

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
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## Derbyshire County Council Adult Care Home Care Medication and Health Related Activities Policy

### Approval and Authorisation

Name	Job Title	Date
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Approved by:	Trevor Thacker Health and Safety Steve Hulme Medicines Management PCT Dianne Harris Lead Pharmacist Bal Gill Project Pharmacist funded by PCT	February 2014
Authorised by:	Quality Assurance Group	July 2016

### Change History

Version	Date	Name	Reason
V 1	February 2014	Jane Parke	Main body of the policy fulfils CQC requirements. The Appendices are stand alone as well as part of the policy for individual usage.
V2	July 2016	Emma Benton	Review and update. Replaces Adults Medication Code.
V3	August 2019	Emma Benton	Review and Update

## Home Care Medication and Health Related Activities

Name of Service:

I have read and understood the policies and procedures set out in the Derbyshire County Council Adult Home Care Medication and Health Related Activities Policy and I agree to adhere to these policies and procedures while working in this service.

[illegible]

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Contents

1. Purpose and Scope of the Policy .....	5
2. Responsibilities .....	7
4. Training .....	10
5. Medication Assessment .....	11
6. Capacity and Consent.....	13
7. Obtaining Prescribed Medication .....	14
8. Medication Purchased by or on Behalf of Clients.....	15
9. Storage of Medication.....	16
10. Medication Administration Record (MAR).....	17
11. Administering Medication .....	20
13. Disposal of Medicines .....	30
14. Anticoagulant Medication.....	31
15. Medication Audits.....	32
16. Medication Errors .....	33
Appendices.....	35
Appendix 1. Letter to Relatives, Friends or Other Carers Involved in Administration of Medication.....	36
Appendix 2 – Staff Observational Competency Check Sheet (Care Worker Community).....	37
Appendix 3a – Competency Form for Specialist Training (Individual Client).....	39
Appendix 3b – Competency Form for Specialist Training (Generic) .....	41
Appendix 4 - Medication Support Contact Details .....	43
Appendix 5a – Clients Requiring Administration of Medicines in Food or Drink .....	45
Appendix 5b – Covert Administration of Medicines in Food or Drink.....	47
Appendix 6 - Health Professional Confirmation Tool.....	49
Appendix 7 - Medication Assessment Record .....	50
Appendix 8 - Medication Administration Check Sheet .....	52
Appendix 9 Home Care Medication Procedures – Easy Guide .....	53
Appendix 10 – Emergency Rescue Medication Protocol .....	62
Appendix 11 - Drugs in Transit Form .....	65

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Appendix 12a – Creams Body Map .....	66
Appendix 12b – Transdermal Patch Body Map.....	67
Appendix 13a – DSO Monthly MAR Check Sheet .....	69
Appendix 13b – Service Manager Monthly Audit of Medication Administration Record .....	70
Appendix 14a – Error Reporting Guidance .....	72
Appendix 14b – Error Report Form.....	77
Appendix 15 - Monthly Medication Error Monitoring Form .....	81

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## 1. Purpose and Scope of the Policy

**The policy is designed to support Adult Care clients to achieve as far as possible, the following outcomes:**

- improved health and wellbeing
- improved quality of life
- making a positive contribution
- exercise choice and control
- personal dignity and respect
- freedom from discrimination or harassment

The policy is written in compliance with the Care Quality Commission Fundamental Standards incorporating the Key Lines of Enquiry.

### Policy Aim

Adult Care is committed to providing the appropriate support to individual clients to enable them to take their medication in a safe and supportive environment.

The policy aims to promote the independence of clients to manage their own medication wherever possible. It is accepted however that in some cases, clients will require support with some parts, or all of their medication.

The policy is designed to provide guidance and support to employees, managers and carers involved in the provision of Home Care services.

### Mission Statement

[The Health and Safety at Work Act 1974](#) places a duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare of employees and others who may be affected by their activities. This includes clients.

This policy is compliant with [The Health and Social Care Act 2008 \(Regulated Activities 2014\)](#), The Medicines Act 1968 and The Derbyshire County Council Adult Care Medication Management Standards.

Clients must be treated with dignity and respect at all times and consideration must be given to their age, beliefs, opinions, experience, ability, culture and any other factor that could impact on their lives. Clients have the right to expect that any support offered is carried out in a professional manner by appropriately trained staff. The client must agree to any support provided.

Consent must be obtained from clients for support with their medication. Where there is an indicator that a client may not have capacity to do this, a legally appointed person (with Lasting Power of Attorney or Deputy for Personal Welfare) may decide. Where there is no legally appointed person,

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

an assessment completed in line with the [Mental Capacity Act 2005](#), and if this indicates a lack of capacity, a 'best interest' decision made and recorded.

Training and competency assessments will be provided for all staff involved in the administration and control of medicines at a level appropriate to their grade.

This policy must be brought to the attention of all staff involved in supporting clients with their medication.

The policy complies with the NICE guidelines '[Managing Medicines for Adults Receiving Social Care in Community](#)' March 2017.

## Legislation

- [Management of Medicines - Regulation 13 of the Health and Social Care Act 2008 \(Regulated Activities\)](#) Regulations 2010 states:

*'The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity'.*

- CQC - SAFE Standard 4 – How does the provider ensure the proper and safe use of medicines?

This is one of the core 16 quality and safety standards that CQC measure against and they check that registered providers follow published guidance about how to use medicines safely.

