.

5. Liability

Hampshire County Council liability insurance covers the personal liability of employees who commission care which involves appropriate support with medication and employees who support service users with medication management as part of an agreed care plan.

In addition to this cover, HCC indemnifies all of its staff whilst they are carrying out official and appropriate duties, in respect of the financial consequences of negligent acts or omissions committed in the course of their duties.

The indemnity does not apply where staff act outside of their contract of employment or authorised duties (e.g. by ignoring instructions or this policy or service specific guidance) and the indemnity does not extend to actions that result from fraud or other deliberate wrongdoing or recklessness on the part of the member of staff.

6. Consent and capacity

Section 5 of the overarching medication policy sets out the responsibilities of staff in relation to issues of consent and capacity. If there is any need for further clarification the service manager must be involved immediately.

- Residents who are capable of giving or withholding consent can refuse to take medication at any time. In these circumstances staff must not attempt to administer medication
- Covert administration (disguising medication in food or drink and not telling the person it is there) of medication for residents who are capable of giving or withholding consent is **NOT PERMITTED UNDER ANY CIRCUMSTANCES**
- If someone does not have capacity to make decisions, health professionals should follow the code of practice that accompanies the **Mental Capacity Act 2005** and the supplementary code of practice on deprivation of liberty safeguards. It must never automatically be assumed that they are not able to give or withhold consent to take medication.
- Giving and obtaining of consent is a process not an isolated event, residents may change their minds and withdraw consent at any time. Consequently, consent must be sought before any administration
- Capacity to consent may fluctuate and must therefore be assessed continually

PART TWO

Approved procedures and practices for staff in residential homes

1. Ordering medication

Monthly ordering (repeat prescriptions).

Because most drugs are dispensed in 28 day amounts, ordering should be done on a regular basis every four weeks. Some larger homes may wish to separate the areas in the home so that smaller orders are made weekly or fortnightly. The ordering, receipt and storage of medication must be done by a designated competent person who has dedicated time allocated to complete the process.

Each home needs to work with both the dispensing pharmacy and GP practices when writing the specific home guidance for ordering medication. The method may vary between both pharmacies and GP practices.

In all cases the following criteria apply for the monthly order :-

- Check the form of the medication (e.g. cream), name, strength, dosage and quantity on the medication administration record (MAR) or care plan to ensure the correct and current medication is ordered
- Check the stock in both the medication trolley, residents' and stock cupboards and refrigerators
- Use the current prescription repeat request slip or 'picking list' issued by the pharmacy and tick the items needed clearly
- If there have been changes to a resident's medication since the last order, the changes must be clearly noted on the form, with the name of the prescriber who made the changes and the date they were made, then signed by the person recording the information
- Requests for changes in quantity can be made to ensure a month's supply is ordered
- Requests for changes in quantity can also be made e.g. if a resident is only taking medication when required. Items which are no longer required can be requested to be deleted from the repeat prescription or picking list
- A record of the order must be kept
- The completed repeat prescriptions or picking lists, can then be sent back to the GP surgery for authorisation.
- The agreed repeat prescriptions then need to go to the pharmacy for dispensing. There are different ways of arranging this and it will vary from home to home.
- When the medications arrive in the home, they must be checked against the order to ensure that all items ordered have arrived. If there are any discrepancies, these must be checked with the pharmacist and prescriber.

Daily ordering, new and acute prescriptions

Some items may be prescribed for an acute illness or new condition and will need to be ordered and obtained at other times. The following must be included on the new prescription:

- The name of the resident
- The name, form, strength and dose of the medication
- The quantity required

A record must be kept of the order.

Where possible the same pharmacy must be used for all prescriptions.

Prescriptions written by a prescriber after visiting a resident may be sent to the pharmacy electronically. Each home will have its own process for doing this. The prescription will then be collected, by the pharmacy representative, when the medication is delivered, or within 48 hours of dispensing.

Prescriptions for controlled drugs must be physically taken to the pharmacy before they are dispensed.

Obtaining medication 'out of hours'

This will vary from home to home and depends on the urgency of the request. The Registered Manager should keep a file describing:-

- The details of the supplying pharmacy and the name of the pharmacist in charge (if possible)
- The procedures for the routine supply of medication
- The procedures for 'out of hours' supply of medication
- The procedure for obtaining emergency medication.

If the medication is required to start as soon as possible (such as a course of antibiotics) it may be necessary to send a member of staff to the nearest chemist to get the medication dispensed.

Verbal orders

All verbal orders for medication or changes in medication or doses, given by prescribers, must be heard by two people, recorded in the care plan and signed by those two people. The medication administration record must also be changed.

The pharmacy will only dispense a prescription for any changes in medication when they have either received a telephone message from the prescriber, or have a written prescription. They cannot supply medication at the request of a member of staff in a care home.

2. Record keeping

There is a statutory requirement that a complete audit trail of medication within the home is kept. The audit trail starts with the receipt of medication into the home through to medication disposal.

Old MAR charts should be filed in the person's individual record and should be treated just like any other confidential record about that person.

CD record books should be kept for six years from the date of the last entry.

Staff signature records sheets

There should be a record of all designated staff signatures and their initials as they appear on the MAR and CD records kept in the home, with the date the record was created and date any new signatories were added. A new staff signature sheet should be made each year.

Old staff signature sheets should be kept in case they need to be referred to.

Recording advice given about medications

Whenever a health professional is contacted for advice or information about medication, a record must be made of the:

- Date
- Query
- Advice given
- Action taken as a result
- The name and role of the person giving the information
- Their place of work.
- The name, role and signature of the person receiving the information

3. Receiving medication into the home

All prescribed medication received into the home is the property of the resident, to be used only by the resident and must not be given to anyone else.

Upon receipt, the medication must be checked carefully against the order, prescription, or the details provided by a resident's carer or prescriber if the resident is being admitted permanently or for respite care. Any discrepancies must be sorted out immediately, with either the dispensing pharmacist or the prescriber.

Controlled drugs must be entered in the controlled drugs register immediately on receipt. (see section 9).

4. Listing a persons medication on admission - Reconciling medication

When a resident is admitted to the home, the medication brought in should be reconciled against the pre-admission assessment and/or the transfer letter

Only medication that is supplied in original packaging from a pharmacy will be accepted into the home.

Medication and packaging must be checked to ensure that it belongs to the person being admitted and that it is in date.

