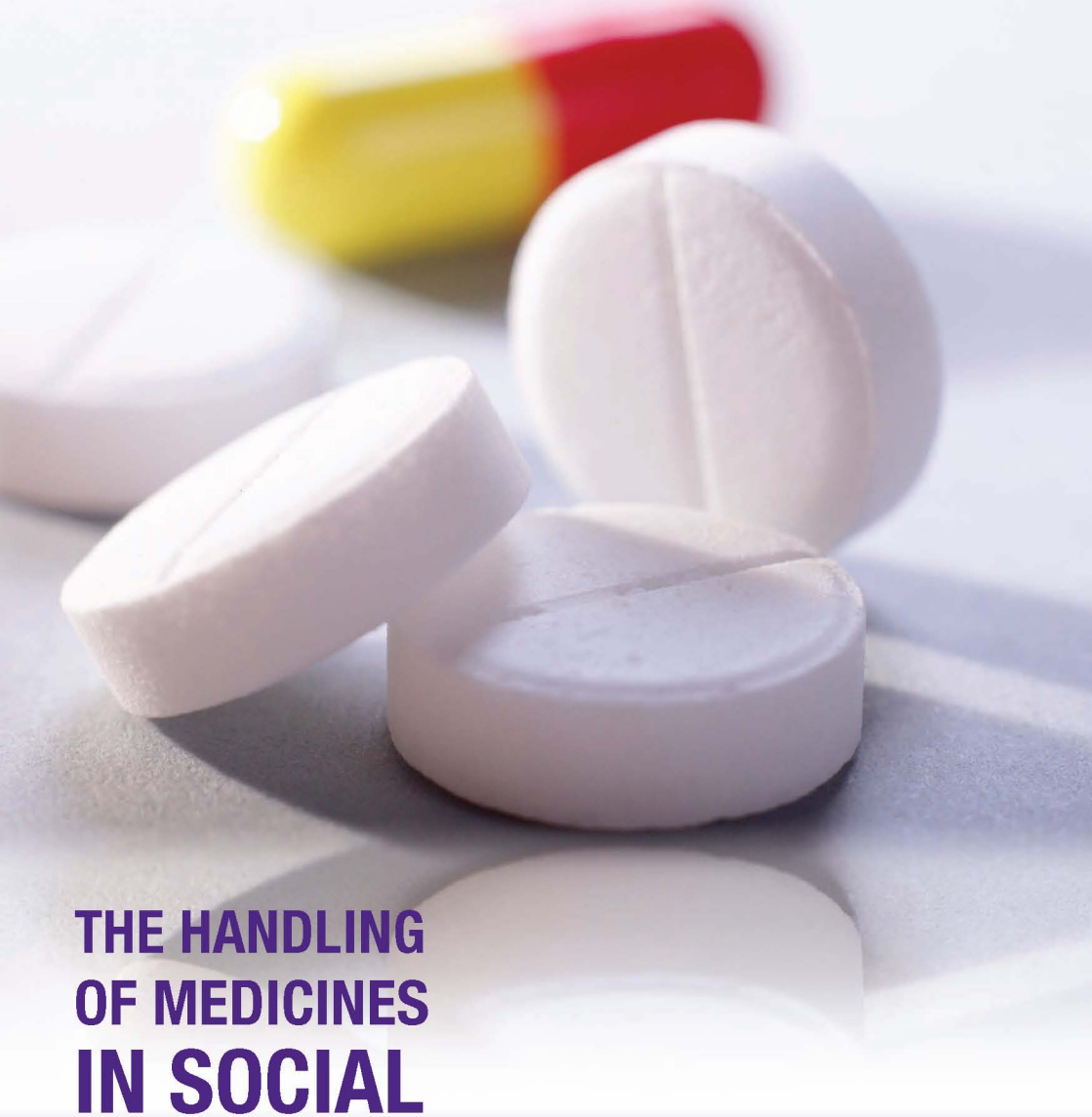


# THE HANDLING OF MEDICINES IN SOCIAL CARE

Royal Pharmaceutical Society of Great Britain

# Contents

# Introduction

Today's medicines are powerful compounds that control disease, ease discomfort and prolong life for millions of people and are generally beneficial. Unfortunately no medicine is without side effects and some are worse than others. Side effects are not the only potential problem with medicines; sometimes people take medicines when they do not need them or use them in the wrong way or even take someone else's medicines. Usually these things happen by accident or because of misunderstandings. Often the consequences are mild but sometimes they can be severe or even life-threatening.

In any situation where care-workers are responsible for the looking after and giving of medicines to other people, be they young or old, healthy or sick, it is important to follow a set of general principles to ensure that this is done safely. In some ways this is similar to the way in which we follow a set of principles or rules in connection with the use of electricity — for example, not fitting electricity sockets in bathrooms and not handling electrical equipment with wet hands.

The purpose of this booklet is to provide ***professional pharmaceutical*** guidance for people in every aspect of social care who are involved in handling medicines. The ***legislation*** that social care providers must comply with differs in England, Wales and Scotland and users of this document must bear this in mind and check the local regulations.

It is not possible to describe every possible situation that may arise and to give hard and fast rules. When a new situation arises you need to use professional judgement — based on sound principles. For this reason we have set out the principles of safe and appropriate handling of medicines and explained how these apply in specific services. We have also listed procedures and methods that represent good professional practice and key reference sources for those who wish to find further information.

## How to use this guidance

We have tried to write this guidance by focusing on the people who receive social care. It is intended to provide a guide to good practice and current legislation governing the handling of medicines. This applies to providers of care services, managers and care workers who deal with these situations every day.

This guidance replaces the earlier publication *The administration and control of medicine in care homes and children's services* (2003). It incorporates a wider range of social care providers and also sets out the issues in a format that is easier to navigate.

Chapter 1 deals with the **principles** that underpin safe handling of medicines in every social care setting. We have tried to explain what can go wrong if care workers ignore principles of good practice.

Chapter 2 describes the **general practical aspects** of medicine handling that are important regardless of setting.

Chapter 3 explains how the general aspects of medicine management relate to **specific care** services and what the care service needs to consider and write into a medication policy.

We have called Chapter 4 **'The Medicines Toolkit'.** It deals with the policies, procedures, systems and devices that are needed in order to implement the measures described in Chapter 2.

### *For example*

- To learn about medicine records in social care, refer to **Principle 2**.
- Then read **Record-keeping** in Chapter 2.
- Look for your specific care service in Chapter 3 to find out what records are important and also check on the website of your regulator what the legal requirements are.
- Finally, there is further information about **Medicine Administration Records** (MAR) in the Medicines Toolkit (Chapter 4).

At the end of the booklet there is a glossary and a list of **reference sources** including legislation and guidance from professional organisations. Where technical or specialised terms are used they are explained in the glossary.

Throughout the document we have included tips and examples to help make issues clearer.

# Chapter 1

# Principles of safe and appropriate handling of medicines

## Principles of safe and appropriate handling of medicines

We have identified eight core principles relating to the safe and appropriate handing of medicines. These apply to every social care setting.

1 People who use social care services have freedom of choice in relation to their provider of pharmaceutical care and services including dispensed medicines.

2 Care staff know which medicines each person has and the social care service keeps a complete account of medicines.

3 Care staff who help people with their medicines are competent.

4 Medicines are given safely and correctly, and care staff preserve the dignity and privacy of the individual when they give medicines to them.

5 Medicines are available when the individual needs them and the care provider makes sure that unwanted medicines are disposed of safely.

6 Medicines are stored safely.

7 The social care service has access to advice from a pharmacist.

8 Medicines are used to cure or prevent disease, or to relieve symptoms, and not to punish or control behaviour.

Throughout this section, we will explain how the principle is relevant to handling medicines and have inserted some examples where things can go wrong if the core principle is not part of everyday practice.

**Principle 1**

**People who use social care services have freedom of choice in relation to their provider of pharmaceutical care and services including dispensed medicines**

In relation to medicines this means:

- Choosing to look after and take their own medicines with help and support from care staff
- Care staff only give medicines with the person's consent
- People are included in decisions about their own treatment, for example, whether or not to have an annual 'flu' vaccination
- People have a say about which pharmacy (or dispensing doctor) supplies their medicines
- The social care service accommodates personal and cultural preferences.

**What can go wrong?**

When there is no real choice available, you may give medicines to someone who:

- Does not want the medicine
- Does not need the medicine.

Expressing choice may be the only independent action the person can take. There are circumstances when you will be expected to act in the person's best interests, but this is not the case for every person all of the time.

If you are asked to give medicine to someone who cannot tell you whether they want it or not, how can you be sure that they 'consent'?
***Observe how that person reacts. Spitting it out may be a better explanantion than words.***

The patient information leaflet (PIL) that is in the medicine pack contains information about the medicine and how it works. It is meant to help people decide whether they want to take the medicine. **But they may need help from care workers to understand what it says.**

**Practical dilemmas:**

*Mr Smith lives in a care home and wants to look after and take his own morphine tablets, but he leaves them in the sitting room when he goes to the toilet. Another person in the care home could take them and become unwell.*

*Sanita has asthma and her inhaler is a life-line. Her breathing problems get worse if she cannot use it quickly. She is at a boarding school where the policy is to lock up all medicines in case another student steals them, but in this case, the outcome may be very poor for Sanita.*

**Giving choice to one person could unfortunately prove risky for others, or it may be a risk to the care service. One person's choice should not adversely affect others. Nor should someone's health be damaged by a set of rules. Each situation must be assessed for the balance of risk.**

Refer to **Chapter 2: Medicine administration** for practical details to implement **Principle 1** and **Chapter 4** for key information about **Choice and Consent.**

**Principle 2**

**Care staff know which medicines each person has and the social care service keeps a complete account of medicines.**

Medicine records are essential in every social care service. If you look after medicines for the people you care for, at any given time you should be able to identify the medicines prescribed for each person and how much they have left.

Even when care staff do not routinely give medicines, it is important to know:

- Whether the person has any medicines
- What the medicines are and how they should be taken
- What conditions the medicines are intended to treat.

In residential care for adults and children where care staff request medicines for the people they look after, it is essential to keep a complete record of all medicines - what comes in, what is used, what goes out. This is often described as an 'audit trail'.

**Audit trails are nothing new. You use one every day to let you know how much money you have got. You look at how much money you have received, how much you have spent, how much you have used to pay bills, etc. This enables you to know how much you should have left.**

When the person looks after and takes their own medicines, care staff must be alert to notice if they are taking too much or not enough. When care is provided in the person's own home, the care provider must accurately record the medicines that care staff have *prompted t*he person to take, as well as the medicines care staff have *given.*

**What can go wrong?**

People may not get the medicines they need and these may be vital to their health and well being. Alternatively, care staff may give entirely the wrong medicine by mistake if there are gaps in the information and that can be devastating not only for the person involved but also for the care worker.

A care worker forgets to sign that she has given furosemide to Mrs Jones. The next care worker who comes on duty sees that there is no signature and gives Mrs Jones another dose.

**Although this may not be a disaster, the drug error could make Mrs Jones very unwell. In this case the lady would have to go to the toilet more often. This could cause her problems if she could not walk very well and she might fall.**

***When a person comes into a residential care setting, you should make a record of the prescribed medicines and any purchased remedies that he or she is taking. This should be a routine task.***

***When children and adults access day care or have occasional respite care, always check whether they are taking regular medicines and make every effort to find out what they are, in advance, if possible.***

**If there was an accident** and you had to explain in a court of law how someone's medicines had been given by care workers, could you do it from your records?

**If someone was stealing resident's medicines in your care home,** would you be able to tell from your records?

**If a young person tells you they have run out of *Ritalin*™** and need some more, would your records show how many you had given them and whether they should still have some left?

**Refer to Chapter 2: Record keeping** for practical details to implement **Principle 2**.

**Principle 3**

**Care staff who help people with their medicines are competent.**

In social care settings, people who are unable to manage their own medicines are entitled to have someone who is adequately trained and knowledgeable to give medicines to them. Only staff who have been given appropriate training and have demonstrated they are competent should do this.

Care providers are responsible for assessing a care worker's competence to give medicines to the people they care for. They should not make assumptions based on that care worker's previous experience.

**What can go wrong?**

If staff do not know how to give medicines safely they may accidentally cause someone harm. An error in giving medicines may be a small mishap but could result in the person's death.

If the training programme for care workers only deals with giving tablets and capsules from a monitored dosage system, you cannot expect a care worker to know how to handle eye drops correctly.

**Poor handling may cause an eye infection. This will add to the eye problem that the person has the treatment for and he/she may need additional treatment for the infection.**

What if a care worker does not feel competent to give medicines because the training has been inadequate? Are they afraid of losing their job if they speak up?

**The care provider should actively encourage staff to openly discuss training needs with their manager.**

See **Chapter 2: Training** for practical details to implement **Principle 3**.