- [The Management of Health and Safety at Work Regulations \(as amended\) 1992](#)

This places a duty on employers to carry out written assessments of the risks to which their employees and others who may be affected, are exposed by their work. This duty extends to all aspects of the provision of care, including the storage, administration and disposal of medicines.

## Published Guidance

- ['Managing Medicines for Adults Receiving Social Care in Community' NICE March 2017.](#)

*'This guideline covers medicines support for adults (aged 18 and over) who are receiving social care in the community. It aims to ensure that people who receive social care are supported to take and look after their medicines effectively and safely at home. It gives advice on assessing if people need help with managing their medicines, who should provide medicines support and how health and social care staff should work together.'*

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## 2. Responsibilities

### Assessor

The assessment of a client's need for support with medication is a fundamental aspect of promoting independent living. The assessor is responsible for ensuring that this area of need is included in the support plan/ personal service plan, and where possible the appropriate electronic medication assessment.

The assessor continues to hold responsibility for ensuring that reviews are conducted whenever there is a change in a long term client's circumstances. Where there is no change **reviews must take place every 12 months and include a review of any medication assessments.**

It is the responsibility of the assessor to ensure that the provider manager of home care is aware of individual client's needs to ensure this is reflected in the support plan/ personal service plan.

### Home Care Managers (Domiciliary Service Organisers and Independent Providers)

The responsibility of the home care manager is based on the individual client's needs which are recorded in the support plan or trusted assessment. They must ensure that the appropriate level of assistance is provided on a day to day basis, as identified in the support plan/personal service plan.

The appropriate level will be determined by the medication assessment carried out by the nominated person.

Where the medication assessment identifies the need to securely store medicines, the home care manager must record this on the support plan/personal service plan and a general health and safety risk assessment must be in place. The manager must inform the staff verbally where the medicine will be stored taking account of safe storage. This must be in conjunction with relevant health care professionals.

### Paid Carers (Adult Care and Independent Sector Home Care Workers)

Following medication assessment, the level of assistance required by individual clients will be defined within the support plan/ personal service plan

It is the responsibility of the home carers to follow the support plan/ personal service plan for medication and risk assessments, reporting any concerns to the manager.

### Service Managers and Corporate responsibilities

Where problems arise which cannot be resolved locally, these must be referred to service managers. Beyond this further appropriate specialist support from PCT prescribing advisers must be sought. In this way a body of knowledge can be generated about problematic issues relating to

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

medication. It is a corporate responsibility to collate and communicate these issues consistently to all relevant personnel.

### **Responsibility of the Client**

The level of responsibility assumed by an individual client will depend on their ability to control this aspect of their lives. Those who are able to assume a greater amount of control and independence will require less assistance than people with reduced physical or cognitive abilities.

The medication assessment and support plan will identify the level of assistance required to support independent living. If assistance with medication is required then the client must provide home carers with access to the prescription medicines and other information to enable them to carry out the duties identified in the support plan/ personal service plan safely.

### **Responsibilities of Unpaid Carers**

Where unpaid carers work with paid carers, such as relatives or friends, it must be clearly stated in support plan/ personal service plan and risk assessments who is responsible for medication at specific times. Serious legal implications could result where responsibility is not clear, or plans not fully adhered to, in case of errors or harm occurring to the client. A MAR must be in place and coded appropriately by all who support with medication. A letter must be sent to those unpaid carers involved in the client's care so that they are informed of our legal obligations. See [appendix 1](#).

### **Health Responsibilities**

#### **General Practitioners (GPs)**

Have a responsibility of care for all of their listed patients to provide general health and medical care, and thus refer for specialist health care or social care. In looking after an individual's health and well-being, the GP or nurse practitioner will prescribe medication to their patient to prevent, treat or relieve medical conditions.

(It should be noted that individual clients might also receive medication prescribed by specialists, and which might have been supplied to them in hospital.)

#### **Pharmacists**

Have a professional responsibility to supply medication prescribed by GPs and other recognised prescribers. The medication must be of a suitable quality and comply with legal and ethical requirements for the packaging and labelling. Additionally, pharmacists have a responsibility to ensure that a patient or carer receives appropriate information and advice to support them in gaining best effect from any medication supplied.



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

The pharmacist will provide on request either a printed MAR sheet or securely attach a duplicate label to an existing MAR sheet or DCC MAR sheet.

### **Nursing Personnel/District Nurses**

Where nursing personnel are involved, they will monitor the health status of the individual and report any changes in circumstances to the GP. This may involve training for home care staff in certain procedures that are included in the provision of personal care.

### **Specialist Nursing**

Specialist nurses, for example stoma nurses or palliative care nurses, will provide nursing and clinical care to individual clients and support their families and homecare staff. These specialist nurses will educate the in coping with their particular condition and assist them in dealing with equipment, drug treatments or therapy as necessary.

It should be noted that certain qualified nurses are now able to prescribe from a list of items to treat wounds and other minor injuries or symptoms.

### **Prescribing Advisers**

Support with compliance aids e.g. blister packs, will generally only be available when the client meets the requirements set out in the [Equality Act 2010](#). The pharmacist's assessment will look at a client's ability to take their medicines e.g. including their ability to open bottles etc. to check whether 'reasonable adjustments' are required in order to promote their independence. This means that clients should only have this equipment if they can self-administer from the compliance aid.

In extreme circumstances the pharmacist may support the service with a blister pack where a client lacks capacity.