A designated person should record the medication the person is currently taking on to a blank MAR sheet:

- Residents details, date of birth, room number, name of unit
- Name of medication; strength of medication; form; dose; route; timing and frequency and what the medication is for (if known)
- Any allergies or reactions known, to drugs or drug ingredients
- GP details
- Time the last dose of PRN medication was taken
- Time and date that any weekly or monthly medication was taken
- Note when medication should be monitored or reviewed (e.g. warfarin)

Each medication being checked-in needs to be counted. The designated person completing these details should check with a second person and record the count on to the MAR.

If there is any doubt about the medication the person is currently taking, the designated person must contact the person's GP or prescriber and ask for clarification.

If any new medication supplies are needed, these should be obtained as soon as possible.

5. Storage of medication

Medication must be stored in a locked cupboard which is only used for the storage of medication. The temperature must not exceed 25° C.

Oral medication should be stored separately from other medications.

Controlled medication must be stored in a specified Controlled Drugs cupboard which is of metal construction, with a lock which must comply with the safe custody regulations in the Misuse of Medication Act 1971. The cupboard must be fixed to a wall of solid construction by means of rag or rawl bolts

Medication which should be stored between 2-8°C must be kept in a locked refrigerator designated solely for the purpose. The temperature of the fridge must be recorded daily, and if it exceeds the limits, the pharmacist must be contacted to see if the medication is suitable for use.

“Homely remedies” must be stored in a separate area to prescribed medications.

Medication may be stored in a locked medication trolley, but this must be secured to the wall when not in use.

Medication that is no longer needed must be stored separately in a clearly labelled place or container within a locked cupboard whilst awaiting disposal. Controlled drugs for disposal should be kept locked in to the CD cupboard and only removed at the point of disposal.

6. Keys

The Registered Manager must ensure that the keys to all cupboards and refrigerators in which medications are stored, are kept securely and are only accessible to designated staff.

All designated staff must ensure that the keys are available to the succeeding designated person at the end of each shift.

Designated staff who inadvertently remove keys from the premises must bring them back, in person, as soon as the error is discovered and must complete an incident form.

7. Disposal of medication

All medication from residential care homes must be returned to a pharmacy, preferably the dispensing pharmacy, for disposal.

This applies to:

- Medication remaining after a resident has died
- Medication that has been discontinued
- Dispensed refused doses
- Medication that is past the expiry date.

A record of the medication for disposal (disposal record book/file) must be kept by the home, and must include:

- The date
- The name of the resident
- The name, form (e.g. tablets), strength and quantity of the medication to be disposed of.

The medication should then be placed in container which is kept securely locked away until it is collected by the pharmacy.

The pharmacist, or designated pharmacy representative, must sign as having received the medication and the disposal record book must be returned to the home.

Controlled drugs should be signed over to the pharmacist in person and the stock balance 'zeroed' in the CD register.

8. Self administration of medication

Wherever possible, adults should take responsibility for their own medications.

Residents may be able to self-medicate some medication but need help from staff to administer others. It is not 'all or nothing'.

Residents who choose to self administer their medication should have a current risk assessment in place. The risk assessment will consider:

- Individual's wishes

- Mental Capacity
- Physical capability (to access medications for example)
- Security of storage
- Disposal of waste and sharps
- Recommendations of the multidisciplinary team

The residents GP, as prescriber, must consider any self administration referral and agree to it before a resident may self-medicate.

A locked cupboard must be provided in the resident's room, where the medication can be stored. The lockable cupboard can be a lock fitted to a drawer.

A small sharps container should be provided for sole use if a resident is self administering injectable medication.

A resident may still ask the designated staff to order their medication for them. In this case records must be kept of all orders and receipts into the home, but 'self-administering' should be written on the medication administration record.

Some self-medicating residents may need a reminder to take their medication, in this case, a record of the prompt must be recorded on the medication administration record. If staff are regularly providing prompts the resident may need a review of their care plan.

Some medications (such as warfarin) need additional checks and tests to ensure dosing levels are effective and not harmful. Staff need to be aware of these and ensure they are completed by Health teams.

Residents who are self medicating must be regularly monitored by staff to ensure they are taking medication correctly, as part of their on-going care. Frequency of nature of the monitoring will depend on the resident's condition.

If there are any concerns, the residents GP must be contacted to review their self-medicating regime.

9. Controlled Drugs (CDs)

These are medications that have a high risk of being abused or stolen so need additional checks and accountability recording.

Recording and administration of CDs

- A separate 'Controlled Drugs' register must be maintained for the recording of storage, administration and disposal of CDs
- All records relating to controlled drugs must be recorded in black ink
- Controlled drugs must be entered in the controlled drugs register immediately on receipt and a running balance of the quantity of each Controlled Drug held must be kept
- In Hampshire County Council, Morphine Sulphate solution (Oramorph) and Temazepam are treated as controlled drugs within the home as a matter of good practice

- Tramadol was classified as a schedule 3 controlled medication in June 2014. There is as yet no requirement for tramadol to be recorded in the CD register. (2015)
- Two members of staff must check all Controlled stock received or disposed of, and both must sign the CD register
- Stock levels must be checked every time CDs are entered into stock or administered
- When a CD is administered, the dose must be measured and checked by the administering person and a competent witness
- Both the administrator and witness must see the resident take the medication and then both must sign the CD register immediately afterwards
- Both administrator and witness must also sign the MAR
- Stock checks must be carried out regularly **and at a minimum of weekly.** A record that the stock has been checked should be written in the CD record book and signed by the two staff completing the check.
- Each home must have a record of the signatures of all staff permitted to sign CD registers
- Controlled drugs that are no longer required should be returned to the pharmacy as soon as possible.
- When CDs are returned to pharmacy, a record should be made in the CD register by home staff, also signed and dated by the receiving person. The stock count should be changed to show what has been returned.
- The pharmacist or receiving person must sign and date the disposal record to confirm receipt of the returned drugs.

10. Anticipatory prescribing

A GP may sometimes prescribe medication for an individual resident, to be kept in the home in case it is needed, usually in the end stage of life, and often needed during hours when the surgery or pharmacy is closed. This medication will often include controlled drugs (CDs) . The medication is prescribed and dispensed as normal for the medication, but the label will have 'just in case' or 'prn' medication written on it.

On receipt of the bag of 'just in case' medication into the home:

- The 'out of hours' service must be notified that there is anticipatory medication within the home
- The pharmacist must provide a printed MAR sheet and the medication must be added to the medication administration record as 'just in case'
- The medication should be counted in and the count noted on the MAR. Expiry dates must be checked.