**Principle 4**

**Medicines are given safely and correctly, and care staff preserve the dignity and privacy of the individuals when they give medicines to them.**

Safe administration of medicines means that medicines are given in a way that avoids causing harm to a person. This is a key element of good practice and has a direct link to Principle 3.

- Only give medicines to the person they were prescribed for
- People should receive the right medicine at the right time and in the right way.

The care provider must also support care workers by written procedures that set out exactly how to give medicines and it is good practice to monitor that care workers follow these procedures. Some medicines such as methotrexate need special care to protect the person who is giving the medicines.

Every effort should be made to preserve the dignity and privacy of individuals in relation to medicine-taking. This means being tactful and sensitive, for example, asking about bowel and bladder function should always be handled discreetly — do not shout across the room so that everyone can hear. It also means keeping personal medical information confidential, for example, a person's medicines administration record (MAR) should not be kept where everyone can see it.

If efforts are not made to preserve the dignity and privacy of the individual, in relation to their medicine, that person can be humiliated and other people can be embarrassed. This can affect the person's emotional security and stability and, in turn, their behaviour. It is a key indicator in the quality of the relationship between carer and the person being cared for.

### What can go wrong?

If you do not have systems for giving medicines safely — and follow them — you can accidentally give medicines in the wrong dose or to the wrong person. You might also accidentally not give medicines to a person who should have them. These are drug errors. They could harm the person you are caring for.

How do you know that you are giving the right medicine to the right person?

If you are there every day you will know people you care for but how will others manage?

**Your written procedures must have enough information so that if all the regular staff had an accident on the same day, someone else would be able to give the right medicines to the right people.**

**If registered nurses are administering medicines they must comply with the most recent guidance published by the Nursing and Midwifery Council (NMC).**

**Some medicines are taken every other day, weekly or monthly and not daily. It is very important not to get these mixed up.**

Refer to **Chapter 2: Medicine administration** for practical details to implement **Principle 4.**

**Principle 5**

**Medicines are available when the individual needs them and the care provider makes sure that unwanted medicines are disposed of safely.**

People expect that the medicines a doctor has prescribed will be available when they need them and in residential care, it is important to retain only those medicines that the current residents need.

When a care service is responsible for requesting a supply of medicines, it is up to the manager to ensure that there is a system in place to get them in a reasonable time frame. Where care workers visit the person's home they may need to clarify who will be responsible for requesting repeat prescriptions — the person or a relative — unless this forms part of the care package.

Continuity of supply of medicines for ongoing treatment is essential. In order to do this, arrangements with a local pharmacy or dispensing doctor should be made in advance. This situation is more likely in a care home but when care is given in the person's home, the care worker may need to prompt the person or their relatives when medicines are running out.

However, out-of-date, damaged or part-used medicines that are no longer required should be disposed of safely so that they cannot accidentally be taken by other people — particularly children — or stolen.

**What can go wrong?**

Delayed or interrupted treatment could make a person ill or delay recovery. For example, delayed treatment with antibiotics could mean that an infection gets worse. Where children or young people are concerned, this may result in un-necessary absence from education. A missed dose of warfarin could increase the risk of stroke. A missed dose of a pain-killer could lead to increased pain and decreased mobility.

People can be harmed if they take out-of-date, damaged or part-used medicines that are no longer required. Some people are reluctant to get rid of these medicines because they feel it is wasteful. A good example to consider is eye drops. They must be disposed of one month after they are opened because bacteria can contaminate the liquid. If kept and used some time later, it could make the person's eye worse.

The disposal of medicines is regulated by law in order to protect the environment. If medicines are put out with normal rubbish and placed in a land-fill site, they could fall into the wrong hands and someone, possibly a child, could be harmed.

Find out in advance about the supply policies of local surgeries and pharmacies.

**Check what the out-of-hours options are.**

Would you use food that was past its use-by date?

**You should not use medicines that are past their use-by dates either.**

Part-used medicines that have been dispensed for one person, but are no longer required, **must not be** used for other people.

See **Chapter 2: Disposing of medicines** and **Chapter 4: Obtaining supplies of medicines** for practical details to implementing **Principle 5.**

## Principle 6

**Medicines are stored safely.**

Medicines need to be stored so that the products are not damaged by:

- Heat or dampness
- They cannot be mixed up with other people's medicines
- They cannot be stolen
- They do not pose a risk to anyone else.

A good rule of thumb is that medicines need to be treated like valuables. Just because many people do not have to pay for their medicines does not mean that they have no value.

### What can go wrong?

Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. For this reason, medicines must not be stored in damp or steamy places such as kitchens or bathrooms. The appearance of the medicine may not change even though it may not be effective any more. In some cases, it may harm the person who takes it.

If medicines are not stored securely, they may be stolen, may accidentally be mixed up with medicines belonging to other people or other people might help themselves and overdose with serious consequences.

James is a student in a special residential school. Each bedroom has an individual medicines cabinet and his medicines are kept there. James cannot self-administer so care workers who help him to get ready in the mornings and evenings give them to him.

For convenience, supplies of medicines that James will need at lunchtime are in the drug trolley which is kept in the dining room.

Mrs Patel lives at home and care workers from two different agencies provide personal care each day. She chooses to keep her medicines on a small table within reach of her usual chair.

**There is no reason to encourage Mrs Patel to keep her medicines in a locked cupboard.**

Refer to **Chapter 2: Storage of Medicines** for practical details to implement **Principle 6.**

**Principle 7**

**The social care service has access to advice from a pharmacist.**

Care workers who are handling medicines should ensure that they have access to advice from a pharmacist.

Pharmacists are the experts in medicines. Every pharmacist has several years of university education concerned with medicines. Pharmacists know how medicines work in the body and they understand the practical problems too.

Pharmacists can find out a lot of information and respond quickly to your questions. Every care setting should ensure that it has the contact numbers for their local pharmacy readily available together with a named person to contact.

**What can go wrong?**

If you cannot get information or advice from a pharmacist, it might take longer to sort out problems with medicines or to get your questions answered. Questions such as:

- Sarah started new treatment last week and is very constipated. Could this be caused by the medicine?
- Can I safely crush the tablets that this person cannot swallow?
- The directions state 'take with or after food' and the person is not eating very well? How important is this?

You can make an arrangement with a local pharmacist to provide advice. This applies even if your medicines are supplied by a dispensing doctor.

In England & Wales there are may pharmacists who provide a 'medicines use review' (MUR) service. This may benefit the people you care for.

**It is good to build up a working relationship with a pharmacist in whom you have confidence. You need someone whom you can contact directly when you need advice about medicines.**

People who look after children need professional help when they are going to treat minor ailments with medicines they buy 'over the counter'.

**It is good advice to 'ask your pharmacist'.**

**Principle 8**

**Medicines are used to cure or prevent disease, or to relieve symptoms, and not to punish or control behaviour.**

Medicines should not be used unnecessarily to sedate or restrain people. This has been referred to as a 'chemical cosh'. This principle is closely related to Principle 1 regarding 'choice'.

The medicines that have the side effect of sedating people are very important in the treatment of disease, for example, epilepsy. In such cases it is important for the care workers to support the person and when necessary give medicines as the doctor prescribes. A clear instruction about when the medicine should be given will support care workers, especially if the direction is to 'take when required'.

Prescribing medicines is the responsibility of healthcare professionals. This process is abused if healthcare professionals are put under pressure to prescribe medicines purely for the convenience of the care service instead of clinical necessity.

**What can go wrong?**

Good care is centred on the needs of the person who receives it. Any form of control or punishment is not a feature of good care.

There have been high profile cases of neglect and abuse involving inappropriate use of medicines. Such examples must act as prompts to care providers to ensure they are not repeated.

When adults and children take medicines regularly for long-term conditions, they must have the support of a specialist registered nurse from the primary care team. If these support services are not in place, a review of medication at planned intervals is recommended.

The prescriber may set this review process in motion, but if this is not the case, the care service may also request a medication review.

A medication review service may be provided by the GP, a registered nurse from the primary care organisation or a pharmacist.

# Chapter 2

## Handling medicines in social care settings

In this chapter we have set out the general description for medicine handling. This covers**:**

- Controlled drugs
- Disposal of medicines
- Medicine administration
- Minor ailments
- Record-keeping
- Storage of medicines
- Self-administration of medicines
- Staff training

When social care organisations look after medicines for the people they care for, the registered provider and the care service manager are jointly responsible for the safe and appropriate handling of medicines. They must ensure that there are written policies and procedures for every aspect of handling medicines and the registered provider is responsible for ensuring that when care workers give medicines they have the right training and are competent to do so.

Where relevant, we cross-reference to further information about policies, procedures, systems and devices set out in **Chapter 4: The Medicines Toolkit.**

## CONTROLLED DRUGS

Controlled drugs (CDs) are prescribed medicines that are usually used to treat severe pain, induce anaesthesia or treat drug dependence and they have additional safety precautions and requirements. Some are also used in other situations, for example, methylphenidate (Ritalin™) is used in the treatment of attention deficit hyperactivity disorder (ADHD). Some people abuse CDs by taking them when there is no clinical reason to do so.

There are legal requirements for the storage, administration, records and disposal of CDs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). They do not apply to every social care service and they do not apply when a person looks after and takes their own medicines.

Since there has been a high profile given to managing CDs since the Shipman Inquiry published the fourth report in 2004. All social care services are recommended to have special arrangements for CDs even though the law does not currently require it.

- Examples of CDs are morphine, fentanyl and methylphenidate
- Storage cupboards for CDs are available commercially. Secure storage is required when a care home looks after CDs and keeps them centrally.
  *Refer to **Chapter 4** for further information about the specification.*
- Hard bound registers are recommended for CD records.

### Obtaining controlled drugs

CDs are prescribed and dispensed for individually named people, in the same way as other medicines.

- There are special legal requirements for CD prescriptions so you should always allow extra time for these to be written
- A prescription that does not comply with these requirements may have to be sent back to the prescriber for altering before it can be dispensed
- If care workers collect CDs from a pharmacy on behalf of someone else, they may be asked to provide identification.

**'Stock' CDs can only be ordered if the organisation has obtained a Home Office Licence.**

### Administration of controlled drugs

In order to give a CD you should follow all the steps involved in giving any other medicine (see **Medicine Administration**). In residential settings it is good practice if a second appropriately trained member of staff witnesses this process.

**In a homecare setting no witness is required.**

### Records for controlled drugs

Residential social care settings for adults should keep a separate record of the receipt, administration and disposal of CDs. It is good practice for records of this type to be kept in children's homes.

- Administration should be recorded both on the MAR and in the CD record book.
- These records must be kept in a bound book with numbered pages
- There should be a separate page for each CD for each person
- Include the balance remaining for each product. This should be checked against the amount in the pack or bottle at each administration and also on a regular basis, e.g. monthly.

In order to determine the Schedules of CDs for which these records should be kept please refer to the best practice for your country, such as the National Minimum Standards in England & Wales and the National Care Standards in Scotland.

**Records of this type are not required in homecare settings.**

### Disposal of controlled drugs

Special arrangements apply to the disposal of CDs in care homes registered to provide nursing care in England & Wales:

- If supplied for a named person: denature CDs using a kit designed for this purpose and then consign to a licensed waste disposal company
- If supplied as a 'stock' for the care home (nursing): an authorised person must witness the disposal.

For all other social care settings, the CDs should be returned to the pharmacist or dispensing doctor who supplied them at the earliest opportunity for safe denaturing and disposal. When CDs are returned for disposal, a record of the return should be made in the CD record book.
It is good practice to obtain a signature for receipt from the pharmacist or dispensing doctor.

There are kits to safely denature CDs.

**Your supplying pharmacist will be able to advise you what is available.**

### Handling non-prescribed controlled drugs and their disposal

Sometimes people bring illicit substances into care homes. The care setting should take advice from local police and if necessary the Serious and Organised Crime Agency concerning appropriate procedures for dealing with this.

Homecare providers should devise policies and procedures in relation to service users using illicit drugs. This may include a requirement for care workers to vacate the premises if a service user is smoking, consuming or injecting illegal substances. Legal advice should be sought in situations where care workers may be at risk of aiding and abetting a service user to perform an illegal act.

### Further information about controlled drugs

Further information about CDs can be found in:

- Guidance produced by the CSCI: Safe management of CDs in care homes www.csci.org.uk/professional
- A guide to good practice in the management of controlled drugs in primary care (England). Second edition Feb 2007 from the National Prescribing Centre (NPC) www.npc.co.uk/controlled_drugs/CDGuide_2ndedition_February_2007.pdf
- Guidance produced by RPSGB: Changes in the management of controlled drugs affecting pharmacists www.rpsgb.org/pdfs/cdmanagechguid.pdf

## DISPOSAL OF MEDICINES

All care settings should have a written policy for the safe disposal of surplus, unwanted or expired medicines. When care staff are responsible for the disposal, a complete record of medicines should be made.