In any situation where home carers are supporting people with medication including blister packs a MAR sheet must be in place. Where clients begin to refuse to take certain medicines this must be reported immediately to the manager and recorded on the MAR Sheet and visit record sheet. Advice should be sought about the missed dose from a GP, pharmacist or through contacting 111. A risk assessment should be completed and clear guidance is included in the support/ personal service plan where there is a continued risk of refusal of medication.

### **Occupational Therapist/Physiotherapist**

In some cases therapy needs will be part of the assessment especially within short term services. OT/physiotherapist will provide a therapy support plan for staff to follow and will review as necessary. They will also assess and arrange the provision of equipment where needed.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## 4. Training

All staff employed in a home care must have an awareness of medicines and attend the administration of medication in the community training which must be refreshed every three years.

It is the managers' responsibility to ensure that all staff undergo an observation of competency before they are able to administer medication without supervision. They must then maintain their competency by the DSO/manager carrying out annual observations of practice or more often if required ([appendix 2](#)).

Records of training, competency assessments and observations of practice must be kept on file for each employee.

Newly recruited care workers will only administer medication once they have received the relevant training.

### Specialised Training

The training referred to above does not cover specialised or other health related activities such as, administration via a PEG, use of oxygen, stoma care, etc.

The important issues are:

- that all the home care team are trained by a relevant health care professional or where appropriate the trainer
- staff must be assessed as competent to perform the tasks whenever relevant ([appendix 3a](#) and [3b](#))
- the client consents to the home care team providing the support as identified in the personal service plan
- clear roles and responsibilities are agreed by the health care professionals and the home care team involved in providing care as recorded in the personal service plan and appropriate risk assessments

Pharmacists are required to provide professional support to ensure that medicines prescribed for clients are used safely and effectively. The pharmacist is available to provide advice and guidance.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## 5. Medication Assessment

### **Clients must be encouraged to self-administer and maintain independence**

Employees must only support with medication following a medication assessment (C2 Medication Risk Assessment) and only as part of an agreed written support plan / personal service plan which must be in place in the client's home. The plan must describe in detail what support is required for ordering, storage, recording and disposal of medication as well as what support is required for the client to take/ use it.

In general home care staff are not expected to carry out any invasive, clinical or nursing procedures and will not make judgements on medication e.g. take as required unless adequate dosage and directions are on the Medication Administration Record (MAR) sheet and pharmacy printed label. The prescriber must write clear instructions on the prescription including the reason for the medicine as well as the dose range and the maximum dose e.g. take two tablets up to four times a day when required for pain relief.

Employees **MUST NOT** offer any assistance with medication unless the support plan, medication and any associated risk assessments and recording documentation are in place and accessible in the client's home. The medication assessment must take account of any part of the process which the client could manage for themselves. Consideration must be given to making suitable changes, e.g. changing the packaging to enable self-administration.

Support with medication will not be provided as a standalone service, but as part of a package of care. However this may mean that if the care package is a morning call only but assistance is required with medication twice daily, it would be reasonable to assist the person with medication for all calls in these situations. Assistive technology could be considered as an alternative.

### **Discharge from Hospital /Preventing Admissions**

When a client is admitted to the service in this way, as much information must be in place to enable the safe provision of medication. The trusted assessor documentation will identify any medication needs if discharged from hospital and the DSO/manager must complete any medication assessments prior to the staff offering any support.

Admissions from the community will not have the trusted assessor documentation therefore the DSO will complete a checklist identifying the client's needs.

If there is no MAR sheet available the DSO must write the medication on the DCC MAR checked and double initialled by a care worker, relevant professional or family member.

If there are any queries around the medication the DSO/manager must contact the GP or ward to confirm the correct medication. This information must be recorded on the client's care records including the date, time and the name of the GP contacted. Staff must not support with medication until it is safe to do so.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Emergency Situations

If there are circumstances that prevent the DSO from visiting prior to the care going in the GP or ward must be contacted to understand the impact of not administering the medication for a short period of time until the medication assessment has been completed.

Where this is not possible the DSO will need to identify crucial medication with the care worker. The care worker will need to administer while the DSO is on the phone and log on the care notes date, time, drug, dose with the DSO doing the same on MOSAIC.

## Supporting with Prescribed Medication

Home care staff can provide clients with all of the following levels of support which **must** be clearly identified in the support plan/personal service plan. Where support is provided all agencies involved must complete and save a copy of the medication support contact details sheet ([appendix 3](#)).

### Level 1 - Assisting with Medicines

This support is offered when the client takes responsibility for their own medication:

- requesting repeat prescriptions from the GP
- collecting medicines from the community pharmacy
- disposing of unwanted medicines safely by return to the supplying pharmacy
- a reminder or prompt from home care staff to the client - where there is a risk that a client would not take medication without this support, confirmation must be obtained and a record made that it has been taken
- reading the label to remind the client of the correct dose for their medication
- manipulation of a container e.g. shaking and opening a bottle for the client to self-administer - this does not include selecting the medication
- handing the client a compliance aid if filled by the pharmacist and properly labelled

### Level 2 - Preparation

This support is offered when the client takes responsibility for their own medication but requires assistance to prepare medicines such as dissolving soluble aspirin in water. The client **must** hand the required medication to the employee for preparation.

### Level 3 - Administer

- taking the medication out of the container and handing it client
- selecting and measuring a dose of liquid medication for the client to self-administer immediately
- physically assisting the client to take the medication
- observing the medication has been consumed
- administering/applying medicated creams/ointment/patches, inserting drops to ear, nose or eye, and administering inhaled medication

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

**These lists are not exhaustive list and other support may be required.**

## **Medication and Falls**

Some drugs are more likely to be associated with falls and those on four or more medications or a central nervous systems suppressant e.g. sleeping tablets, anti-depressant are at greater risk of having a fall. An electronic generic risk assess re falls prevention must be completed for each client that meet this criteria. For further information refer to the DCC Falls Prevention and Falls Guidance.