- The bag must be resealed until required. If a bag containing controlled drugs is resealed, the person resealing it and a witness should first check that the container has not been opened, and should then sign across the seal of the bag, securing the seal with transparent tape if necessary
- The medication must only be used under the instruction of a healthcare professional if it is level 3 medication to be administered by specialist technique. (Syringe driver for instance).
- Once the bag has been opened and any of the medication has been used, the remainder must be treated as any other medication for the resident. That is, signed into the MAR, disposed of as other medication.
- If the first dose of the medication is used 'out of hours', the prescriber must be contacted on the next working day and the resident's condition reviewed
- When the medication is no longer needed it must be disposed of in accordance with this procedure.

11. Respite, D2A (Discharge to Assess) and Emergency Care

Before an individual is admitted for short term care such as respite, D2A or emergency care, the following information must be obtained:

- A list of current medication, with explicit instructions for administration, from the individual's prescriber and main carer, or from the hospital
- 'When required' medication must have details of dose, frequency and the conditions under which the medication may be given
- Consent to administer un-prescribed medication which the individual has been taking at home must be obtained from the individual's main prescriber before the medication can be administered. This must include homely remedies already kept by the home
- An assessment of the level of support required by the individual around medication, whilst in the home, recorded in the care plan

Sufficient medication must be provided for the planned duration of the visit for respite, D2A and reablement care

All medication must be in original containers provided by the pharmacy or the hospital

All medication received into the home must be checked and witnessed by two designated staff

Where it is not possible to obtain a pharmacy printed MAR sheet, it will be necessary for the designated staff to hand-write the information onto a MAR. The detail must be transcribed accurately, in black ink, and must be signed and witnessed by the two designated staff who received the medication.

It must include:

- The individual's full name, date of birth, GP, allergies

- Medication details, name, strength, form (e.g. tablets) quantity, dose, frequency and any other instructions e.g. 'after food'
- Recorded doses, those taken or refused, quantity, and time.

Whilst an individual is staying in respite care, the daily medication routine must be as close as possible to the normal pattern for the individual

An individual's medication is their property. There must be procedures in place for an audit trail for the receipt, storage, and administration of the medication and on leaving the home a signature must be obtained from the individual or the individual's carer when their medication is handed back.

The home should ensure that the individual has sufficient medications on discharge to last until they are able to obtain a repeat prescription.

Controlled Drugs that are to be handed back to the resident should be kept in the CD cupboard and signed out by two staff at the point where the resident leaves the building.

12. Use of 'homely remedies' and non prescribed medication

'A homely remedy is a medicinal preparation that may normally be bought by a person without calling a doctor'.

The Care Quality Commission agrees that a small range of products may be kept in stock in a care home for residents for the treatment of minor ailments.

The home may purchase and keep a stock of household 'homely remedies' and these must be kept in a separate place from individuals own medicines.

or

Residents may purchase and bring in their own homely remedies.

Homely remedies held by the home

A list of homely remedies which may be made available by the home to residents must be sent to each person's GP to approve, sign and return to the home. These lists must be kept in the same folder as the person's Medication Administration Record. (An example of a homely remedy agreement can be seen in **appendix 2**)

Homely remedies must be stored in a separate, labelled cupboard. Expiry dates and storage details must be checked regularly and unused and expired items returned to the pharmacy in the normal way.

Homely remedies must only be administered at the request of the resident, or by a designated member of staff, for the condition specified on the homely remedy chart.

Before administering a homely remedy, the homely remedy chart must be checked to make sure that the resident's GP has given permission for the particular homely remedy to be administered and that the resident is not allergic to the homely remedy.

The guidelines for each medication must be followed, and if there is any query a pharmacist or the prescriber must be consulted before the medication is administered.

A record must be kept on the MAR sheet of the date, time, quantity of the medication given, and the fact that it was a homely remedy.

Homely remedies may only be given for a maximum of 48 hours. After that time, the GP should be contacted to see if they need to see the resident and check that the symptoms are not caused by something more serious.

If at any time there is concern about the resident's condition, a doctor must be informed.

If a medication which is included on the 'Homely Remedy' list is already prescribed by a doctor for a resident, it cannot be also be used as a homely remedy for that resident, but must be given according to the instructions on the prescription.

Individuals own 'Homely Remedies'

Some people like to take their own non-prescribed medication (such as vitamin tablets or homeopathic remedies).

Where possible, people should be encouraged to tell staff what they are taking so that a record of their medication can be kept

Any non-prescribed medication which a resident may wish to take, must be checked with the pharmacist to ensure there is no contra-indication to prescribed medication.

Designated staff must only administer non-prescribed medication with the agreement of the resident's prescriber. The residents own non-prescribed items should be added to the medication administration record (MAR) with the words 'not prescribed'

A record must be kept on the MAR sheet of the date, time and quantity of the non-prescribed medication administered by staff.

Non-prescribed medication must not be ordered or bought by the care home staff for residents use.

13. Administration of medication

The prescriber must provide sufficient information to enable a designated person to administer medication correctly, by written instructions on the prescription. The pharmacist will transcribe those instructions to the container label. If the instructions are insufficient or unclear, the prescriber must be contacted before the medication is administered. Any additional information must be written clearly and legibly in black ink, in the care plan.

Before administering any medication, designated staff must check the dose has not already been given and that the following '**five corrects**' are observed:

The correct Resident: Identify the resident and make sure their correct name is on the medication

The correct Medication: Check the name of the medication corresponds with the name given on the medication administration record (MAR) sheet. If there is any discrepancy it may be because there is a generic or brand name in use, if there is any doubt, this must be checked with the dispensing pharmacist

The correct Dose: Check the strength and quantity of the medication being given with that recorded on the MAR sheet

The correct Time: Check the dose is being given at the correct time; this includes any additional instructions such as before or after food

The correct Route: Check how the medication must be administered e.g. eye, ear and nose drops.

No medication may be given until the designated member of staff is sure that all the above are correct. If there is any concern, the duty manager must be contacted.

Administering medication.