The normal method for disposing of medicines should be by returning them to the supplier. The supplier can then ensure that these medicines are disposed of in accordance with current waste regulations. In England, care homes (nursing) must not return medicines to a community pharmacist but use a licensed waste management company. Additional advice is provided by CSCI in *Safe disposal of waste medicines from care homes (nursing)* www.csci.org.uk/professional.

The situations when medicines might need to be disposed of include:

- A person's treatment is changed or discontinued — the remaining supplies of it should be disposed of safely (with the person's consent)
- A person transfers to another care service — they should take all of their medicines with them, unless they agree to dispose of any that are no longer needed
- A person dies. The person's medicines should be kept for seven days, in case the Coroner's Office, Procurator Fiscal (in Scotland) or courts ask for them
- The medicine reaches its expiry date. Some medicine expiry dates are shortened when the product has been opened and is in use, for example, eye drops. When applicable, this is stated in the product information leaflet (PIL).

Surplus, unwanted or expired medicines should not be stored in residential care settings.

**They cannot be used for anyone else but they could get mixed up and accidentally be given to other people and may cause harm.**

All disposals of medicines must be clearly documented**.** The details are set out in the section on record-keeping.

## MEDICINE ADMINISTRATION

Safe administration of medicines means that medicines are given in such a way as to maximise benefit and to avoid causing harm.

Whenever possible people in care settings should be responsible for looking after and taking their own medicines but some will be given medicines by care workers.

In order to give a medicine safely, you need to be able to:

- Identify the medicines correctly. To do so, the medicine pack must have a label attached by the pharmacist or dispensing GP.
- Identify the person correctly
- Know what the medicine is intended to do, for example, to help the person breathe more easily
- Know whether there are any special precautions, for example, give the medicine with food.

There should be a simple easy-to-follow written procedure for giving medicines. You should be familiar with this and follow it carefully. If you are responsible for running a care service you should also monitor periodically how well staff follow this procedure. We have suggested a procedure in Chapter 3.

You should only give medicines that you have been trained to give. Care workers can give or assist people in:

- Taking tablets, capsules, oral mixtures
- Applying a medicated cream/ointment
- Inserting drops to ear, nose or eye
- Administering inhaled medication.

Care workers should not undertake the following unless they have satisfactorily completed additional training:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Injectable drugs such as insulin
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Giving oxygen.

Please refer to the section on Staff Training for more detail.

Some medicines need to be given at specific times, for example:

- Before, with or after food — the absence/presence of food in the stomach can affect how the medicine works and may cause unwanted effects
- Some illness can only be controlled with very precise dose timings, e.g. some medicines for Parkinson's disease have to be taken five times during the day, some people's fits are only controlled if they take their tablets at set times.

Monitored dosage systems (MDS) or compliance aids can sometimes be used to help people to take their own medicines safely. You can find out more about this in 'MDS and compliance aids' in Chapter 4.

According to the law (The Medicines Act 1968) medicines can be given by a third party, e.g. a suitably-trained care worker, to the person that they were intended for when this is strictly in accordance with the directions that the prescriber has given.

**Medicines that have been prescribed and dispensed for one person should not, under any circumstances, be given to another person or used for a purpose that is different from the one they were prescribed for.**

**Medicines must be given from the container they are supplied in.**

This means that doses of medicines must not be put out in advance of administration in egg-cups or medicine pots. This is secondary dispensing and it can lead to accidental mix-ups and errors. In domiciliary care, if it has been agreed with the patient and it is the care plan, doses can be left out for that individual to take at a later time, e.g. sleeping tablet.

It is important to know how to react when an adult or child refuses to take medicine that the doctor has prescribed and this must be clearly stated in the written procedure. Generally, it is worthwhile waiting for a short time before going back to the adult or child and again offering the medicine. The care worker must never force an adult or child to take medicine, but it may be necessary to contact the GP for further advice.

Even though some people do not mind being given eye drops or using an inhaler in public, many would prefer to do these things in private and other people may not wish to see medicines given to other people while they are having a meal.

Some people will be embarrassed if a member of the opposite sex gives medicines to them because of cultural or religious beliefs.

**Treat medicine-taking sensitively — find out what each individual prefers.**

### What if there is a mistake or incident?

Errors can occur in the prescribing, dispensing or administration of medicines. Most medication errors do not harm the individual although a few errors can have serious consequences. It is important that errors are recorded and the cause investigated so that we can learn from the incident and prevent a similar error happening in the future.

Examples of administration errors are:

- Wrong dose is given, too much, too little
- Medication is not given
- Medication is given to the wrong child or adult.

**Service providers**
Should not ignore errors but encourage a culture that allows their staff to report incidents without the fear of an unjustifiable level of recrimination. To achieve this they must:

- Have a clear incident reporting system
- Investigate reports and decide whether they need to offer training to an individual or review existing procedures
- Record any action taken
- Report serious incidents to the regulatory body.

**Carers**

- You must immediately report any error or incident in the administration of medicines. This would usually be to your line manager or person in charge of the setting.

You can find further information about this in the Department of Health (2004) document, *Building a Safer NHS for Patients, Improving Medication Safety*.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4071443.

### What if the person has an adverse drug reaction?

If you give a new medicine to a child or adult and they become unwell, this could be caused by the medicine and you must get medical help immediately.

Doctors, nurses and pharmacists can report adverse drug reactions to the Medicine and Healthcare products Regulatory Agency. There are some occasions when it is appropriate for an individual or their carer to make this report. You can get further information from their website www.mhra.gov.uk.

## MINOR AILMENTS

The care service needs to consider carefully whether or not to treat minor ailments with 'homely remedies'. This applies mainly to residential services and there is a special scheme already operating in Scotland directly from community pharmacies.

Anyone can buy 'homely remedies', for example, paracetamol for a headache and it is the kind of treatment that we all want to have immediately. A GP may prescribe something to take 'when required' when it is possible to predict in advance what that person may need, but the GP may not be willing to provide a supply of paracetamol for every resident in a care home just in case they may need it for an occasional headache or toothache.

If someone is living at home, they can choose whether to buy remedies and take them and they still have that choice when they receive social care. But there are situations when the care service will have to make this decision either because they are looking after children or the adult is unable to make the choice.

Treatments for minor ailments are not ***prescribed*** for individuals, so there is no conflict with what was said about the Medicines Act in the previous section. But if a care provider decides to give treatment to people, they must:

- Get advice from a doctor, pharmacist or nurse
- Be clear about the problems they will allow care workers to treat, for example, headache, heartburn, cough
- Choose the medicines that are suitable for the age range they care for
- Write a detailed protocol for staff to refer to
- Make sure that the people you care for, their relatives and GPs know what your policy is
- Keep records of the purchase, administration and disposal.

There are risks that prescribed medicines will interact with medicines purchased over the counter and cause harm. This includes

- Herbal products
- Traditional Chinese medicines.

**Celia lives in a care home and has a particular preference for one remedy that the service does not keep. The manager arranges to supply it for Celia's use only, after checking with the pharmacist that it does not interact with any of her prescribed medicines.**

**If a relative buys 'over the counter' medicines for the person in residential care, encourage them to ask the GP or pharmacist whether they will interact with prescribed medicines. This includes the purchase of supplements such as iron or vitamins.**

## RECORD-KEEPING

It is important to record what you do when you do it. Do not rely on your memory to write information accurately at a later time and if you record giving medicines to people, there is no point making that record when you prepare the medicines. The person may decide they do not want it, but your record means that they have accepted and taken it.

From your records, anyone should be able to understand exactly what you, the care worker has done and be able to account for all of the medicines you have managed for an individual. The service provider needs to decide on the way in which a care service keeps records. Whatever format is chosen, the records must be complete, legible, up to date, written in ink, dated and signed to show who has made the record.

*Self-administration:* The individual's record shows the date a care worker gave a stated quantity of a named medicine to that person.

**This information will help you assess whether the person is taking his/her medicines correctly.**

*Care at home:* The individual's care notes include the date and time that the care worker prompted the person to take his/her medicine.

**This information is vital to other care workers who also visit this person.**

*Printed MAR chart in a care home:* The use of an agreed code alerts other care workers that this person has not taken the medicine for a recorded reason.

**This information may be essential when the GP reviews the treatment for this person.**

*Minor ailments in a boarding school:* The record details what is given to whom on a specified date.

**This information may indicate that a persistent problem should be referred to a GP and not treated by care workers.**

An up to date list of current medicines prescribed for each person is essential and a care plan should make it clear whether the person needs support to look after and take some or all medicines or if care workers are responsible for giving them. Written confirmation of the medicine a person is taking should be obtained from an authoritative source if possible.

If you are responsible for requesting and/or collecting medicines for a child or adult, you must record:

- What you received including the name and strength of the medicine
- How much you received
- When you received it.

In residential settings, this is an important record when the person first arrives with supplies of medicine from home or hospital or another social care setting.

It is useful to record requests for prescriptions on behalf of a service user.

**You can use this list to check that all items ordered have been received and that no inadvertent unexpected changes to the medication have been made.**

In every social care service where care workers give medicines, they must have a MAR chart to refer to. The MAR chart must detail:

- Which medicines are prescribed for the person
- When they must be given
- What the dose is
- Any special information, such as giving the medicines with food.

**Registered nurses must comply with the most recent guidance published by the NMC about records and record-keeping.**

When medicines are disposed of you need to make a record to show that they were handled properly. You should record the following information:

- Date of disposal/return to pharmacy
- Name and strength of medicine
- Quantity removed
- Person for whom medication was prescribed or purchased
- Signature of the member of staff who arranges disposal of the medicines.

Care homes and homecare providers that decide to store people's records on a computer should take advice concerning the Data Protection Act 1998. Any records made electronically must identify the person who made the record and be tamper-evident.

The supplying pharmacist or dispensing doctor may offer printed MAR charts and these can usually be used to record medicine receipt and disposal. If care workers use hand-written MAR charts, there must be a system to check that the details are correct.

We have included detailed information about MAR charts in **Chapter 4**. There are examples of how to use the chart and we have included some examples of bad practice.

Because the legal requirements for care services vary between countries and are service-specific we recommend that you check the website of the appropriate regulator to find out the service-specific requirements.

**Commission for Social Care Inspection**
www.csci.org.uk

***Care and Social Services Inspectorate Wales***
www.cssiw.org.uk

***Healthcare Commission***
www.healthcarecommission.org.uk

***Office for Standards in Education, Children's Services and Skills (Ofsted)***
www.ofsted.gov.uk

***Scottish Commission for the Regulation of Care***
www.carecommission.com

Clear records will help to prevent drug errors. Problems are more likely to occur when:

- People have long lists of prescribed medicines
- Some medicines are taken regularly, and some are taken only when required for specific reasons, e.g. for pain relief
- Labels say 'take as directed' and the person is unable to explain or cannot remember what this means
- The dose of a medicine is not constant but depends on the results of blood tests, e.g. warfarin (a medicine given to thin the blood to avoid the risk of stroke or thrombosis)
- More than one prescriber is involved. More than one doctor might prescribe medicines for the same person; dentists and a range of other healthcare professionals such as some nurses and pharmacists can also prescribe medicines.
- People have hoarded medicines that the doctor has told them to stop taking
- People are confused about what they should be taking
- An individual is also taking complementary medicines. For example, someone with arthritis might have tablets from the GP but could also be buying glucosamine from a health food shop.
- When a new medicine is introduced or the dose changes
- There are frequent changes to treatment.

Everyone involved in looking after medicines for other people is responsible for keeping good records.

When people bring their medicines with them into a care setting, or at the start of a new home care package, how can you be sure that all of the medication is for a current treatment?

**There are two quick checks you can make immediately:**

1. **The label attached to the medicine, which has the person's name on it, will also have a date when the medicine was prepared. If it is more than six months ago, check with the person's GP whether they should still have it.**
2. **What is the expiry date printed on the pack? You must not give date expired medicine and this may also indicate that the person has not been taking this medicine recently. Check with the person's GP whether they should still have it.**

## STORAGE OF MEDICINES

When social care is provided in a person's own home, they will decide where and how to store medicines.

In residential care, you can choose to provide medicine storage for individuals in their own rooms and this is essential when the person looks after and takes their own medicines. If you choose to store medicines centrally, the cupboards must be big enough, well constructed and have a good quality lock. If the people you care for have bottles of liquid medicines, make sure that the shelf height is suitable or have adjustable shelving. You should not store anything other than medicines in these cupboards.

You should also consider storage of:

- Controlled drugs (refer to Chapter 3)
- Nutritional supplements
- Medicines that need refrigeration (refer to Chapter 4)
- Dressings, ostomy products and catheters
- Medicines supplied in monitored dosage systems, which need much more storage space to cover the change-over period each month.