Medication reviews can plan an important part in falls prevention and must be arranged with their prescribing health care professional.

## **Medication Review**

The support plan and any associated assessments including risk assessments must be reviewed with all interested parties whenever there is a change in the client's circumstances and if any problems are identified/ reported. Where there is no change, reviews **must** take place every 12 months.

## **6. Capacity and Consent**

Clients with mental capacity to make decisions about their medication retain responsibility for and control of their medication but may require varying levels of support and assistance. Risk assessment is used to determine the level of support required

Where it appears that the client may lack capacity to make decisions about their medication, Mental Capacity Act procedures must be followed to assess capacity. If the assessment confirms that the client does not have capacity, a best interest decision must be made in consultation with their lasting power of attorney (LPA) health & welfare, family and relevant health professionals.

Even where written consent to administer medication or carry out related tasks is held, staff must seek the client's consent each time support is provided.

Where a client has capacity but requires that their medication is placed in food or drink e.g. swallowing difficulties, this must be discussed and agreed with the prescribing professional to ensure there are no alternatives. The suitability of these medicines to be given this way must be verified with the pharmacist. This agreement must be documented using 'Clients Requiring Administrations in Food or Drink' form ([Appendix 5a](#)).

Where a client lacks capacity and a best interest decision is in place confirming that the client is at risk if the medication is not taken, it may be necessary to give medicine in food or drink (covert medication). The capacity assessment and best interest decision must involve the relevant prescribing professional. The 'Covert Administration of Medication in Food or Drink' form must be completed and signed by the appropriate relevant health care professional, the domiciliary service

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

organiser, service manager and the client's representative. The suitability of the medicine to be given in this way must be checked with the community pharmacist and clear, descriptive details of the method of administration must be documented in the medication assessment and personal service plan ([appendix 5b](#)). This document must be reviewed regularly and this must be planned from the previous meeting.

A best interest decision must be made for each of the clients medications prescribed and must only be administered using the covert method in exceptional circumstances and when all other suitable options have failed – details of previous methods tried must be recorded.

The best interest decision must identify that it's the least restrictive option and include:

- details of the medication which is to be administered covertly and the benefits to the client
- whether covert administration will occur during each administration or whether this may fluctuate - if it's identified that this is not a regular process, it must detail when covert administration will be used. The administration process must then be recorded on the back of the MAR so this can be reviewed

## 7. Obtaining Prescribed Medication

**All prescription medicines must be provided in the original pharmacy produced labelled packaging/or compliance aid with clear instructions on how and when to give the medication.**

Home Care staff may be requested to support clients in acquiring prescriptions/medicines from the Pharmacy by:

- requesting a repeat prescription from the gp surgery and recording the name, strength and quantity for each medication ordered in the care logs
- taking a prescription to the pharmacy to collect medication and also recording this in the care logs
- record when medicines have been supplied
- check for any discrepancies between the medicines ordered and those supplied and report these to your manager

All medicines should ideally be for the same number of days, usually 28. If the client is running out of some medicines before others then Home Care staff will need to inform the family/carer/domiciliary services organiser/surgery as appropriate to allow the quantities to be adjusted.

Home Care staff must only support the client with this procedure as part of the support plan/personal service plan.

Most pharmacies will offer a prescription collection service which includes the ordering, collection and delivery of the medication.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Instructions on labels/MAR should be clear and unambiguous, 'as before' or 'as directed' are unacceptable and must be queried with the pharmacist or prescriber for clarification.

Instructions such as 'when required' should be expanded with a reason, e.g. 'as and when required for pain'. The dose range and a maximum dose must be stated. Complicated dosage instructions which would not fit onto a label/MAR should be discussed with the GP.

This information can be gained by using the confirmation tool to identify 'as and when required' medication directions completed by the DSO/manager.

### **Use of Health Professional Confirmation Tool ([Appendix 6](#))**

If the community pharmacist cannot help with clarification of 'as required' medication, the prescriber must be asked to complete the health professional confirmation tool and send via email to the social care provider. It must then be kept with the MAR sheet for safe administration.

The 'health professional confirmation' tool should be used in the following circumstances if the information on the Medication Administration Record (MAR) sheet is not complete:

- details of medication to be administered
- the dose of medication inc. quantity and regularity
- details of specific directions
- confirmation of discontinuation of a drug
- clarification on any other discrepancy on mar sheet, label of medicine, directions stated by client or client's family
- to provide advice and guidance when completing/reviewing a prn protocol

## **8. Medication Purchased by or on Behalf of Clients**

Clients and their representatives may sometimes purchase over the counter medication. It is a person's right to be able to do so, but it is often not in their best interest. The use of purchased medication in addition to those prescribed by the health care professional may constitute a health risk due to interactions between medications.

Whilst the purchase of medication may take place as a shopping provision, the home carer **must not** assist or offer advice with these medications, including skin treatments, unless stated on the support plan/Personal Service Plan. It is the responsibility of the domiciliary service organiser to consult with the client's GP/pharmacist to ensure it is safe to support with the medication.

It is advisable that all prescriptions and non-prescription medication is obtained from the same pharmacist.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Non-prescription medication include herbal remedies or medicines you can buy over the counter, such as cough syrup or paracetamol.