1. Wash hands.
2. Prepare equipment required e.g. PPE; medication; Water jug and cups; medicine pots; sharps disposal box; clinical waste bag.
3. Put on 'do not disturb' tabard, to minimise interruptions during medication administration if doing a medication 'round'.
4. Deal with one resident at a time. Explain what you are doing and confirm their consent.
5. Prepare the drug by checking the following:
 - The MAR sheet, read it carefully and check that the medication has not already been given or given within a minimum interval e.g. less than 4 hrly
 - The name of the resident
 - The name of the medication
 - The strength of the medication
 - The prescribed dose
 - The time of administration
 - The route by which the medication is to be administered and Special instructions e.g. 'with food', 'swallow whole'
 - The calculation if any
 - The expiry date of the drug as appropriate
 - Any allergies the resident has been recorded as having
5. Administer the medication and observe it being taken
6. Complete and sign the MAR sheet in black ink
7. Return the medication to safe storage

Designated staff **must not:**

- Administer any medication which has not been prescribed or agreed by the resident's current prescriber

- Crush or break tablets unless authorised to do so by the prescriber or pharmacist
- Administer injections, unless they have received specific training e.g. for an insulin pen or an auto injector
- Administer medication which is not stored in the original container supplied by the pharmacy
- Leave a medication trolley or cupboard unlocked whilst unattended, for any reason. This includes whilst administering medication to a resident or service user.

Medication given too early or too late

Some medications need to be given within certain time limits. For example, medication for Parkinson's disease, diabetes or epilepsy may be more time critical than other medication and for some people these need to be prioritised.

Information about when medications should be taken will be given by the pharmacist or the prescriber and the times should be written on the MAR.

Any time critical medication and how it is best offered to the person should form part of the person's care and support plan.

14. Refusal of medication

All residents have the right to refuse medication. The designated person should pay due regard to the Mental Capacity Act 2005 and associated Codes of Practice before responding.

- If the person has capacity to refuse medication, try to find out why they do not want to take their medication. Offer to arrange for the prescriber to come and discuss the issues with the resident if necessary and mark the medication as 'declined' or 'refused' on the MAR.
- If the person does not have capacity, offer the medication again after an appropriate, short period
- Ask another designated member of staff to present the medication, possibly accompanied by a staff member who has the resident's trust
- Try and find out why the person is refusing medications, may be the tablets are difficult to swallow and need to be offered in a different form
- If someone is pretending to take medications then hiding them, point out your concerns and remind them that they can refuse to take them
- Never allow the resident to be coerced into taking medication by sanctions e.g. turning off the TV, as this can be construed as abuse.
- If the medication is still refused, complete the MAR sheet and record the event in the care plan.
- A risk assessment must be carried out to record if the resident is likely to come to any harm from refused doses of any prescribed medication. This will depend on the type of medication and the health of the resident

- Contact the prescriber if it is identified that the person is at risk from not taking their prescribed medication. The pharmacist will be able to advise on this
- Contact the prescriber if the person refuses prescribed medication for more than 48 hours, whatever medication it is.
- Refused medication should be disposed of in the same way as all other disposals.

15. Disguising medication - Covert administration.

A clear distinction must always be made between those residents who have the capacity to refuse medication and whose refusal must be respected, and those who lack this capacity and the Mental Capacity Act 2005 provides guidance.

Where a person has been assessed as lacking capacity to consent to medication is refusing to take medication, it may be decided to give the medication covertly, that is hidden in food or drink.

The decision to disguise medication will be taken by the prescriber, after discussion with the family, advocates, other staff and healthcare professionals. The decision must be made in the person's best interests:

- The medication must be essential for the resident's health and well being, or for the safety of others, and must only be given in the 'best interest' of the individual
- A pharmacist must also be consulted if covert medication administration is approved, as the addition of medication to food can alter its effectiveness
- Regular attempts must be made to encourage the resident to take the medication voluntarily.

Some people like to take medication with food, for example a tablet with a spoonful of yoghurt, because it makes the tablet easier to swallow. If the person knows that the medication is there, it is **not** covert administration.

16. Use of the Medication Administration Records (MAR)

It is the responsibility of the person administering the medication to keep accurate records of all medication they have administered to residents.

- A record of all medication prescribed for the person must be kept on the individuals MAR sheet/s
- The MAR sheet must be signed only *after* the resident has taken their medication or after medication has been administered
- Staff should sign the MAR with their initials
- The MAR sheet must not be signed using any initials which have been designated for certain information e.g. R for 'resident in hospital', as this will cause confusion

- Registered Managers must keep a record of the signatures and initials of designated staff as they may appear on the MAR sheets. This must be updated at least annually.
- If there is a variable dose e.g. 'one or two tablets' the number of tablets given must be recorded
- If there is any reason why a dose is not given, or if a dose is refused, this must also be entered. This information is as important as doses taken. An explanation must be added to the back of the MAR chart and further actions taken recorded in the resident's daily diary notes
- When a medication is refused, this must be reported to the duty manager. Further immediate action *may* need to be taken depending on the individual circumstances and the type of medication that has been refused.
- If there is any change in a dose or drug, a new section must be used in the MAR sheet and a line, in this form |-----|, put through the remaining days of the original prescription
- If a drug is discontinued the date must be entered on the MAR sheet and a line drawn, as above, through the remaining days. Write who discontinued the drug and the date in the space above the line
- If a medication is administered by a healthcare professional (e.g. district nurse giving an injection or applying cream) they must also sign the MAR sheet when this has been completed.
- The condition of the resident must be monitored both before and after a dose of medication is given and any changes must be noted.

17. 'When required' or 'PRN' medication

Some medication such as pain relief, laxatives and indigestion remedies, do not need to be taken regularly and will be prescribed 'PRN' or 'when required'. (PRN stands for Pro re nata and is Latin for "as the situation arises")

All residents taking PRN medications should have a PRN protocol in place alongside and as well as the prescription on their MAR. (see **appendix 3** for an example PRN protocol chart).

On the PRN protocol there must be a clear indication of the use of the medication e.g. "paracetamol for pain in left knee".

- Directions must include a specific dose or range of doses e.g. one or two tablets as required
- There must be an indication of the timing, e.g. at night; no more than 4 hourly
- There must be an indication of the maximum daily dose e.g. no more than 4 doses in 24 hours
- There must be an indication of how long the prescriber is willing to allow the PRN medication to be given for before the person needs a review.

- There may need to be an indication of what signs and symptoms the person may show if they need the PRN medication.

All requests for PRN medication must come from the resident. However some residents may need to be asked if they require PRN medication.

If a person does not require PRN medication and you do not offer it because you know the person will ask if they need it, then there is no need to record anything on the MAR.

If you offer a PRN medication and the person declines it, put 'NR' against the time and date on the MAR to indicate that the medication was offered but was not required.