Also the storage of medicines needs to be in the right place. Filing cabinets are not suitable for storing medicines, neither are:

- Kitchens
- Bathrooms
- Toilets, sluices
- Windowsills or areas next to heaters.

These places are too damp or too warm (or both) or unhygienic for storing medicines. Some storage rooms become too hot for medicine storage unless there is good ventilation or an air conditioning unit. If the temperature is more than 25°C, it is too hot.

The designated place for storing medicines must be secure and only those staff who handle medicines should have access. It is good practice to make sure that nothing else is stored in a medicine cupboard. The medicine cupboard should not be used as a safe for valuables and should not be used as a food cupboard. The only reason to open the medicine cupboard should be to get access medicines.

Many medicines are attractive commodities. You should arrange for medicines to be stored discreetly and not be 'advertised'. Your local pharmacist or Crime Prevention Officer will be able to give advice about this.

**Think...**
**If somebody wanted to help themselves to medicines in your establishment — have you made it difficult for them?**

Remember that children visit relatives, particularly grandparents, and friends, and often like to have a look around and touch things.

**Ensure that medicines are out of reach of curious young visitors.**

Key security is an important part of medicines security therefore only authorised members of staff should have access to them.

- The keys for the medicine area or cupboard should not be part of the master system
- Where medicines are stored centrally, there should be a procedure that says who keeps the keys. There is no point in having a locked cupboard if the key is left on top of it.

**Safe practice tip**

Who is the authorised person to carry the key(s) for the medicines cupboard(s)?

What is the procedure if the key(s) are missing?

Multiple keys is not a safe solution — if you find that medicines are missing, a lot of staff may be under suspicion!

If your medicine cupboard is cluttered, it is harder to find what you want.

**Store medicines tidily.**

If your medicine refrigerator is too small and you over-fill it, it will not work properly.

## SELF-ADMINISTRATION OF MEDICINES

Whenever possible children and adults should take responsibility for their own medicine. This preserves independence regardless of the social care environment and it is an important feature of intermediate care because it prepares people to look after their own medicines when they return home. Care workers should not assume that medicines can automatically be removed from people in a residential care setting.

Self-administration of medicines is not an 'all or nothing' situation. For example, some people might keep and use their own inhalers but not their other medicines. Alternatively, a person might be able to manage his/her medicines provided that care workers assist him/her. For example:

- A person who has suffered a stroke and is unable to open containers may want to keep medicines and ask care workers to assist at the time he/she chooses to take the medication
- A young person may be given a tube of cream to apply privately even though care workers give other prescribed medicines
- A person who has limited understanding and awareness may able to cope with a day's supply of medicines in a compliance aid.

In residential settings, the risk of someone else accidentally (or intentionally) taking medicines intended for another person is greater. A robust system of risk assessment is essential. The assessment must explore whether the person:

- Wants to take responsibility for looking after and taking medicines
- Knows the medicines they take, what they are for, how and when to take them and what is likely to happen if they omit taking them
- Understands how important it is not to leave the medicines lying around where someone else may unintentionally take them and be harmed as a result.

The level of support and resulting responsibility of the care worker should be written in the care plan for each person. This should also include how to monitor whether the person is still able to self-administer medicines without constantly invading their privacy. The assessment is a continuing process. Monitoring how the person manages to take their medicines and regular review form part of the person's care. The medicine records will help the review and monitoring process.

A residential service should provide secure storage in the person's room. This can be a lock fitted to a drawer and does not need to be made of metal or even look like a medicine cupboard. If the room is shared, there must be separate storage facilities for each person.

The boarding school where Adam (age 10) lives has decided to keep all medicines in the appropriate house, but Adam suffers from asthma and sometimes needs his inhaler to take part in sporty activity.

Adam understands why he must keep his inhaler and how to use it. He keeps it in his trouser pocket.

**Another student could remove the inhaler as a joke. But the school recognises how important it is for Adam to have the inhaler because when he needs it, he needs it immediately.**

Edith is cared for in a care home and fully understands the medicines her GP prescribed and how important they are. She has suffered a stroke and cannot manage medicine packs. Edith tells care workers which medicines she wants when she wants them. Care workers get her medicines out of her personal drawer and put the tablets into her 'pill box'.

**Edith is responsible for taking her medicines. The records of what care workers provide her with each month give the care service the information to monitor self-administration and the confidence to support Edith.**

## STAFF TRAINING

Care workers must be appropriately trained in the handling and use of medication, and have their competence assessed. The service provider's policy should state how frequently this should happen and when it will be reviewed and updated. All staff training should be documented for each care worker.

As a minimum training should cover:

- The supply, storage and disposal of medicines
- Safe administration of medicines
- Quality assurance and record-keeping
- Accountability, responsibility and confidentiality.

### Induction training

The care service must identify whether the new employee has had previous training and experience of giving medicines to people. If so, whether the care worker is competent to give medicines when they get to know the people in the care service and their needs.

A care worker who has never worked in social care before should be instructed not to give medicines until they have been trained to do so safely. The 'training' at induction will therefore consist mainly of 'what not to do'.

A good example is that a new employee should not offer treatment for minor ailments to any adult or child in their care but ask another senior colleague to deal with these requests.

### Basic training in safe handling of medicines

There are many varied providers of medicine training. The basic elements that a care worker needs to know before giving medicines include giving medicines:

- Into the mouth (tablets, capsules, liquids)
- Ear, nose and eye drops
- Inhalers
- Medicines applied to the skin.

This level of training *will not* cover giving medicines that use 'invasive' techniques such as giving suppositories, enemas, and injections.

There must be a formal assessment on completion, devised by the care provider or manager. The aim is to make sure that the care worker can confidently and correctly give medicines prescribed for the people you care for. You can achieve this by accompanying the care worker when they give medicines and observing that they do key important tasks linked to the care service policy and procedures. This is not the same as a test or attendance certificate issued as part of a training course.

**Key tasks during medicines administration will include that the care worker:**

- Checks what the person takes: on the MAR chart and the medicine label
- Checks it is the right person
- Asks whether the person wants the medicine
- Makes sure that no-one else has already given it to him/her
- Prepares the correct dose for the time of day
- Gives the medicine to the person and also offers a drink of water
- Signs the record.

There are many training organisations in the UK who provide training in the safe administration of medicines for care workers.

- Community pharmacists may be able to provide training locally; and there are courses at colleges and universities
- Most training courses concentrate on care home practice. As the basic principles are the same regardless of setting, these courses would also be of benefit to homecare workers.

Further details of the skills and knowledge required for medicines handling can be found at the Skills for Care website www.skillsforcare.org.uk.

### Specialised training to give medicines

There may be occasions when care workers are willing to give medicines that registered nurses normally administer. This only happens when the registered nurse 'delegates' and the NMC have set out their guidance for this. It is helpful in many situations, for example, when a rectal solution is given to a young adult to control an epileptic fit. No one would prefer to wait for a registered nurse, doctor or paramedic to give such important treatment. The important issues are:

- The person consents to a care worker giving this treatment
- The care worker(s) agree to do so
- Clear roles and responsibilities are agreed by the agencies and the people involved in providing care.

This training is both person-specific and care worker-specific.

There is guidance on the CSCI website that applies to England, *Training care workers to safely administer medicines in care homes* www.csci.org.uk/professional.

# CHAPTER 3

## HANDLING MEDICINES — REQUIREMENTS FOR SPECIFIC SERVICES

We have provided important information about handling medicines in Chapter 2. You need to check the specific requirements that apply for your care setting and for your home country.

First of all, check what your care setting is registered for, as this determines the standards to which you have to work. Settings registered to deliver health care have to meet different standards from settings registered to provide social care. In the table below we have included links to the websites of regulators in England, Scotland and Wales where you will be able to access relevant legislation and current national minimum standards.

| | | |
|---|---|---|
| England:<br>Adult social care services | Commission for Social Care Inspection | www.csci.org.uk |
| England:<br>Children's social care services | Ofsted | www.ofsted.gov.uk |
| England:<br>Health care services | Healthcare Commission | www.healthcarecommission.org.uk |
| Scotland | Scottish Commission for the regulation of care | www.carecommission.com |
| Wales | Care and Social Services Inspectorate Wales (CSSIW) | www.cssiw.org.uk |

We have set out specific issues that each service should consider. These are not absolute, as there are always exceptions to general statements, but it should help you to recognise what is important to include in your medication policy; and what may not be relevant to you. The general principles for safe use of medicines apply to all medication whether bought over the counter (non-prescribed) or prescribed (by a GP, dentist, pharmacist, etc).

In addition, we have provided a *Quick Reference Guide* for the medication issues that are most likely to apply to different settings at the end of this chapter. The care settings we have included are:

- Adult placement
- Boarding schools, school care accommodation, special residential schools
- Care at home, domiciliary care
- Child care, early education
- Children's home, secure accommodation, short break and respite services
- Day care
- Drug and alcohol rehabilitation
- Foster care
- Housing support, supported living
- Palliative care
- Residential care for adults, residential care for older people, short break and respite services
- Residential family centre.

## ADULT PLACEMENT

In adult placement, there is an expectation that handling of medicines will not differ from normal household arrangements. However a formal written policy or procedure should be in place to ensure that people who need help taking their medication are assisted in a manner that is safe and suits them best. It is important to consider:

- Storing medicines in a suitable place that is not affected by extreme heat and moisture
- Supporting the adult to look after his/her own medicines if appropriate
- If the adult cannot self-administer, making sure that the carer has full information about when and how to give medicines. This is particularly important when the carer decides to give a medicine that is not prescribed and would be termed a 'homely remedy' in a care home as there may be interactions between prescribed medicines and homely remedies.

## BOARDING SCHOOLS
## SCHOOL CARE ACCOMMODATION
## SPECIAL RESIDENTIAL SCHOOLS

It is essential that care workers and house matrons have a written medication policy. The school should consider the following:

- Obtaining and storing medicines that young people need on a regular basis or when they have episodes of illness
- When appropriate, working with local NHS providers for services such as immunisation
- Support for young people to take their own medicines
- The way that the care worker keeps records
- The treatment of minor ailments
- Taking special care with medicines that are CDs
- Dealing with foreign medicines that young people bring to the school.

Most young people in boarding schools are fit and well. However, many boarding schools employ registered nurses to safeguard the welfare of the students and they may work with local GPs to provide immunisation clinics and treat minor ailments.

Boarding schools also employ House Matrons who look after young people on a day-to-day basis but are not registered nurses. They need support through robust policies and training to handle medicines safely.

Special schools are likely to have young people who are taking regular medicines, often with complicated regimes. Particular care is necessary when there is a change in health of the student. This may result in a change of regular medicines or the dose of medicine. A consultant based in a hospital or the young person's GP at home may make the decision about medicine and dose — yet the local GP will be the one to write the new prescription. The school needs a robust policy for dealing with this sort of event.

See also, *Managing Medicines in Schools and Early Years Settings.*
*www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108489*.

## CARE AT HOME
## DOMICILIARY CARE

It is essential that care workers have a written medication policy and procedures for helping people with their medicines in their own homes. Homecare providers should satisfy themselves that their insurance policy provides suitable indemnification for the policies and procedures that are followed.

The majority of people who receive domiciliary care are taking medicines that come as tablets, capsule, liquids, eye, ear and nose drops, inhalers and products that are applied to the skin. However, a small number could also be having specialist treatments such as subcutaneous insulin, intravenous feeding (TPN), cytotoxics, anti-cancer medicines, or intravenous antibiotics. This may result in the person having care at home from several different agencies.

Care at home is offered to both children and adults. Care workers may give some medicines to children because parents are out of the home. The particular issues that must be considered by people providing care at home include:

- The amount of help and support with medicines that the person needs from the care worker
- Which medicines the care worker may administer, after being trained to do so
- The way that the care worker keeps records
- What the care worker **must not do**, for example, offer advice on treatment of minor ailments.

It is not usually appropriate for a care worker to influence:

- How the person chooses to obtain medicines
- How and where the person chooses to keep medicines in the home
- How medicines that are no longer in use are disposed of
- The choice of over-the-counter medicines that the person/parent wishes to buy.

**Home care workers often work alone. Adequate training is essential before the care worker helps people with their medicines. This will protect the people receiving care and the care worker.**

Personal care is still a mainstay of a home care service, but many of the people who are cared for in their own homes need help with taking their medicines. The care provider must be very clear whether care workers are involved in medicine administration or are limited to providing general support for each child or adult they care for. This will be recorded in the plan of care and must be monitored and reviewed regularly.

It can be a real challenge to find out what medicines the person has so that the care worker may support the person safely. The home care service may not be responsible for ordering repeat medicines and will not be notified officially when the person's treatment changes. Unlike a care home, there may not be links with a single community pharmacy. Communications between care workers, their supervisors and prescribers must be robust and effective.