**Under no circumstances should support be offered with non-prescribed medication without guidance from the client's GP.**

If this medication is to be supported then it will need to be recorded on a MAR sheet as a non-prescribed medication.

## **Moisturising Creams and Body Lotion**

Where clients have been using certain brands of cream i.e. moisturising creams for general personal care, it is acceptable for Home Care staff to continue this care. This will be recorded in the Personal Service Plan.

If the client chooses to change the brand or type of cream, this **must not** be used until agreed by the relevant health care professional and brand name recorded in the personal service plan.

## **9. Storage of Medication**

Medicines must be stored as advised on the label and where they are readily accessible to the client/ all carers as appropriate.

Should they need to be stored securely or out of the reach of the client, the home care manager must ensure that risk assessments include this and that information on their location is available to all carers.

### **Medicines must be kept out of the reach of children**

In rare cases where a child is the sole or main carer, then medicines must be accessible to them as necessary. Nevertheless, all medicines must be stored away from other children who may visit the home. A record of which child is the main carer must be written on the support plan and personal service plan.

The hiding of medicines will **only** occur where the assessment indicates this is needed to protect the health and safety of the client. In some cases it may be necessary to have a lockable container to prevent inappropriate access to medicines in the home. Consent to do this would need to be recorded, in line with the [Mental Capacity Act 2005 \(MCA\)](#) where a lack of capacity is indicated.

The medicines must be stored in the original packaging or compliance aids supplied and labelled by the pharmacists.

### **DO NOT SEPARATE MEDICINES FROM THE PHARMACY LABEL**



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Medication/drops/lotions/creams etc. have a shelf life and containers are marked with an expiry date.

Out of date medication must not be used; must be returned to the pharmacy by family/carer/home care staff as appropriate and a record kept.

Medication must be stored at room temperature which does not exceed 25 degrees C unless stated otherwise on the original container. Medication requiring lower temperatures should be safely stored in a refrigerator. Medication stored incorrectly can cause it to deteriorate, particularly if it exposed to heat and light sources.

It must be noted that clients may choose not to act on the advice given regarding the correct storage of medication, this needs to be respected but must be recorded and reported to your DSO/manager. This then needs discussing with the relevant health care professional for further guidance. If it is agreed that the medication can be stored in this way it must be recorded in the medication assessment.

## 10. Medication Administration Record (MAR)

**A MAR is a legal document ([See Appendix 7](#)).**

The MAR will be taken as an accurate record of all medication administered. The MAR will be referred to for evidence by statutory bodies such as coroner or CQC. These documents are for the protection of staff as well as clients and it is in the interests of both that they are completed accurately and at the time of administration.

All support with medication, irrespective of the format, must be recorded at the time it is provided, by the person who provides it. A MAR sheet must be kept in the client's home with the support plan/ personal service plan.

The MAR sheet must list the client's current medication, and contain the product name, strength, quantity, dose, frequency and route. There should be space to record the date, time and when medication has been administered, or to record a reason for non-administration using one of the codes identified on the MAR sheet.

In some areas the pharmacist will provide a MAR sheet when the prescription is dispensed. Where a pharmacist is unable to provide a MAR sheet the blank MAR ([appendix 7](#)) must be completed. The pharmacist may agree to use the blank DCC MAR by attaching the dispensing labels securely on to the sheet, photocopying it and returning it along with the medication. Where they will not do this please refer to the hand written entry section on how to complete the MAR.

Any concern that doses are being given by others and not recorded, must be reported to the DSO/manager immediately.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

It is very important that MAR sheets are kept up to date. GPs/pharmacists are required to follow good practice requirements when changing prescribed medication or leaving a prescription in a client's home where domiciliary care is provided, including:

- If visiting the home the GP may make changes on the MAR sheet and initial the change.
- The GP should alert the pharmacist either verbally or by fax to make them aware of the change
- At this stage arrangements regarding the collection and dispensing could be arranged.
- The pharmacist should make contact with the agency to inform them of these changes by fax or email.

The DSO/manager must ensure completed MAR sheets are securely retained and/ or scanned on to the electronic social care records monthly. Systems must be in place to ensure any gaps or other errors are investigated as soon as possible; this must not be left until MARs are reviewed/stored.

Staff must follow the guidance contained within this policy and accurately record all assistance provided.

**DCC staff only: Derbyshire County Council's Insurers have confirmed that DCC staff will be indemnified under the terms of the public liability cover in respect of claims arising out of the assistance with medication or health related activity as long as the guidance contained within this policy is adhered to.**

### **Hand Written Entries**

In an emergency situation a health care professional such as GP or district nurse can write on the MAR. Such situations would include when antibiotics are prescribed part way through a month or changes to existing medication.

In other extreme circumstances which may require a handwritten entry on the MAR sheet the DSO/manager can write on the MAR which must be witnessed and double signed. In further extreme circumstances where the DSO/manager is unable to complete the hand written entry on the MAR then the care worker can do this providing there is another person to witness the hand written entry being made and double sign the MAR sheet.

### **Use of Initials and Codes on the MAR**

Support must be recorded using the appropriate code on the MAR sheet. The MAR sheet must only be initialled by the staff when medication has actually been administered.

MAR sheets can vary in the codes used to record the support given. The relevant code must be used in accordance with that specific MAR.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

**MAR sheets must only be initialised by staff workers if administering medication otherwise the appropriate code must be used.**

**There must be no gaps on the MAR sheet where medication is administered or support is offered.** If there is a gap on the MAR sheet which indicates a dose of medicine may have been missed during the previous visit Staffs **MUST NOT** offer a double dose unless otherwise advised by the relevant health care professional, and details of which must be clearly recorded on the back of the MAR.