Designated staff should use their judgement and knowledge of the resident to determine when residents may need to be asked.

If a PRN medication is for pain, the use of a pain chart will support designated staff in deciding whether the resident needs any PRN medication

Before a PRN medication is administered

- The MAR must be checked to ensure another dose has not been given within the minimum time limit
- The reason for giving the medication must be checked. This is especially important for pain relief, as pain in a new area may indicate an undiagnosed condition. If this is the case, it must be reported to the duty manager and the prescriber (GP).

18. Medication for use away from the home

If a resident needs medication whilst out of the home, every effort must be made to provide the medication in the container supplied by the pharmacy.

If this is not possible, and the resident is away regularly such as at a day service, a medication review must be requested from the prescriber to determine if the medication can be changed to avoid the dosage due when the resident is out.

If medication is taken out of the home it should be checked out and signed out by two staff.

The MAR sheet should be signed as normal to indicate that the dose was taken. Wherever possible, this should be the signature of the person having witnessed the dose being taken.

To avoid losing the original MAR, a photocopy of the original MAR may be taken out with the resident so that the medication can be signed for when administered on the photocopy. This copy should be kept with (or stapled to) the original MAR on return to the unit and clearly identified that it was used when the person went out.

If the resident is regularly going home, a separate supply of medication could be obtained and kept with the care giver.

Designated staff should only sign the MAR if they administer the medication. If designated staff believe the medication was given when the resident was away from

the home, they could tick the space in the MAR and write an explanation on the back of the MAR chart.

19. Diagnostic testing and monitoring

In some residential homes, staff may be asked to perform tests, such as blood sugar monitoring, for individual residents.

The Health Professional (e.g. District Nurse) requesting that care staff do this retains the responsibility for interpreting the results of any tests and making changes to the treatment regime.

The Health Professional requesting that care staff perform tests must train the care staff to do the tests and be confident that the care staff have the skills and knowledge to correctly carry out the tests and write down the results.

Any equipment required will be supplied by the Health Professional requesting the tests.

20. Medication incidents and incident reporting

These can refer to:

- Prescribing errors
- Ordering errors
- Dispensing errors
- Storage errors
- Administration errors
- Recording errors
- Inappropriate, inaccurate or omission of advice, either verbal or written, to and from other professionals, residents and carers
- Near misses
- Accidental overdoses

If an incident or error occurs that involves medication, it must be reported and immediate action taken to protect the service user from harm.

Staff should report incidents that they make and incidents that they notice others may have made to the registered manager or person in charge of the service at the time.

If the medication error or incident involves a service user receiving incorrect medication or not receiving medication as prescribed to them, then advice should be sought from the service user's GP (or out-of-hours GP) immediately.

The manager of the home should respond to the medication incident and consider further actions:

- Complete a risk assessment
- Review the individuals care plans

- Inform relatives
- Inform Safeguarding
- Inform CQC and other agencies as necessary
- Consider reporting under Duty of Candour

The staff member discovering the incident should complete an incident reporting form and pass it to the person in charge of the service at the time, so that others become aware of it.

The incident will be logged on to HCC Adult Services Incident Reporting System and a central record of medication incidents will be maintained.

The Care Governance team may investigate medication errors further

21. Sharing information about medications.

Designated staff should ensure that the following information is available for medicines reconciliation on the day that a resident transfers in to or out from a care home:

- resident's details, including full name, date of birth and weight
- GP's details
- details of other relevant contacts (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- Medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- changes to medicines, including medicines started, stopped or dosage changed and reason for change
- date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine
- any information that has been given to the resident and/or family members or carers
- the name and job role of the person completing the transfer information.

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Appendix 1

Types of medication and methods of administration

1. Tablets and Capsules

Tablets

There are many different types of tablets. If in doubt about how they should be given, the pharmacist should be consulted.

Uncoated tablets often have a scored line across them, these can be broken in half before administration. If it is necessary to do this, it should be entered in the care plan, and a tablet cutter purchased from the pharmacy. Cutters must be cleaned after every use to ensure that no residue remains.

Coated tablets have a shiny outer layer to enable them to be swallowed more easily. These must not be cut.

Enteric coated tablets (e/c or e/n in the drug name) should be swallowed whole with plenty of water so that the coating, which prevents the tablet from dissolving in the stomach, is not damaged.

Slow release tablets (S/R, M/R, C/R, XL, LA) should be swallowed whole. They do not work properly if chewed or crushed and there is a risk the resident could receive all the dose designed to be released over hours, in one go

Dispersible or soluble tablets should always be dissolved in water before taking. They are very useful if an individual has difficulty swallowing.

Oro-dispersible tablets are a form of tablet made to dissolve in the mouth. They should be sucked, and this information will be on the label.

Pastilles and lozenges should be sucked, and the individual should not have a drink for at least half an hour after taking this form of medication.

Buccal and sublingual tablets are made to dissolve quickly in the mouth. Buccal tablets are placed between the upper lip and the gum and sublingual tablets are dissolved under the tongue. This medication is absorbed directly into the bloodstream and can act very quickly e.g. for pain relief. They are also very useful if an individual is unable to tolerate swallowing a tablet

Capsules

Capsules may contain either liquid, powder or pellets and should be swallowed whole. If necessary, capsules may be opened and the contents sprinkled on to food, but this must only be done when it is part of the care plan, and with the agreement of the prescriber or dispensing pharmacist.

Some capsules are designed to be inhaled, either by adding to hot water, or for use in inhalers, and these should not be swallowed. They will be labelled 'not to be taken'.

Administering tablets or capsules

- Always wash your hands before administering medication and keep everything as clean as possible
- Explain the procedure to the recipient so they know what to expect
- Ensure the resident has some water to hand. In some cases medication may be given with other liquids, but this should be checked with the pharmacist and documented in the care plan
- Help the resident to sit as upright as possible
- Check the label on the container and follow the 'five corrects' protocol. If there is any discrepancy, or concern the duty manager must be contacted.
- Follow the directions for giving the medication e.g. 'after food'
- Avoid handling the medication and give it to the resident
- Encourage the resident to take the drink if appropriate (see lozenges and pastilles), this ensures the medication is washed into the stomach
- Complete the MAR sheet and return the medication containers to a safe storage place.