Care workers need procedures for the following:

- What to do if a person refuses or decides not to take his/her normal medications
- What to do if a person's mental or physical state changes significantly
- How to communicate between care workers and different agencies.

In England, there is guidance about administering medicines in domiciliary care available from the CSCI website www.csci.org.uk/professional.

## CHILDCARE
## EARLY EDUCATION

It is essential that care workers have a written medication policy. The medication policy must consider the following:

- Obtaining written permission from parents for someone else to give medicines
- Information that is required from parents
- Which medicines the care worker may administer after being trained to do so
- Supervision if the child self-administers
- The way that the care service keeps records
- How to deal with an incident or error
- Disposing of time-expired or surplus medication.

**The information that a care service needs from parents will include:**

- What to give and why
- How, when and how much to give
- When the parent last gave the medication.

The service should not be expected to give the first dose of a new medicine to the child. Parents should have already given at least one dose to ensure the child does not have an adverse reaction to the medication, e.g. allergy to an antibiotic.

When medicine is provided for the care service to give, check dosage with the parents and against the label. Care staff may have concerns over the instructions given by the parents. For example:

- The label states a maximum of 1 x 5ml dose at any time but the parents ask you to give double
- The patient information leaflet suggests it is not suitable for the reason the parents have asked you to give it for.

This should be queried by the care staff with the parents or be checked with the GP, or a pharmacist or NHS Direct/NHS 24.

Check expiry date and date when medicines were dispensed. Then ask yourself whether this medication is for the current condition.

**If a medicine has not been dispensed recently is it still appropriate for use?**
Liquid antibiotics usually only have a 7 to 10-day shelf-life, eye drops should be discarded 28 days after opening. Something prescribed for a condition six months ago might not be appropriate now.

**The following does not apply to children's hospices. These are health care services and different regulations apply.**

It is essential that care workers have a written medication policy. The medication policy must consider the following:

- Obtaining and storing medicines that children need on a regular basis or when they have episodes of illness
- Support for the child to take their own medicines
- Which medicines the care worker may administer after being trained to do so
- The way that the care worker keeps records
- The use of medicines for minor ailments or complementary treatments
- Taking special care with medicines that are CDs.

In general, children's homes are likely to have fewer medicines because most of the children who live there are well.

- Some children will need occasional treatment for minor illnesses
- Some children will need regular treatment, e.g. for asthma or eczema
- When managers decide what to buy and how much to give to young people for the treatment of minor ailments, they need access to professional help.

**In Scotland all children should be eligible for the Minor Ailments Scheme, which allows pharmacists to prescribe and supply (free-of-charge) medicines to treat minor ailments. Similar schemes may operate in some places in England and Wales. Homes should contact their local primary care organisation to find out what is available locally.**

Arrangements for medicine storage will depend on the quantity of medicines that have to be stored. But the cupboards must be well constructed and secure. This applies to central storage and to individual storage.

Some children in care who have attention deficit hyperactivity disorder (ADHD) could be having treatment with methylphenidate *(Ritalin™)*.

**This is a CD. You should consider special storage and record-keeping.**
**(See Controlled drugs in Chapter 2, Part 1)**

If the children's home accepts young people for planned respite for a pre-agreed period of time, the service could consider asking the person's family or carers to arrange for the GP to write prescriptions for a new supply of medicines to cover the period of respite. The service can arrange to have these medicines dispensed in advance by their local pharmacist.

Where the young person brings their own medicines into the service to cover the break or respite period, the family and carers should be asked to supply the medicines in the original containers, supplied and labelled by the pharmacist or dispensing GP practice.

If there is any confusion or ambiguity about what medicines or doses are to be given the care provider should make every effort to clarify the details with the prescriber. Advice could also be sought from a pharmacist or NHS Direct/NHS 24 if the prescriber cannot be contacted.

## DAY CARE

When people attend for day care they may not need to take medicines at all. For example, if a person was prescribed a medicine that is taken in three daily doses, then it can be taken at home in the morning, when they get home at tea-time and in the evening and need not be brought to the day centre.

People who attend day care may be able to manage their own medicines with no support from care workers. Others may need differing levels of support — when this happens it is essential for the care service to have a written policy document that sets out:

- Information that is required from carers at home
- Whether the day care has storage facilities or people keep their own medicines with them
- Which medicines the care worker may administer after being trained to do so
- How to support self-administration
- The way that the care service keeps records
- How to deal with an incident or error
- Disposing of time-expired or surplus medication.

If the care service accepts responsibility for giving medicines, it may be possible to arrange for a specially dispensed supply just for use while in the service. If the service does not have facilities to keep medicines on the premises they will need to be brought into the service each time the person visits. These medicines should always be sent to the service in the original containers supplied and labelled by the pharmacist or dispensing GP practice.

If medication has to be given on a 'when required' basis, it is important for the provider to record what the medication has been given for, e.g. for pain, wheezing, eyes running or itchy, sneezing, etc. There has to be a system in place for the provider to be made aware of any doses of 'when required' medicines which were given prior to attending the service and, when the person goes home, to tell the family or carers about doses given while attending.

If there is any confusion or ambiguity about what medicines or doses are to be given the provider should make every effort to clarify the details with the prescriber. Advice could be sought from a pharmacist or NHS Direct/NHS 24 if the prescriber cannot be contacted.

## DRUG AND ALCOHOL REHABILITATION

Rehabilitation is offered by a variety of different care providers, some of whom are registered with one of the Care Commissions. In any situation where care workers are responsible for prescribed drugs, it is essential to have a written policy document that sets out:

- How medicines are obtained for residents
- Procedure to assess self-administration
- Obtaining resident's consent if care workers give medicines
- How medicines are stored, centrally and for self-administration
- Procedure for administration
- Procedure to assess competence to administer medicines safely
- Procedures for CDs
- Procedures for providing medicines when residents take 'leave'
- What records are held
- How to deal with drug errors and incidents
- How to dispose of medicines
- Treatment of minor ailments.

The following care providers may legally purchase 'stock' medicines instead of medicines individually prescribed for named residents for use in the service:

- Care home registered to provide nursing care
- Independent clinic.

The service must have a written prescription, signed by the prescriber, before the medicines can be given. When the GP gives a verbal order to give medicines, this must be followed up by the written prescription within 24 hours.

If the stock drugs fall into the category of 'CDs', the care service must first apply for a licence from the Home Office. Verbal orders are not appropriate for the administration of CDs. If the care service needs to dispose of CD stock, an authorised person must witness this.

**Care homes registered to provide personal care cannot legally obtain stock supplies of prescription-only medicines (POMs).**

## FOSTER CARE

When a child is placed with foster parents, there is an expectation that handling of medicines will not differ from normal household arrangements. A formal written policy is not appropriate, but it is still important to consider:

- Storing medicines in a suitable place that is not affected by extreme heat and moisture
- Supporting the child to look after his/her own medicines if appropriate
- If the foster parents need to give a medicine to the child, ensure that they have full information about when and how to give them. This is particularly important when the foster parent decides to give a medicine that is not prescribed and would be termed a 'homely remedy' in a children's home as there may be interactions between prescribed medicines and homely remedies.

## HOUSING SUPPORT
## SUPPORTED LIVING ARRANGEMENTS

'Supported living' is a term to describe a number of people who share a home and look after themselves with limited support from care workers during the day. There may be occasions when the care service is more involved with support for medicines because the residents may have mental health needs.

It is essential that care workers have a written policy document that sets out:

- How to support residents to take responsibility for their own medicines
- Action to be taken if a resident becomes unwell and unable to take full responsibility for medicines
- Obtaining resident's consent if care workers give medicines
- Which medicines the care worker may administer, after being trained to do so
- The way that the care worker keeps records
- Providing medicine storage on an individual resident basis
- Treatment of minor ailments.

It is not usually appropriate for a care worker to influence:

- How the person chooses to obtain medicines
- How medicines that are no longer in use are disposed of.

## PALLIATIVE CARE

Palliative care is given in a number of settings including care homes (personal care), care homes (nursing care) and hospices. Although many elements will be common to all settings, the scope of care will vary and the regulatory provisions will differ.

Care homes (both nursing care and personal care) can have people who are receiving palliative care. Handling medicines in these settings is no different for palliative or end of life care. The use of tools including Gold Standards Framework and Liverpool Care Pathway does present some challenges for medicine supply to care homes. (For further information about these see, *End of Life Care Programme* www.endoflifecare.nhs.uk/eolc/eolcpublications/Guide%20To%20EoLC%20care%20homes%20lo.pdf). Instead of relying on a stock supply for the care home, the use of an individually prescribed pack of medicine 'just in case' may be more appropriate.

In England & Wales care homes registered to provide nursing care may legally purchase 'stock' medicines instead of individually prescribed medicines for named residents for use in the service. The service must have a written prescription, signed by the prescriber, before the medicines can be given — This can be prescribed on a 'when required' basis in advance of need.

If the stock drugs fall into the category of 'CDs', the care service must first apply for a licence from the Home Office. If the care service needs to dispose of controlled drug stock, an authorised person must witness this.

**Hospices are registered health care services and have different regulations to work to.**

See also: *Guidance: Palliative and end of life care within all care home settings* published by CSCI on its website www.csci.org.uk/professional.

## RESIDENTIAL CARE FOR ADULTS
## RESIDENTIAL CARE FOR OLDER PEOPLE
## SHORT BREAK AND RESPITE SERVICES

Care homes must consider how to provide for the safe and secure management of medicines for their residents. All of the general aspects of handling medicines set out in **Chapter 2** apply and it is essential that care workers have a written policy document that sets out:

- How medicines are obtained for residents
- Procedure to assess self-administration
- Obtaining resident's consent if care workers give medicines
- How medicines are stored, centrally and for self-administration
- Procedure for administration
- Procedure to assess competence to administer medicines safely
- Procedures for CDs
- Procedures for providing medicines when residents take 'leave'
- What records are held
- How to deal with drug errors and incidents
- How to dispose of medicines
- Treatment of minor ailments.

There is supplementary information in **Chapter 4.**

One of the most important issues in the care home is to find out which residents want to look after their own medicines and are able, with your support, to do so.

A particular consideration is how and where to store medicines. If there is a central location for medicine storage you should consider:

- How many people will have prescribed medicines
- The types of medicines supplied
- Whether nutritional supplements, prescribed dressings, continence appliances (catheters, bags, etc) and ostomy products will have to be stored. If so, there must be enough shelving — medicinal products should not be stored on the floor.

Another way to store medicines is to have individual locked medicine cupboards or drawers in people's rooms. This would be essential for people who take their own medicines but it can also be used in systems where care workers give medicines.

Storage of monitored dosage systems (MDS) will need special consideration.

- Adequate lockable storage must be provided at all times for medicines supplied in MDS containers
- Lockable storage must also be provided for medicines during the change over period when new supplies are received from the pharmacy.

It is now a legal requirement to make special arrangements for storage of medicines designated as CDs. (See **Controlled drugs** in **Chapter 2**)

If you do not provide individual cupboards in resident's bedrooms you should also consider how to transport medicines securely and safely in the care home. A drug trolley may be necessary but this is sometimes regarded as 'institutional' rather than 'homely'. If a mobile drug trolley is not used then there needs to be a safe and secure way of moving medicines from the storage area to people. When doses of medicines are given they should be removed from the original labelled containers when you are with person.

If you decide to use a drug trolley, it should:

- Be made of a suitable material
- Be big enough for your needs
- Be designed so that each person's medicines can be kept separately
- Have enough space for all medicines to be locked away in an emergency during the medicines administration round
- Have a mechanism for fixing it to the wall when not used for medicines administration or be locked inside a cupboard or storage area.

It may be difficult to balance the needs and wishes of individual residents with a structured system of giving medicines. There must be flexibility because the optimal way to give medicines depends both on the individual concerned and the medicines that are prescribed.

There is the potential for drug error when medicines are:

- Prepared in advance into pots. This is termed secondary dispensing. Even when a name is attached to the pot, this process has removed a vital safety net — to check the drug, strength and dose with the care home record and label on the medicine at the same time you check the identity of the person.
- Prepared in a pot and placed somewhere for the person to take later. An example of this is when a pot of medicine is placed where the person usually sits for meals. If people change place then someone else could accidentally take the medicines and may be harmed.
- Prepared and given to another member of staff to take to the person in another part of the care home. The person who prepares the medicine and signs the record should also witness the person taking it.

Specific to residential care is the additional challenge of providing medicines when a resident goes out to a day centre or has a day outing or a longer holiday. You should ask the supplying pharmacist for help and advice in dealing with the specific circumstances. These may include:

- Having a separate container of medicines specific to the time of day that the person takes regular leave, for example, lunch-time medicines for a person attending an adult training centre.
- Having a separate supply of medicines for the full period of a holiday.