Home care staff must only record their own support offered. If more than one home care worker is involved in the support of the medication for the client, it is the responsibility of the worker who actually provides the support to record appropriately on the MAR sheet.

Home care staff must not become involved where it is recorded on the support plan/personal service plan that medicines are self-administered or administered by others such as family/friend etc.

Where mixed packages of care are in place, the same MAR sheet must be used to ensure a complete record of medication administration is maintained. Family carers involved in the package of care will also be required to either initial or appropriately code the MAR. The person responsible for each dose of medication must be clearly identified e.g. if home care staff are required to administer medication, family/ friends must not do this on their behalf.

- **Use of Codes**

When medication isn't administered as per direction the relevant code must be used in accordance with that specific MAR.

**'Not Required Must Not be Confused with Refused'**

- when 'as and when required' medications are not needed by the client the 'offered but not required' code must be used
- when medication is prescribed for administration at set times throughout the day and doesn't state as required the 'refused' code must be used
- when medication has been refused details of the refusal must be recorded on the back of the MAR to identify whether a pattern is occurring
- the result of the wrong code being used will instigate a medication error form needing to be completed as it will not give a true picture of the reasons why the medication hasn't been administered

**As and When Required Medication (PRN)**

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Some medication will only be required to be taken when needed e.g. painkillers. The PRN Protocol, which can be found at the back of the C2 electronic medication risk assessment, will need to record the following:

- medication prescribed
- signs that the medication is required
- what to try before giving medication and how long to wait
- capacity/best interest
- how to administer
- dose per administration and frequency
- minimum time between doses
- maximum number of doses in 24hrs
- possible side effects
- special precautions/monitoring

The MAR must be completed with the appropriate code when the medication has been offered but not required and initialled for when it has been taken.

Where a client lacks the capacity to identify when PRN medication is required e.g. due to dementia the medication assessment must include the behavioural indicators that the client may display when they need the medication. Advice and guidance may be sought from regular carers, GP, district nurse, psycho-geriatrician, etc. to inform the assessment.

If there is an option to give one or two tablets, the record must be made on either the front with the administrators initial or on the back of the MAR in the carers' notes, to show how many were taken. A recording system must provide a detailed picture of exactly what has taken place during medication administration.

## 11. Administering Medication

**Medication must only be administered by workers who have received the relevant Derbyshire County Council medication training, (refer to Section 1 - Training).**

**Only give medicine to the person named on the label of the original container/compliance aid dispensed by the pharmacist.**

**Compliance aids filled by families/carers must never be used under any circumstance.**

Prior to any assistance being provided, the staff must check all the details on the pharmacy printed label and cross reference this information with the MAR, refer to administration check sheet ([appendix 8](#)), a copy of which must be kept in front of the MAR in the clients personal held record folder in their home. If there are no directions on the label refer to DSO who will refer to the pharmacist. Do not support with the medication until the problem has been resolved.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

All support provided must ensure compliance with 'The 6 R's':

- right person
- right route
- right time
- right dose
- right medication
- right to refuse

The types of support which may be offered with prescribed medicines will correspond to the level of need of the client and be identified in the support plan/ personal service plan. This will be based on the client's physical ability and mental capacity. This list is not exhaustive. Other forms of support may be offered with approval from managers and appropriate training. The support we provide via the various different routes is identified within the medication procedures 'will do, won't do' list ([appendix 9](#)).

Any concern about a client and their medication must be reported to the home care manager, domiciliary services officer or other manager immediately, who will seek appropriate advice from the relevant health care professional.

Whenever supporting with medication, Standard Infection Prevention and Control Precautions (SIP & CP) must be adhered to:

- wash and dry your hands before and after any task
- where suitable facilities are not available approved wipes or solutions must be provided
- wear disposable gloves and aprons and dispose of after each task
- cover all cuts and abrasions with a waterproof dressing

The staff must wash and thoroughly dry any utensil that may be required e.g. medicine spoon or pot. Only purpose-made calibrated pots/ spoons should be used to administer medication.

Because of the nature of infections and the way they can be contracted it is possible that individuals are not aware of the bacteria they may be carrying. This statement is applicable to Home Care staff as much as the client. It is therefore extremely important that Home Care staff employ the Standard Infection Prevention and Control Precautions (SIP & CP) set out above **whatever** personal care they are providing and **whoever** they are providing it for. For more information, please see the [Infection Control Policy](#).

Where physical support is provided, medicines should be handled as little as possible. If removing a tablet or capsule from a bottle or foil (blister) strip, this is best achieved if tipped or pushed out over a medicine pot. Where medication is dispensed in individual boxes the name of the medication and strength on the back of the foil strip must be checked and confirmed as correct prior to **each** preparation/administration.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

A client must be asked prior to dispensing any as required medication to establish the need first and record the appropriate code on the MAR if not required, the number of tablets given must also be recorded on the MAR if this is a variable dose. E.g. take one or two tablets.

As a check it is good practice to put a small dot on the MAR as the medicine is selected.

Clients should be asked to sit upright or to stand when taking tablets or capsules to reduce the possibility of the medicines sticking in the oesophagus (gullet). A Staff should not attempt to assist with oral medication for a client who is in a prone position (lying down).