Crushing tablets and opening capsules

If a person has difficulty swallowing their medication, the reason must be identified and reported to the GP. Various alternatives are available and this should be discussed with the pharmacist or prescriber. On no account should the tablets be crushed or capsules opened unless the specific actions are agreed by the prescriber and the details and reason written in the care plan. Crushing tablets can alter the way in which the drug works, and may have adverse effects. If an individual has swallowing difficulties:

- Determine the reason
- Record this in the care plan
- Inform the duty manager
- Contact the pharmacist or GP depending on the reason
- When a solution is agreed, record it in the care plan.

2. Liquid medication

These include **emulsions, linctuses, mixtures, suspensions and syrups**. Directions must be followed carefully as these may need shaking well before use, and some have to be used within two or three months after opening. Where there is a 'used before' warning, the date of opening of the container must be written on the label. The pharmacist should be contacted if further information is needed.

Administering liquid medicines

- Wash hands
- Prepare half a tumbler of water

- Explain what you are about to do and help the recipient to sit as upright as possible
- If the medication requires shaking, check the cap is tight and
- shake the bottle
- Check the label on the container using the ‘five corrects’ protocol. If there is any discrepancy, or concern the duty manager must be informed
- Follow the directions for administering the medication
- Measure the dose always keeping the instruction label uppermost, to prevent any liquid which may trickle down the bottle, from obscuring the directions. Some liquids where larger quantities are needed, e.g. lactulose and magnesium hydroxide mixture, can be measured in a medicine cup. Other liquids should always be measured using an oral syringe, or an accurate medication measure purchased from a pharmacy or a pharmaceutical supplier
- Some liquids may be given orally as drops. The dropper supplied with the medication must be used, and the drops placed directly in the recipient’s mouth. The dropper must be rinsed and drained between doses.
- After administering the medication, where appropriate, offer the recipient a drink of water. Some liquids should be taken in water, in which case the liquid should be added to the water prior to administration
- Replace the cap on the bottle. The neck of the bottle may first need to be wiped with a clean tissue
- Complete the medication administration record (MAR) sheet
- Return the bottle to a safe storage place.

3. Creams and ointments

Creams are water based, easy to rub in, do not leave the skin greasy and are suitable for moist areas.

Ointments are greasy, more suitable for dry areas, and better for keeping the skin moist.

Care staff will be trained by a designated person to administer creams and ointments for specific individuals and the directions must be clearly written on the cream MAR chart. Monitoring the skin condition is essential and changes must be recorded and reported to the duty manager.

Creams and ointments must never be shared.

Applying skin creams and ointments

- Explain what you are about to do and assist the individual into a comfortable position
- Wash and dry hands and put on disposable gloves and a plastic apron

- Make sure the area to which the cream or ointment is to be applied is clean and dry
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy or concern the duty manager must be informed
- Follow the directions for applying the medication
- Squeeze the tube from the bottom and place an appropriate amount onto your fingers
- Apply the cream in the direction of the hair growth or as otherwise instructed
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Replace the lid/cap on the tube/jar
- Complete the medication administration record (MAR) sheet
- Return the medicine to a safe storage place.

4. Eye ointments

Eye ointments have an expiry date after the tube has been opened, which is usually 28 days. The date of opening must therefore be written on the label.

Individuals who wear contact lenses should not wear them while they are using eye ointments.

Administering eye ointments

- Check the ointment is still in date
- Explain what you are about to do and help the individual to a position where they can comfortably tilt their head back
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy or concern the duty manager must be informed
- Follow the directions for giving the medication
- Wash your hands and put on gloves
- With your finger, gently pull down the lower eyelid to form a space between the lower eyelid and the eye
- Squeeze about 1cm (1/2 inch) or as directed, of ointment into the space, taking care not to touch the eye with the tip of the tube
- Ask the person to blink several times to spread the ointment and then to close their eye for about a minute. Warn them that their vision might be impaired for a short time.
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Replace the lid/cap on the tube/jar
- Complete the medication administration record (MAR) sheet
- Return the medicine to a safe storage place.

5. Ear, eye and nose drops

It is very important that the correct number of drops are administered in the correct place for the correct length of time. Specific instructions need to be given by the prescriber. Drops should not be administered until specific instructions are obtained.

All ear, eye and nose drops have a maximum number of days effectiveness once the bottle is open. This is usually 28 days, but some may have expiry dates of 14 or 7 days.

It is very important that the date of opening the bottle is written on the label, and that any liquid remaining after the expiry date is returned to the pharmacy for disposal.

Some eye drops are dispensed as single use, and the plastic container can be discarded in the normal rubbish.

Some drops must be kept in a refrigerator, and this will be specified on the dispensing label.

Administering eye drops

- Check the eye drops are still in date
- Explain what you are about to do and help the individual into a comfortable position where they can tilt their head back
- Ensure any contact lenses have been removed
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy, or concern the duty manager must be informed.
- Wash your hands, put on gloves and remove the top of the bottle
- Follow the directions for giving the medication.
- Ask the individual to look at the ceiling and with your finger, gently lower their bottom eyelid to form a space between the eyelid and eye
- Squeeze one drop inside the lower eyelid, taking care not to touch the eye with the bottle nozzle. If more than one drop is given at a time, the second drop will run out of the eye
- Ask the person to close their eye for 30 seconds to allow the eye drop solution to spread over the eyeball
- Provide a clean tissue or gently dab round the eye with a tissue if necessary
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Replace the cap on the bottle
- Complete the medicines administration record (MAR) sheet
- Return the drops to a safe storage place.
- If the individual is prescribed more than one type of eye drop to be administered at the same time, leave at least five minutes between prescriptions to ensure that the first medication has been absorbed

- Check the resident for pain, itching swelling or redness in the eye.

Administering ear drops

- Check the ear drops are still in date
- Explain what you are about to do and help the individual into a comfortable position where they can tilt their head back
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy, or concern the duty manager must be informed.
- Wash your hands, put on gloves
- Follow the directions for giving the medication.
- Warm the ear-drop bottle by holding it in your hands for a few minutes before shaking the bottle well and removing the cap
- Gently pull the individual's earlobe upwards and backwards, away from the neck
- Squeeze the correct number of drops into the ear. Do not let the dropper touch the ear
- Ask the individual to keep their head tilted for about five minutes so that the drops can spread into the ear
- Replace the cap on the bottle
- Ask the individual to straighten their head and wipe away any extra liquid with a clean tissue.
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Complete the medicines administration record (MAR) sheet
- Return the drops to a safe storage place.
- If the individual is prescribed more than one type of ear drop to be administered at the same time, leave at least five minutes between prescriptions to ensure that the first medication has been absorbed.