If the person regularly goes to spend weekends with family, there is no reason why their medicines should not go with them. The medicines are the person's property, not the care home's.

If the service provides short-term or respite care, they must also consider how they will obtain a supply of medicines for the duration of the stay. For planned respite for a pre-agreed period of time, the service could consider asking the person's family or carers to arrange for the GP to write prescriptions for a new supply of medicines to cover the period of respite. The service can arrange to have these medicines dispensed in advance by their local pharmacist.

Where a person brings their own medicines into the service to cover the break or respite period, the family and carers should be asked to supply the medicines in the original containers supplied and labelled by the pharmacist or dispensing GP practice.

If there is any confusion or ambiguity about what medicines or doses are to be given the provider should make every effort to clarify the details with the prescriber. Advice could also be sought from a pharmacist or NHS Direct/NHS 24 if the prescriber cannot be contacted.

The disposal of medicines is referred to in **Chapter 2** and differs according to the type of care home and country that the service is registered in. It is important to stress that in England & Wales care homes registered to provide nursing care ***must not*** return any medicines to the supplier for destruction. They must have a robust arrangement with a licensed waste disposal company.

## RESIDENTIAL FAMILY CENTRE

In these centres, parents will usually handle medicines for themselves and their children, but it is still essential for care workers to have a written policy document that sets out:

- How to support families to take responsibility for their own medicines, including assessment, monitoring and review
- Obtaining consent if care workers give medicines
- Which medicines the care worker may administer, after being trained to do so
- Action that may be needed if a parent becomes unwell and is unable to take full responsibility for medicines for a child or young person
- The way that the care worker keeps records
- Providing medicine storage on an individual family basis or centrally
- Treatment of minor ailments.

### Quick Reference Chart

| | Obtaining medicines | Records | Storage | Admini-stration | Self-admini-stration | CD legislation | Disposal of medicines | Minor ailments | Training |
|---|---|---|---|---|---|---|---|---|---|
| Boarding school | ▲ | ▲ | ▲ | ▲ | ▲ | | ▲ | ▲ | ▲ |
| Children's home | ▲ | ▲ | ▲ | ▲ | ▲ | | ▲ | ▲ | ▲ |
| Child care | ▲ | ▲ | | ▲ | ▲ | | | | ▲ |
| Foster care | ▲ | ▲ | | | ▲ | | | ▲ | |
| Adult placement | ▲ | ▲ | | | ▲ | | | ▲ | |
| Care at home | | ▲ | | ▲ | ▲ | | | | ▲ |
| Drug & alcohol | ▲ | ▲ | ▲ | ▲ | | ▲ | ▲ | ▲ | ▲ |
| Palliative care | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ |
| Residential care | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ |
| Residential family centre | | | ▲ | ▲ | ▲ | | | | ▲ |
| Day care | ▲ | ▲ | ▲ | ▲ | ▲ | | | | ▲ |
| Housing support | | ▲ | ▲ | ▲ | ▲ | | | ▲ | ▲ |

# Chapter 4

## The Medicines Toolkit

This chapter contains more detailed information about procedures that will help you implement the good practice activities described in **Chapter 2**. We have also included specifications for medicine storage in residential care and examples of records.

Wherever possible we have included links to other websites and publications for further reference.

### Choice and consent

### Obtaining supplies of medicines

- Repeat prescriptions
- Acute prescriptions
- NHS prescription forms
- Changing pharmacy supplier
- Verbal orders

### Administration of medicines

- Procedures for giving medicines
- Giving medicines to people who cannot swallow
- Covert administration
- Monitored dosage systems and compliance aids

### Storage of medicines

- Controlled drugs
- Refrigerated storage

### Record-keeping

- Medicine Administration Record charts

### Transfer of medicines when people move to another health/social care setting

- Transferring to another setting
- Returning from hospital stays

## CHOICE AND CONSENT

You can find more guidance on choice and the capacity to consent at:

***England***
*Consent key documents. Consent to treatment forms and guidance.*
www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Consent/Consentgeneralinformation/index.htm

***Wales***
*Patient consent to examination or treatment*
www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=11930

***Scotland***
*A Good Practice Guide on Consent for Health Professionals in NHS Scotland*
www.sehd.scot.nhs.uk/mels/HDL2006_34.pdf

There is very little published information about cultural requirements and medicine management. The following have been established and should be carefully considered by care services:

- Vegetarians and people from some religious groups do not want gelatin capsules (made from animal products)
- Some people may prefer to have medicines given to them by people of the same gender
- Some religious festivals include fasting and some people prefer not to have medicines given at certain times
- Muslims may be concerned about medicines containing 'unclean' substances. Advice has been given about these. The use of unlawful or juridically unclean substances in food and medicine www.islamset.com/bioethics/8thfiqh.html#2.

## OBTAINING SUPPLIES OF MEDICINES

### Repeat prescriptions

These procedures apply when care workers act on behalf of someone to:

- Request a repeat prescription from the GP surgery
- Request a repeat prescription through the pharmacy's collection service
- Obtain medicine prescribed as a 'one off'.

**Contact with the GP surgery**
Each GP surgery will have a different way to do this and you should check what will be most suitable and efficient. In particular, find out how many days the surgery needs to process your requests. There is usually a computer record given to the person with repeat prescriptions that also details when a review of the treatment is due.

It is important not to over-order and this can happen:

- When medicines are taken infrequently, for example, pain relief prescribed 'when required'
- For creams and ointments when it is difficult to predict how much the person will need to last four weeks.

Check the amount that the person has. If there is enough of the medicine to last until the next time you place a request, leave it off the list.

Medicines are valuable and costly even though people who receive social care may not have to pay for them. All medicines returned to a supplier are destroyed. They cannot be used for anyone else.

**It is unacceptable to return unused medicine each month to the supplier and at the same time request more supplies.**

When you receive written prescriptions from the GP surgery, check them against your request list. You should do this before they are submitted to the pharmacy for dispensing:

- To ensure that all medication ordered has been correctly prescribed
- To ensure that no new medication has been added by mistake.

If there are unexpected changes these should first be checked with the GP.

If the GP surgery also dispenses the medicines, you will not have the original written prescription to check. So it is very important to keep records of what you asked the GP to prescribe for each person. If the medication you receive is different from what you expect, check with the GP before you give it.

**Contact with a pharmacy**
The care service should present prescriptions to the pharmacy in sufficient time for the medication to be prepared and delivered in time to start the new supply. The pharmacist will be able to tell you how long this will normally take. If the pharmacy is arranging for the prescription collection service it will include the time that the GP surgery needs.

On receipt of the medication the staff in the care service should check the dispensed medication against the list of prescribed medicines.

Remember that changes can happen after you checked the prescriptions and sent them to the pharmacy.

**If the medication you receive is different from what you expect, check with the supplying pharmacist before you give it.**

The routine ordering of the repeat prescriptions should be done by the care service. It should never be delegated to the pharmacy staff, as they may not be aware of any recent additions or deletions to the prescribed medication. There can be exceptions:

- If the person requires MDS, for the practical reasons of assembly, the pharmacy may have to order the repeat prescriptions from the surgery on behalf of the person, although this is not generally recommended as good practice
- If the pharmacy is contracted by the primary care trust in England to provide support for care homes.

In residential care, the service should give the pharmacy full details of a person's medicines when:

- They initially take up residence
- They return from a period in hospital
- There is any change to the medicines .

This information will be helpful before prescription forms are sent for dispensing. It should include all regular medication ordered from the GP surgery and any other items such as 'when required' medication. This is very important when the pharmacy provides computer generated MAR charts and the 'when required' medication is not requested every month but is still being used.

If you cannot find a supply of someone's medicine, check:

- What will happen if the person misses a dose?
- Is the medicine needed immediately?
- Has it really run out or has it just been put back in the wrong place? Check your records. A good recording system (audit trail) should be able to tell you if the item is still in stock.

If you really need a new supply of the medicine, you should explain to the person concerned that there is none but that you will get a new supply as soon as you can. And get advice from your community pharmacist as soon as you can.

**Remember — running out of a medicine because of 'bad housekeeping' should not be an excuse to contact emergency services. The out-of-hours medical service may not be able to help you.**

### Obtaining 'acute' medicines

When a prescription is written for a medicine that the person has not had before or does not take regularly, it is termed an 'acute' supply. These prescriptions are more likely when the adult or child has a new health problem and you take them to see the doctor; or the doctor or nurse visits them where they live. This medicine will not usually be listed on a GP list of repeat prescriptions. It is obtained as and when it is needed. It is really important to start the new treatment as soon as possible, within 24 hours at the latest. An example of an acute supply is a course of antibiotics to treat a chest infection. The treatment is usually for a specified limited time such as five or seven days. The care service must have a separate process to deal quickly and efficiently with these prescriptions.

### NHS prescription forms

Each NHS prescriber has a supply of prescription forms. They have a code to identify who has prescribed the medicine. This enables the NHS to audit how medicines are prescribed, indicate trends of prescribing and limit fraudulent use.

A prescription can only be dispensed when the legitimate prescriber has signed it and it is normal for healthcare professionals to keep their own pad of prescription forms.

We recommend that a residential service does not request or agree to hold a supply of prescriptions forms on the premises.

### Changing pharmacy supplier

Most residential care services receive dispensed medication from a single community pharmacy. When a service decides to change supplier there can be a risk to the care and continuity of medicines supply to users of the care service.

The care service should give careful consideration to the reasons for wanting to change pharmaceutical supplier, and the potential problems associated with the change.

From any community pharmacy you should expect medicines of appropriate quality and suitably labelled for the intended recipient. Dispensing services should be:

- Accurate
- Accessible
- Prompt.

When the care service operates a synchronised supply cycle, the medicines are requested every 28 days and all the new supplies of medicines are started on the same day. As repeat medicines for all residents are requested at the same time a changeover is simplified. It is more difficult to organise the change when the service has operated a non-synchronised repeat medication system and plans to move to a synchronised cycle.

The essential steps are:

- Agree the date for change with the new pharmacy and each GP practice involved.
- Agree the method for requesting repeat prescription orders and any new paperwork involved with the new pharmacy and each GP practice
- A few weeks prior to commencement of the new supply, the service initiates the order for prescriptions. This is a good time to request a medication review for residents. The service should also ensure that any excess stocks of current medicines are used up before arranging for reordering
- Dispose of any medication from the previous supplier that is no longer required by residents before the change over date. Remember to get the resident's permission to do so.

**It may seem a good operational measure to clear out everything, return it all to the old pharmacy and start afresh with the new one, but this will increase medication waste and is an unnecessary cost to the NHS.**

### Verbal orders

Problems can occur when doses are changed by means of a verbal order but no written document is sent. Usually, this happens when a GP telephones a dose change. But A new prescription is not always necessary.

Mr Brown has been taking two furosemide tablets (40mg) each morning. At the medication review the GP decides that this can be reduced to one tablet each morning. Mr Brown has a good supply of furosemide 40mg. If he lives in his own home with support from a domiciliary care/care at home service, the doctor will not write a new prescription. The doctor will record the change at the surgery so that when Mr Brown asks for a repeat prescription the new dose will be prescribed. The same applies if Mr Brown is a care home resident.

**If the care provider insists on a new prescription for Mr Brown, the previous supply must be destroyed and this is a waste of NHS resources.**

The care service should have a procedure to communicate changes clearly. A careful record should be made of:

- Who took the telephone call
- The time of the call
- The name of the person who called
- The change(s) made.

It is good practice to:

- Read back the information that has been written down to reduce the chance of misunderstandings
- Spell out the name(s) of the medicine(s)
- Ask the GP to repeat the message to another member of staff, if possible
- Request written confirmation a soon as possible by fax, letter or by issue of a new prescription.

## ADMINISTRATION OF MEDICINES

### Procedures for giving medicines

The following is a process for selecting the right medicines, preparing the right dose and giving in the right way to the right person.

1. Check you are giving the medicines to the right person. This may be a challenge in care homes. The best system is to ask them what their name is. If this is not possible, consider use of recent photographs, cross reference of name and room number on the MAR chart, or make sure that the care worker really knows the residents by name.

2. Select all of the correct medicines for this time of day for that person. Even when medicines are supplied in MDS, there may be other medicines in the fridge and remember that this person may have different medicines since the last time you were on duty. This is why it is so important to refer to the MAR chart instead of relying on memory.

3. Ask the person if they want their medicines before you take them out of the pack. People can refuse medicines for different reasons. When this is an important medicine, it may be better to wait a little while and ask them later. If the person continues to refuse, you must never force the medicine on them and this means that hiding medicine in food or drink is not acceptable practice in any setting.

4. Some medicines are meant to be taken occasionally when there is a specific need, for example, tablets for pain. If the directions say 'to be taken as required', somehow you need to find out whether the person has any pain before you prepare and offer the tablets. Other medicines like this include treatments for constipation, indigestion, and anxiety.