For the same reason, tablets or capsules should be swallowed with at least half a glass of cold water, hot drinks should be avoided as many medicines can be affected by heat.

### **Dissolvable/Dispersible Medication**

Medication which is to be dissolved before administration should be put into a glass and sufficient water added to allow dissolving completely. Follow guidance in the Patient Information Leaflets (PILs) on the amount of water needed. If appropriate stir the solution before handing to the client.

It should be noted that some tablets do not completely dissolve but DISPERSE. These should be added to a smaller volume of water (see PILs), allowed to break up and disperse and the liquid should be swirled around before handing to the client to ensure that no particles are left in the bottom of the glass.

### **Liquid Medication**

Liquid medicines should be selected in the same way as tablets and capsules, the label being checked against the MAR. The bottle should be shaken well and the dose poured into a small medicine pot whilst on a flat surface and handed to the client. For small doses of liquid medication the pharmacist must provide a measuring syringe.

### **Health Related Activities**

It is the person administering the medication that has responsibility for other health related tasks such as eye drops, inhalers, PEG feeds, Stoma Care etc. The person administering must be trained and signed off as competent to do so where needed by the relevant health care professional using the Staff Competency Form ([appendix 3a & b](#)). *(For further information on health related activities refer to [appendix 9](#) Medication Procedures 'will do won't do' List)*

#### **Eye/ear/nose drops**

Home care staff must write the date of opening on the bottle and record this date on the MAR sheet. Once opened these must be discarded after 28 days. Check the expiry date on the bottle prior to opening. Any bottles without a record of date opened must be discussed with the pharmacy to ascertain whether it is safe to administer or if repeat prescription will be required.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Topical preparations

Refer to Section 9

## Medicines for Emergency Use

Supplies for prescription medicines for emergency use must only be used for named clients e.g. glucagon injection for diabetic, midazolam for epilepsy and epipens for anaphylactic shock.

All staff must be up to date with relevant first aid training.

## Rescue medication inside the mouth (Buccal)

All workers must attend the epilepsy awareness training which provides generic information about how to administer via the buccal route including the awareness of protocols.

The health care professional will provide a detailed person specific protocol explaining the agreed ways of working to the staff team. It's the manager's responsibility to ensure that as many staff meet with a health care professional and then inform all others who were not present.

All staff must read the detailed Emergency Rescue Medication Protocol, signing and dating the back once they had read and understood it ([appendix 10](#)).

The generic training covers the staff for a 3 year period but will require regular monitoring. The individual protocol will need to be reviewed regularly dependent on individual need. It will be a health care professional who carries out the review and any changes must be relayed to all staff.

## Epipens

Epipens must remain with the client at all times. If it is identified via the risk assessment that it's unsafe for the client to retain the medication it must be stored in an agreed place as identified within the assessment.

Training is required from a health care professional who will need to complete the Competency Form for Specialised Training (Generic) ([appendix 3b](#)).

## Medicinal Oxygen

If a health care professional prescribes oxygen, they will organise the supply, dependent on the system used.

Follow the storage instructions from the supplier.

The domiciliary services organiser must ensure that all staff are trained in the safety/use, of oxygen. Please refer to 'will do, won't do' list ([appendix 9](#)).

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## **Side Effects/Adverse Reactions**

All drugs have some side effects, most of which do not cause problems. Information should be available about possible side effects. Should concern arise, the home carer should note whether any new medicine or change of dose to existing medicines have occurred, and refer to the possible side effects. The home care manager should be informed who will discuss with the GP, pharmacist or nurse as appropriate.

Occasionally a client may suffer an adverse drug reaction (or interaction). Particular care must be taken to observe clients when a new drug is introduced and any adverse reactions must be reported immediately to the health care professional. These reactions can also be reported using the yellow card system at <https://yellowcard.mhra.gov.uk/>

No medicine should be administered with alcohol, or given to a client known to have consumed a large amount of alcohol. It is important that the GP is made aware of any client consuming regular considerable quantities of alcohol and the possibility of interactions between any prescribed medicines and alcohol should be confirmed with the pharmacist.

## **Client Consuming Alcohol or Using Illicit Drugs**

Should a client appear to be under the effects of alcohol or illicit substances on arrival at their home, a Home Carer must seek advice from the relevant health care professional as to whether or not the medication should be given. Details of this must be recorded on the MAR sheet /visit record sheet and reported to the home care manager or out of hour's service.

It is a client's own decision to drink alcohol or use illicit substances. A risk assessment should be compiled where a risk is identified in relation to alcohol or use illicit substances and medication with clear guidance for home carers. Home carers would not be held responsible for incidents that occur in the client's home as a result of alcohol or illicit drug usage. Should a client request alcoholic drink with medication, this must be refused and reported to the home care manager who will inform the GP or pharmacist.

## **Swallowing Difficulties**

It is important to be aware of individuals who have swallowing difficulties. This can be due to a number of reasons. Some of the signs could include people refusing, concealing or chewing tablets.

Do not crush tablets without consulting a pharmacist as this will have an effect on how the tablet will work. With any guidance on crushing and breaking tablets in half due to swallowing difficulties, written consent must be given from the health care professional and must be stored with the MAR.

Consult GP/pharmacist if you are aware of a person chewing their medication.



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Consult GP to see if tablets could be changed to capsules or liquid form.

If necessary complete the 'Medication in Food/Drink' form in conjunction with other agencies (*Appendix 5a/5b*).