Administering nose drops

- Check the nose drops are still in date
- Explain what you are about to do and help the individual into a comfortable position where they can tilt their head back
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy, or concern the duty manager must be informed.
- Wash your hands and put on gloves
- Follow the directions for giving the medication.

- Warm the nose drop bottle by holding it in your hands for a few minutes before shaking the bottle well and removing the cap
- Ask the individual to blow their nose to ensure it is clear
- Hold the dropper just above the nose and put the correct number of drops into the nostril. Do not let the dropper touch the inside of the nose
- Ask the individual to keep their head tilted back for two or three minutes to help the drops run to the back of the nose
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Replace the cap on the bottle
- Complete the medicines administration record (MAR) sheet
- Return the drops to a safe storage place.
- If the individual is prescribed more than one type of nose drop to be administered at the same time, leave at least five minutes between prescriptions to ensure that the first medication has been absorbed.

6. Inhaled medication

Medicines can be inhaled via inhalers and nebulisers. Oxygen is also, generally, inhaled.

Inhalers

There are two main types of medication which can be used in inhalers.

Preventers, which should be used regularly to stop the individual's condition from deteriorating further. These are used as directed by the prescriber.

Bronchodilators, which help to dilate the airways and increase the flow of air into the lungs. These inhalers can be used when required.

There are many types of inhaler and it is very important that they are used correctly. Some inhalers squirt the medication into the lungs, whereas others rely on an intake of breath to draw the medication into the lungs. Details of how to use specific inhalers must be included in the care plan, and can usually be found in the patient information leaflet provided with the inhaler.

An appointment may be made with an asthma nurse at the local surgery, or the dispensing or community pharmacist, if the individual wishes to self-administer.

Spacer devices. Some residents may need a spacer device to help them co-ordinate their breathing when using the inhaler. These spacer devices must be washed in warm soapy water, rinsed and left to drain, not dried with a cloth. Each resident must have their own spacer device, they are not to be shared between residents.

Nebulisers

- A nebuliser is a pump which forces the liquid medication into a fine mist. This fine mist is inhaled using a mouthpiece or mask.

- The prescriber is responsible for assessing the individual's ability to manage a nebuliser. The medicines will be prescribed as normal and written on the medicines administration record (MAR) sheet.
- A healthcare professional should demonstrate the use of the nebuliser to the individual and designated staff and the details should be written in the care plan

Guidelines for using a nebuliser

- Ensure the filter is clean
- Set up the nebuliser. There will be a compressor, tubing, nebuliser, mouth piece/face mask, read the instructions if necessary
- Check the label on the container using the 'five corrects' protocol. If there is any discrepancy, or concern the duty manager must be informed
- Wash your hands and put on gloves
- Follow the directions for giving the medication
- Open the appropriate medicine vial, pour it into the chamber and switch on the machine. Return the remaining medication vials to safe storage
- Check vapour is coming out before the mask/mouthpiece is positioned on the resident
- Let the resident breathe the vapour until the chamber is empty, or for the time specified by the prescriber. The lid of the nebuliser should be open during this time
- If there is any liquid left in the chamber at the end of the treatment, this should be disposed of according to the usual procedure
- Dispose of the gloves in the contaminated waste bin and wash your hands
- Complete the medicines administration record (MAR) sheet
- Clean the nebuliser according to the manufacturers instructions

7. Oxygen therapy

Oxygen is now provided directly from the supplier and is no longer available from community pharmacies. There are various sizes of oxygen cylinders, and concentrators can also be used for individuals who require constant administration.

If nasal tubing is used, a water-based gel such as KY Jelly should be used to lubricate the nose. Paraffin based products such as Vaseline should not be used as they are flammable and may also cause irritation.

If oxygen therapy is to be administered, staff must have received specific training from a suitably qualified person, e.g. healthcare professional or company representative. Responsibility for this remains with the prescriber.

The use of Oxygen and lubricants must be risk assessed and relevant precautions must be made for the overall safety of the individual, staff and other residents and visitors

The fire information and manuals must indicate that there is oxygen in the home and where it is located.

8. Medicated patches

Medication may be prescribed by patches applied to the skin. Medication administered in this way include nicotine, fentanyl or GTN.

These patches are like large sticking plasters. The drug is contained in them and absorbed through the skin into the bloodstream.

Usual places to apply patches are the tops of the arms, back, stomach or thighs. Avoid placing patches on hairy, sweaty or oily areas. Also avoid bony areas such as the shoulders or hips.

- Remove the previous patch before applying a new one. Fold it in half sticking it to itself before discarding it in the general rubbish.
- Choose a smooth, intact area of skin. Wash and dry the skin if necessary. (if it is oily or has cream applied previously)
- Open the patch and peel off the backing paper being careful not to touch the medicated area of patch
- Place the patch on to the skin, smoothing it down like a sticking plaster
- Avoid placing a new patch on the same site as the previous one, it can cause irritation.
- Write the date on the patch itself
- Complete MAR, CD and any other records
- Ensure that the MAR is clear about when the next patch needs to be applied

9. Injections of insulin

Only designated staff, who have received specific training may administer insulin to residents. They may only do so using a pre-filled pen where the dose has been set by a healthcare professional. The details must be written in the care plan.

They may not:

Change the dose prior to administering it

Change the dose and leave it for the resident to use later

No other form of injection may be administered by designated staff in residential care homes

10. Diagnostic testing and monitoring

Where diagnostic testing (e.g. blood glucose) or monitoring is required the Registered Manager must ensure that:

- The equipment used is serviced regularly and is recording accurately
- Staff know how to use the equipment and there are written instructions kept with the equipment
- Staff understand how to read the results but have no responsibility to interpret them
- The results are recorded accurately in the care plan
- The range of results outside of which the prescriber must be contacted are fully documented and understood.

11. Administration of Rescue Medication: rectal diazepam and buccal midazolam

Designated staff may only administer rectal diazepam and buccal midazolam following specific training and competency assessment by the member of Health team delegating the procedure.

The Registered Manager of the home or unit is responsible for ensuring that a record is kept of all staff who are so designated, with copies of their signatures and initials

If a resident is prescribed rectal diazepam or buccal midazolam for emergency treatment of epileptic seizures, their medication must be available to them at all times, including in the community.