5. Make sure that there is a glass (tumbler) of water to wash the tablets or capsules down.

**It is almost impossible to swallow tablets or capsules without drinking some water. Even if people say they can manage without, taking tablets and capsules with a drink of water is a good habit to encourage. A hot cup of tea instead of water is not a good idea because many medicines are badly affected by heat.**

6. Encourage the person to sit upright or to stand.

**It is very difficult to swallow tablets or capsules when lying down. It is very likely that the table or capsule could get stuck in the throat or gullet where it could cause difficulty with swallowing or could damage the lining of the gullet.**

7. If the tablets/capsules are in a monitored dosage or compliance pack open the appropriate section and empty the tablets/capsules into a medicine pot and hand it to the person.

   If the tablets/capsules are in bottles or strip packs transfer the appropriate number of tablets/capsules into a medicine pot and hand it to the person.

   If the medicine is a syrup or mixture make sure that you use the medicine spoon or measure that the pharmacist provided — do not just guess or use any spoon or allow the person to drink from the bottle.

It is very important not to handle any medicines. So you need to prepare them by a 'clean' technique — that is pushing a tablet or capsule out of the blister directly into a medicine pot.

**Some medicines may be harmful to the care worker if they have direct contact with them. It may be advisable to wear plastic gloves if you know there is a health and safety risk.**

8. The dose of some medicines depends on the results of blood tests. An example is warfarin. Each area has a system to let the person or people who provide care know what the correct dose is. The latest information needs to be kept with the MAR chart.

9. If you are applying medicines to the skin it is really important to use gloves both for your own protection and also to prevent cross-infection. These medicines are directly absorbed through the skin. If you do not protect yourself, your body will also absorb the medicine.

It can be difficult to know how much of a cream or ointment to use. Some directions are unclear, for example, 'apply sparingly' and it is equally difficult to know how long to use the product.

**The local community pharmacist will be able to advise you.**

10. Always make a record of exactly what you have done at the time. This includes a record when the person refuses the medicine.

### Giving medicines to people who cannot swallow or need to have their medicines given via their feeding tube

If a patient cannot swallow tablets or capsules, then the problem should be discussed with a healthcare professional who will be able to find out whether a suitable liquid product is available. This could be a liquid version of the original medicine or a different medicine that has the same effect. In either case, this will have to be discussed with the prescriber or pharmacist.

Normally tablets should not be crushed and capsules should not be opened either to make them easier to swallow or to hide them from the patient because this may affect the way that the medicine works.

**Tip**
Information is available for:

- Patients or parents of children who can't swallow tablets or pills
- Healthcare professionals requiring guidance on how to administer medicines to patients with swallowing difficulties or using enteral feed tubes

See www.swallowingdifficulties.com/index.hm

### Covert administration of medicines

'Covert' is the term used 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.

Covert medication is sometimes necessary and justified, but should never be given to people who are capable of deciding about their medical treatment. Giving medication by deception is potentially an assault. The covert administration of medicines should only take place within the context of existing legal and best practice frameworks (see links below) to protect the person receiving the medicines and the care workers involved in giving the medicines.

See also:
*Rights, risks and limits to freedom. Guidance for practitioners considering restraint in residential care*. Mental Welfare Commission for Scotland. June 2006

*Covert medication.* Mental Welfare Commission for Scotland. November 2006
www.mwcscot.org.uk/web/FILES/Publications/covertmedication.pdf

Mental Health Law Briefing: *The covert administration of medicine* Number 101
www.rlb-law.com/Repository/42/files/61_mhlb101_june2006.pdf

*UKCC position statement on the covert administration of medicines*
www.nmc-uk.org.uk/aFrameDisplay.aspx?DocumentID=623

### Monitored dosage systems and compliance aids

If a care service uses a MDS or compliance aid, it must be a recognised product. In this document we are providing some examples but there are others available. Your local community pharmacist is the best person to give you this information.

MDS has been promoted as a safe system of medicine administration in care homes, but MDS are merely a convenient form of packaging for a limited group of medicines. Safe practice is not guaranteed by use of a system alone but is promoted by only allowing care workers who are trained and competent to give medicines.

MDS do improve some procedures including:

- The system of organising repeat prescriptions for residents
- Supply to the care home of printed MAR charts
- A visual check whether medicines have been prepared and given to the resident.

MDS can only be used for tablets and capsules, but there are exceptions and the following should not be put into MDS:

- Medicines that are sensitive to moisture, e.g. effervescent tablets
- Light-sensitive medicines, e.g. chlorpromazine
- Medicines that should only be dispensed in glass bottles, e.g. glyceryl trinitrate (GTN)
- Medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate
- Medicines that should only be taken when required, e.g. painkillers
- Medicines whose dose may vary depending on test results, e.g. warfarin.

Liquid medicines, creams, eye drops, inhalers must be supplied in traditional containers. Therefore, any care home that uses MDS will have two different systems operating.

MDS work well when a person's medication is regular and does not change frequently. Care providers must consider carefully how any changes that the prescriber makes to the person's medicines can be dealt with by the supplying pharmacy quickly. This may involve:

- Introducing new medicines into the pack
- Removing medicines from the pack.

Packaging of medicines for 'as required' use in MDS is not suitable.

The NHS does not fund MDS systems so the care provider may be asked to pay for the equipment. Suppliers of medicines (community pharmacists, dispensing GPs) cannot be compelled to provide medicines in this way, however much the care provider may want it. Individuals can be assessed under the Disability Discrimination Act criteria or local initatives (in Scotland) for support needed to manage medicines themselves. This does not apply to entire care environments where the main benefit is to care workers.

Some care providers who have been unable to get medicines in MDS have allowed care workers to re-package medicines in compliance aids. This is also known as 'secondary dispensing'. Repackaging of medicines by care workers should not take place in care homes. The risk of making a mistake is too great.

## STORAGE OF MEDICINES

### Controlled drugs in care homes

In care homes, CDs must be stored in cupboards that meet the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973 as amended unless the resident is keeping and looking after the CDs prescibed and dispensed for themselves. The regulations specify the quality, construction, method of fixing and lock and key for the cupboard.

- The security of the location also needs careful consideration
- For safe practice the CD cupboards should only be used for the storage of CDs. Items of value such as jewellery or money should not be placed here
- Only those with authorised access should hold keys to the CD cupboard
- If a person in a residential setting is self-administering they can hold their own individually-dispensed supply of CDs in their personal lockable cupboard
- No special cupboards are required in a domiciliary setting.

**Temazepam is also a CD and is subject to the legal requirements for storage but the requirements for record-keeping are less stringent than for other CDs such as morphine. This means that temazepam must be kept in the CD cupboard.**

The legislation does not apply to children's services. However, any person, such as the manager of a children's home or a teacher in a school, must keep the CDs in a locked receptacle that can only be opened by them or a person authorised by them.

### Refrigerated storage

Some medicines must be stored in a refrigerator because at room temperature they break down or 'go off'. You need to know which medicines need to be kept cool. The Patient Information Leaflet that is supplied with a medicine will state whether the medicines needs to be kept in a fridge.

- In residential care, there should be a separate, secure fridge that is only used for medicines that require cold storage
- A separate fridge may not be necessary in a small home unless there is a constant need to refrigerate medicines that a resident takes regularly, for example, insulin
- If someone has care at home, a separate fridge is not necessary.

The temperature of the medicine refrigerator should be monitored daily when it is in use, and recorded. A maximum/minimum thermometer is recommended for this.

- The care service should have a written procedure of action to take if the temperature is outside the normal range — usually between 2 and 8 degrees Celsius
- If the fridge breaks down, it is important to identify the fault quickly, otherwise medicines may be wasted
- Clean and defrost the fridge regularly
- Care workers who provide home care should check that the person's fridge appears to be working correctly if there are medicines stored in it.

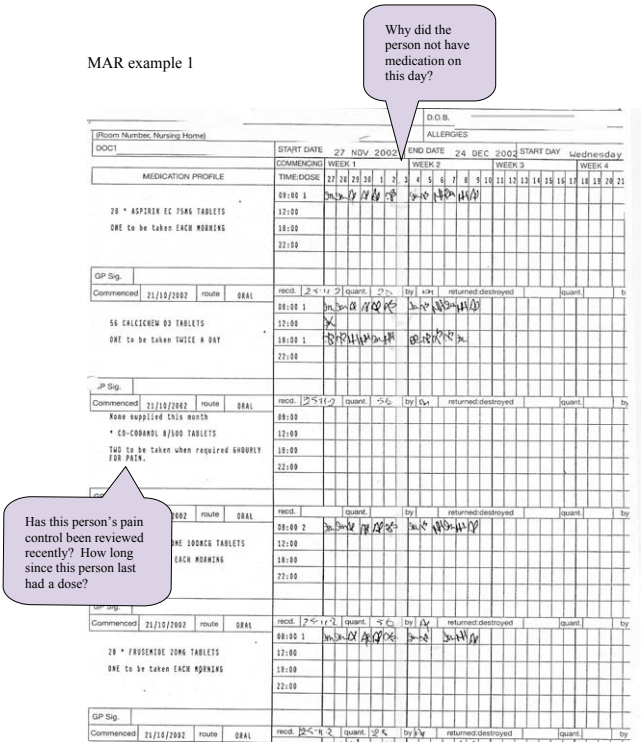
**If you are holding supplies of the 'flu vaccine', it is important to keep them in the medicine refrigerator.**

## Medication administration record (MAR) charts

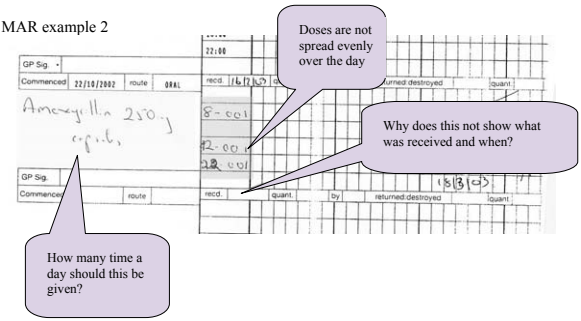
The MAR chart lists a patient's medicines and doses along with spaces to record when the doses have been given and to specify exactly ***how much*** is given when the directions state, for example, 'one or two'.

It is also important to keep a record when prescribed medicine has ***not*** been given. Different letter 'codes' can be used to record when medicines have not been given. The MAR chart must explain what the code mean.

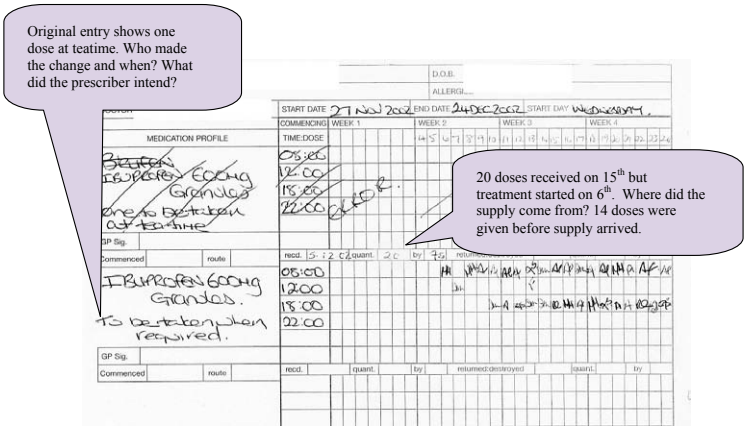
MAR example 1



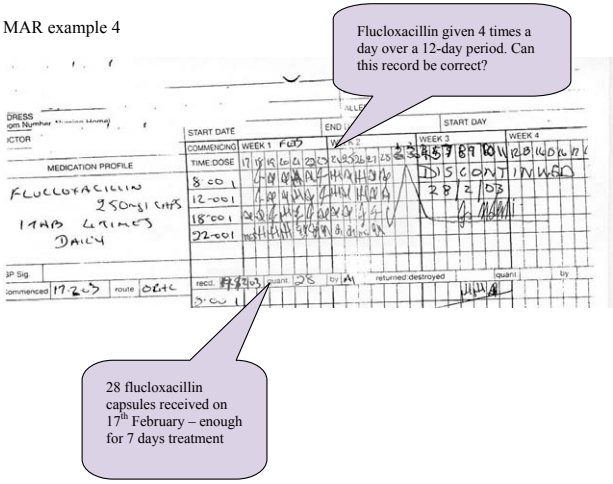

MAR example 2



MAR example 3




MAR example 4




The information on the MAR chart will be supplemented by the person's care plan. The care plan will include personal preferences, including ethnic issues such as whether the care worker who gives the medicines should be the same sex as the person.

The MAR chart can be a useful tool for the care provider to keep track of medicines that are not requested every month but only taken occasionally. The provider can use the MAR chart to record medicines carried over from a previous chart.

Responsibility for providing MAR charts rests with the care provider. Neither the pharmacist or/nor the dispensing GP is responsible but may be prepared to provide them on request.

The CSCI guidance *Medicine administration records in care homes and domiciliary care* provides further detailed information. Available at www.csci.org.uk/professional.

MAR charts used in care homes and domiciliary care look similar to 'prescription' charts used in hospitals but they are not equivalent to the prescription chart. The MAR chart is only a record of what care workers administer to people who use care services and belongs to the care provider. It is not a chart for prescribing medicines.

The Royal Pharmaceutical Society of Great Britain has also published guidance for pharmacists about the supply of MAR charts. You can find this at www.rpsgb.org.uk.

## TRANSFER OF MEDICINES WHEN PEOPLE MOVE TO ANOTHER HEALTH OR SOCIAL CARE SETTING

People who receive social care may need to transfer to another care setting. This may be a permanent move but can also be a short-term solution to a problem. Transfers include:

- Hospital admission
- Respite care in a social care setting
- Permanent move to a care home.

### Transferring to another setting

It is essential that the person's medication is sent with the person. This is to ensure continuity of care for the person. The new care service may not have all the current medication available.

When care workers are responsible for giving medicines to the person, a copy of the record of administration is also essential. This will inform the new care service which medicines have been taken regularly and whether the person refuses to take any.

Mr McCann went into a care home for two weeks while his daughter and son-in-law took a much needed holiday. Mr McCann is confused and relies on his daughter to prepare and give him his medicines. The family provided bottles of medicines but no written instructions about what he normally took. The bottle of *Senna* tablets stated 'Take up to four tablets at night'. The family did not inform the care service that Mr McCann only needed two *Senna* tablets occasionally and the care service did not ask them what the normal pattern of administration was.

**Care workers gave Mr McCann four *Senna* tablets every night. After a few days, Mr McCann had diarrhoea. He got out of bed without assistance in a hurry to reach the en-suite toilet. Mr McCann fell and injured himself.**

When a person is transferred to another care provider you should make a record of the medicines that were sent with him/her. You should record the following information:

- Date of transfer
- Name and strength of medicine
- Quantity
- Signature of the member of staff who arranges the transfer of the medicines.

### Returning from hospital stays

All people discharged from hospital should have complete documentation listing all their current medication at the time of discharge. This may have changed considerably from the medicines that were taken into hospital. It is essential that this new list is compared with the old list. The hospital will inform the person's GP but if you are responsible for the person's medicines you should:

- Let the supplying pharmacy know the changes as soon as possible
- Prepare a new MAR chart
- Dispose of any unwanted or discontinued drugs
- Request a new prescription as soon as possible.

If you usually use a MDS it may be possible to liaise with the hospital pharmacist to arrange for your usual pharmacy to dispense a new supply in your current system at the time of discharge.

## LEGISLATION AND GUIDANCE

**Care Standards Act 2000**
www.opsi.gov.uk/acts/acts2000/20000014.htm

**Care Commission Medication Guidance (Scotland)**
www.carecommission.com/index.php?option=com_content&task=view&id4542
www.carecommission.com/index.php?option=com_content&task=view&id4665
www.carecommission.com/index.php?option=com_content&task=bbqcategory&id=62&itemid=161

**CSCI medication guidance**

- Immunisation in care homes (nursing)
- Medicine Administration records in care homes and domiciliary care
- The Administration of medicines in care homes
- The Administration of medicines in domiciliary care
- The safe disposal of waste medicines from care homes (nursing)
- The safe management of controlled drugs in care homes
- Training care workers to safely administer medicines in care homes
- Palliative and end-of-life care within all care home settings.

www.csci.org.uk/professional

**National Practice Statements for General Palliative Care Homes in Scotland**
http://palliativecarescotland.org.uk/publicationa/making%20good%20care%20better%20care%20homes%20practice%20statements.pdf

**National Service Framework for children, young people and maternity services**
www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childrenservicesinformation/index.htm

**National Service Framework for long term conditions**
www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/index.htm

**National Service Framework for mental health**
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_400598

**National Service Framework for Older People**
www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeoplesservices/index.htm

**National Service Framework (Wales) relating to Children, Older People & Mental Health**
www.wales.nhs.uk/sites3/home.cfm?orgID=334

**Regulations and National Care Standards, Scotland**
www.scotland.gov.uk

**Regulations and National Minimum Standards, England**
www.csci.org.uk/professional

**Regulations and National Minimum Standards, Wales**
www.cssiw.org.uk

## KEY REFERENCES/BIBLIOGRAPHY

A guide to good practice in the management of controlled drugs in primary care (England). Second Edition Feb 2007 from the National Prescribing Centre (NPC)
http://www.npc.co.uk/controlled_drugs/CDGuide_2ndedition_February_2007.pdf

Building a Safer NHS for Patients, Improving Medication Safety
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance//DH_4071443

Building on the best: Choice, responsiveness and equity in the NHS — response document 9/12/2003
www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4068391

End of Life Care Programme
http://www.endoflifecare.nhs.uk/eolc/eolcpublications/Guide%20To%20EoLC%20care%20homes%20lo.pdf

Managing medicines in schools and early years settings. March 2005 DES/DH.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108489

### Nursing & midwifery council publications

- Guidelines for the administration of medicines.
- Guidelines for records and record-keeping
- Guidelines for professional practice.

www.nmc-uk.org

Rights, risks and limits to freedom. Guidance for practitioners considering restraint in residential care. Mental Welfare Commission for Scotland. June 2006
www.mwcscot.org.uk. See restraint refs earlier (NCB).

Scottish Version of Schools and medication
http://www.scotland.gov.uk/Publications/2001/09/10006/File-1 (SCRC)

### Contact details

Care and Social Services Inspectorate for Wales (CSSIW)
www.cssiw.org.uk

Commission for Social Care Inspection (CSCI)
www.csci.org.uk

Council for Disabled Children
www.ncb.org.uk/Page.asp?sve=785

Healthcare Commission
www.healthcarecommission.org.uk

Medicine and Healthcare products Regulatory Agency
www.mhra.gov.uk

National Centre for Excellence in Residential Child Care (NCERCC)
www.ncb.org.uk/Page.asp?sve=934

Office for Standards in Education, Children's Services and Skills (Ofsted)
www.ofsted.gov.uk

Scottish Commission for the Regulation of Care
www.carecommission.com

Skills for Care
www.skillsforcare.org.uk

## GLOSSARY

| Word | Definition |
|---|---|
| **Attention deficit hyperactivity disorder (ADHD)** | A common developmental and behavioural disorder; characterised by poor concentration, distractibility, hyperactivity, and impulsiveness that are inappropriate for the child's age. |
| **Analgesic medicine** | Pain reliever |
| **Anaesthesia** | Loss of awareness or feeling, e.g. in preparation for a surgical operation. Induction of anaesthesia — the process of causing loss of feeling or awareness using a drug |
| **'As required' medicine** | Medicine to be given when required for defined problem, e.g. pain, constipation |
| **Audit trail** | Step-by-step record by which financial and product usage data can be traced to its source |
| **Care provider** | Organisation that is responsible for providing care |
| **Care worker** | Individual who works in a care setting |
| **Chemist** | Community pharmacist or community pharmacy |
| **Community pharmacist** | Pharmacist based in a community (high street) pharmacy |
| **Complementary medicines** | Medicines that are used together with mainstream medicines; examples include acupuncture, homoeopathy and herbal medicines |
| **Compliance aid** | Device that makes it easier for users to take medicines correctly |
| **Cytotoxic** | Anti-cancer medicine |
| **DDA** | Disability Discrimination Act |
| **Denaturing** | Changing the form of a drug. For example, controlled drugs must be denatured before disposal in a pharmacy so that they cannot be retrieved and used. |
| **Dispensing** | Making up of medicines (in a pharmacy) |
| **Dispensing assistant** | Assistant to pharmacist |
| **Drug dependence** | Also known as drug addiction. A state in which regular doses of a drug are needed to avoid withdrawal symptoms |
| **Glyceryl trinitrate (GTN)** | Medicine used to relieve pain of angina. Can be a tablet that is put under the tongue to dissolve or a spray that is sprayed into the mouth |
| **Homely remedies** | Medicines for minor ailments that could be bought over the counter, such as paracetamol for headaches or indigestion remedies |
| **Hospice** | Health care facility devoted to palliative and end-of-life care |
| **Intravenous** | Given directly into a vein, e.g. intravenous antibiotics are antibiotics that are injected or infused directly into a vein |
| **Licensed medicine** | A medicine that has been licensed in the UK (by the Medicines and Healthcare products Regulatory Agency (MHRA) for specific conditions |
| **Maximum/minimum thermometer** | A thermometer that shows the current temperature and also the highest and lowest temperatures since the thermometer was last read and reset |
| **Medication review** | A review of current medications to check that they are all being used correctly, are having the desired effects and are still needed. Includes clinical medication reviews and medicines use reviews |
| **Medicine** | Includes all medicinal products — tablets, capsules, drops, inhalers, injections, oral syrups and mixtures, creams and ointments |

| Word | Definition |
|---|---|
| **Medicines administration record (MAR)** | A document on which details of all medicines given in a care setting are recorded. Usually designed to show the dose given, the time when given and the identity of the person who gave it. |
| **Medicines management** | Medicines management seeks to maximise health gain through the optimum use of medicines. It encompasses all aspects of medicines use, from the prescribing of medicines through the ways in which medicines are taken or not taken by patients. |
| **Medicines use review (MUR)** | A review of prescribed medicines carried out with the patient by a community pharmacist in order to identify problems with the use of medicines and to help people get the best out of their treatment |
| **MHRA** | Medicines and Healthcare products Regulatory Agency — the government agency which is responsible for ensuring that medicines and medical devices work, and are acceptably safe |
| **Monitored dosage systems** | Systems for packing medicines to make use easier, e.g. by putting medicines for each time of day in separate blisters or compartments |
| **NCS** | National Care Standards (apply to Scotland) |
| **Nurse prescriber** | Nurse who has undertaken additional training in order to enable him/her to prescribe medicines |
| **NMS** | National Minimum Standards |
| **Palliative care** | Palliative care is care of patients with serious illness from which recovery is not expected. Dealing with pain and other symptoms is important, but palliative care also looks at the person as a whole, including their overall sense of wellbeing as well as their physical condition. |
| **PCO** | Primary Care Organisation. Exact names differ — in England these organisations are Primary Care Trusts, in Wales they are Local Health Boards and in Scotland they are Health Boards. The local NHS organisation that is responsible for managing the health service in the locality. |
| **PCT pharmacist** | Pharmacist who works for a Primary Care Trust |
| **PEG (Percutaneous endoscopic gastrostomy) tube** | A flexible tube that goes through the abdominal wall directly into the stomach. Used for giving liquid food. |
| **PGD** | Patient Group Direction. A written instruction for the sale, supply and/or administration of named prescription only medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. |
| **Pharmaceutical care** | The process through which a pharmacist co-operates with a patient and other professionals in designing, implementing and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient. |
| **Pharmacist** | Person who has studied pharmacy at University and is on the register of Pharmaceutical Chemists |
| **Pharmacist prescriber** | Pharmacist who has undertaken additional training in order to enable him/her to prescribe medicines |
| **Pharmacy technician** | Person who has studied pharmaceutical sciences to S/NVQ level 3 and works under the supervision of a pharmacist |
| **Prescription only medicine (POM)** | Medicine that can only be obtained with a prescription written and signed by a qualified prescriber |

| Word | Definition |
|---|---|
| **PRN** | Latin abbreviation meaning 'when required' |
| **Rectal administration** | Giving of a medicine, usually an enema or suppository, via the rectum (back passage) |
| **Registered manager** | The person who is in day-to-day charge of a registered care setting |
| **Registered owner** | The owner of a registered care setting |
| **Registered person** | Registered owner or manager of a care setting |
| **Secondary dispensing** | Re-packaging a medicine that has already been dispensed by a pharmacist or a dispensing doctor |
| **Stroke** | Sudden disabling attack usually due to a blood clot or burst blood vessel in the brain. |
| **Subcutaneous** | Under the skin. For example, insulin has to be injected subcutaneously. |
| **Synchronised supply** | Supply of medicines where all quantities have been adjusted to finish at the same time. Intended to help people to avoid accumulating medicines that they need now and again but do not use very often. |
| **Temazepam** | A 'sleeping tablet'. Temazepam belongs to the benzodiazepine group of medicines and is also classified as a controlled drug (Schedule 3) |
| **Therapeutics** | The science of using medicines |
| **Thrombosis** | A blood clot that blocks a blood vessel |
| **Unlicensed medicine** | A medicinal product that has not been licensed by the MHRA |
| **Verbal order** | Request to change treatment that is made over the telephone and is not in writing |

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| | |
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