Seizure Management plan

Any service user prescribed rectal diazepam and / or buccal Midazolam must have an individual seizure management plan in place and the prescribing medical practitioner must draw this up with specific guidelines for administration. The individual seizure management plan should include:

- Name of the service user
- Seizure classification and description
- Possible seizure triggers
- Possible seizure warning signs
- Usual duration of seizure
- Usual recovery from seizure
- When rectal diazepam or buccal Midazolam should be administered
- How much is to be given
- What the usual reaction is
- Whether a repeated dose can be given

- Time interval for repeated dose
- Maximum amount that can be given in any 24 hr period
- When rectal diazepam or buccal Midazolam should not be given
- When emergency services should be contacted
- Other people who should be contacted

The seizure plan must have a review date of no longer than six months and should state when a shorter review period is required. **A review should be considered and discussed with the prescriber, following every administration of the medication.**

The method of administration of rectal diazepam and buccal midazolam will form part of the training specific for the individual and for safety reasons is not described here.

12. Administration of rectal diazepam

As stated, only specifically trained staff may carry out this procedure. Designated staff must follow the individual care plan and prescription for the administration of rectal Diazepam.

Staff must assess the environment and ensure their own and the resident's safety. If the resident has sustained a major injury or head injury during the incident, an ambulance must be called.

Staff must be aware of the resident's dignity and protect it as far as possible by having the area cleared and covering or shielding the resident from view. A blanket or other suitable covering is carried with the medication for this purpose.

Staff must prepare the Rectal Diazepam before removing the minimum amount of clothing necessary to be able to administer the medication, and must re-clothe the resident immediately after the medication has been administered.

Staff must observe recovery e.g. convulsions stopping within ten minutes of administration and any side effects e.g. breathing problems.

If there is any concern about the recovery an ambulance must be called, unless the care plan directs other specific action.

Staff must use their professional skill and knowledge, to assess the situation following the resident's recovery and either continue with their activities or return the resident to the home, in accordance with the guidance in the care plan

The care plan must be reviewed after each incident and where appropriate discussed with the prescriber

13. Administration of buccal Midazolam

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

Buccal midazolam is prescribed for a named service user only and must never be used for another service user even in an emergency.

14. Taking rectal diazepam or buccal midazolam out in the community.

The medication must be checked in and out of the home ensuring that it is:

- The current drug
- Is in the correct form
- Is prescribed for the named individual
- Is the correct dosage
- Is within the expiry date
- Is stored at the correct temperature

The medication must be stored in the original labelled container and must be kept available and accessible to the carer and resident at all times. Some carers have a 'bum bag' or knapsack for this purpose.

The medication must be kept with the up to date seizure management plan detailing under what circumstances it must be given.

The MAR sheet, specifically for rectal diazepam or buccal midazolam, should be carried with the medication in the community.

The MAR sheet should be signed by the resident (where possible), the prescriber and other relevant individuals involved in the resident's care. Details of the resident's name, date of birth, address and known allergies must accompany the medication.

Rectal Diazepam must not be allowed to get hot as this can impair its effectiveness. It must not be kept in hot cars or near heat sources. If this happens it must be disposed of according to the policy and new Diazepam must be ordered.

Disposable gloves, a yellow contaminated waste bag and a blanket for covering the individual during the fitting incident should be carried.

The used Rectal Diazepam and gloves must be disposed of as clinical waste on return to the home.

The MAR sheet must be completed immediately after the drug has been administered

The details of the seizure, all interventions and the outcome must be recorded and the duty manager and GP must be informed

15. Adrenaline for Anaphylaxis

Only carers who have received specific training from a qualified healthcare professional may administer adrenaline for anaphylaxis. This training must be updated annually. Only pre-filled pens suitable for self-administration may be used by carers.

Anaphylaxis is a condition in which an individual has an allergic response e.g. to an insect sting or food such as peanuts. Allergic reactions vary but may include:

- Swelling of the face, throat, tongue and lips
- Difficulty in swallowing
- Flushed complexion
- Rashes
- Collapse or unconsciousness.

Adrenaline needs to be injected immediately to avoid rapid collapse.

When the need for an individual to keep a pen for immediate treatment has been identified, the care plan must include:

- The cause of the allergy and possible reaction
- Clear instructions on how to use the adrenaline pen, which must be kept with the pen
- Details of exactly where the pen is kept
- Regular checks on the expiry date of the adrenaline pen, as these can have a short shelf life, often only six months
- Routine ordering of a new pen two weeks before the expiry date of the existing stock

A consent form, signed by the individual with the allergy, or their representative where appropriate, with specific instructions on the circumstances in which the pen is to be used. The individual should be given a copy of this consent form.

Administration of the pen

The three most commonly used pens (Epipen, Jext and Emerade) work as follows:

- Hold the auto-injector about 10 cm away from the thigh
- 'Swing and jab' the tip (needle end) into the upper outer thigh at a 90 degree angle
- Hold in place for 10 seconds
- Remove the pen and massage the injection site for 10 seconds
- Call 999 immediately
- It is the responsibility of the designated person to dispose of the empty pen into a 'sharps' disposal container.

Appendix 2. Homely remedies sample chart.

Condition	Drug	Dose	Max dose 24hrs	Cautions	GP approval
Constipation	Senna Tablets	One or two tablets at night	2 tablets	May colour the urine or stools	
Constipation	Lactulose	15mls twice daily	30mls	May take up to 48 hours to work. Can cause wind.	
Dry Cough	Simple Linctus Sugar-free	10mls three times a day, can be taken in warm water	30mls	Sugar free linctus can be given to diabetics	
Indigestion	Gaviscon Advance	10 mls after food			
Mild Pain Temperature	Paracetamol 500mg tablets	One or two tablets four times a day leaving at least four hours between doses	8 tablets	Contraindication: Persons with reduced liver function, or already taking other medication containing Paracetamol e.g. Co-Proxamol, Co-Dydramol.	

I authorise the medication indicated to be given at the request of the resident or the discretion of the manager. I have checked that the resident has no allergies to the medications listed.

NAME OF RESIDENT.....D.O.B.....

DOCTOR.....DATE.....

PRACTICE.....

Appendix 3. PRN Protocol

PRN Protocol

Name of Home:		
Name of Resident:		Room no.
Drug:	Strength:	Form:
Directions dose and frequency:		
When should this medication be given?		
What should the medication do?		
Time gap between doses:		
Maximum dose in 24 hours		
How long should the medication work for		
When should GP or medical advice be sought?		
How does the resident let you know that they need this medication?		
Other notes:		
Prescriber signature		Date
Prescriber name		