For further information see <https://swallowingdifficulties.com/>

## **Spoiled Doses**

A single spoiled or refused dose should *not* be returned to the container. It must be placed into a small envelope, food bag, disposable glove with the details recorded on the back of the MAR and placed into a safe cupboard awaiting to be returned to the pharmacy. Another tablet must then be administered informing the manager as another tablet will have to be ordered to replace the spoilt dose.

If the client requests that a spoilt dose is not destroyed (e.g. after having been dropped on the floor) and that the dose be administered the details must be recorded on the back of the client's MAR sheet and staff should report the administration of the spoiled dose to their manager.

## **Blister Packs**

Where blister packs are provided to promote the clients independence to self-administer and we have no involvement as stated in the medication assessment, a MAR sheet would not be required.

Where possible the medication will need to be transferred to the original container if support with administration is required on a long term basis and a discussion must be held with the pharmacist.

Most pharmacists do not provide MAR sheets when a blister pack is in place. If this occurs it can be overcome with DCC/ care provider MAR sheets (appendix 7). **See section 8.**

A blister pack which contains multiple tablets must have a description of each tablet on the blister. If the client refuses any tablet from the pack the home carer will be able to identify the tablet being refused. Under these circumstances a record that describes the colour, size, shape of the tablet being refused will need to be included on the back of the MAR sheet.

Some tablets are not compatible with a blister; the pharmacist will advise where this is not appropriate.

If a dose has been removed from a blister pack and not recorded on the MAR sheet home care staff must not break into the next blister but must be reported to the home care manager immediately.

Home care workers must never administer medication from blister packs if they appear to have been tampered with. This includes packs that have been altered by a pharmacist and taped back up.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## **Client Unwell**

Should the client appear to be unwell, distressed, or not their usual selves on a visit, the Home Carer must contact the individual's GP or, if unavailable, contact 111. Guidance must be sought as to whether due medication should be offered to the client. The home care staff must update the DSO and record on the visit record sheet plus add the appropriate code on the MAR sheet.

## **Refusal of Medication**

It is a client's choice not to take medication if there is no indication that they lack capacity to make this decision. They cannot be coerced or forced in any way but some degree of encouragement can be given.

If a client refuses to take medication from either the original container or compliance aid e.g. blister pack, the Home Carer must record using the appropriate code on the Medication Administration Record (MAR) sheet along with details of the refusal on the back of the MAR (appendix 7). If and when this occurs the information must be reported to the manager and advice must be sought from the relevant healthcare professional and acted upon. This must then be risk assessed and guidance added to the support plan/Personal Service Plan.

## **Day Service Attendance**

Where a client is attending an outlet such as day care and medication is required, the medication should be sent in the original pharmacist packaging accompanied by a drugs in transit form ([appendix 11](#)) which should be stored with MAR sheets.

## **Hospital Admission**

On occasions where a home care worker is present at the time a client is being admitted to hospital, it is important to ensure that the clients medication goes with them. This is usually asked for by the ambulance staff. All medication that has been taken with them must be recorded by the care worker in the client's notes and reported to their manager.

# **12. Topical Preparations**

## **Creams/Ointments/Lotions**

Creams, ointments and lotions must not be stored on window ledges, next to radiators or elsewhere where the temperature exceeds 25c. In some cases, creams need to be stored at refrigerated temperatures. Care should be taken not to administer the cream straight onto the skin from the fridge.

The MAR and labels on products for application to the skin must indicate the areas of the body to which it should be applied. This is particularly important if a client has several different creams, ointments or lotions. The area must also be indicated on the body map which is within

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

[Appendix 12a](#) and must be kept updated as changes occur.

Creams, lotions and ointments, must be applied following the infection control procedures. Directions on the label/Creams MAR will indicate how much to use and how long the treatment will last. The date opened must be recorded on the tube/bottle as the outer box may be discarded. Creams in pots must be discarded if they appear to be contaminated, or if you have any other concerns about their appearance, or if the lid has been left off for any indeterminate period. Expiry dates must be checked at each use. Where staff are uncertain of the shelf-life of a particular medicine once opened, they must check the information supplied with the medicine or contact a pharmacist for advice.

Body charts should be used to clearly identify where topical medicines should be applied. Where physical assistance is provided with skin applications, protective gloves must always be worn. Apply small quantities at a time and rub in gently to the affected area. Creams must not be applied to broken skin unless under the guidance of the District Nurse.

- **Application**

All medication belongs to the client whose name is on the pharmacy label and must only be used for them.

Commonly prescribed creams and ointments:

Emollients are used as first line treatment for a range of dry skin conditions for the following reasons:

- they hydrate the skin and can be applied frequently 3-4 times a day
- regular use of emollients can reduce the amount of steroid cream used
- apply in the direction of hair growth
- aqueous cream to be used as a soap substitute only not as an emollient (moisturiser)

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

### **Fire Risk from Use of Emollient Creams**

When supporting people to use emollient creams, it is important to be aware of the risks.

If using a paraffin based emollient product, and cover this with a dressing or clothing, there's a danger that smoking or using a naked flame could cause these dressings or clothing to catch fire. There may also be reactions between emollients and fibres of dressings, clothing and items such as towels when used to carry out personal care.

Managers must make sure that:

- all emollients are stored securely
- risk assessments reflect the use and storage of emollients and are reviewed regularly
- clients clothing and bedding regularly changed because emollients soak into fabric and can become a fire hazard

Advise clients who are using emollient creams of the risks the creams may pose and not to smoke, use naked flames and not to go near anyone with either of these.

Steroid cream:

- be aware of potency of each steroid product. more potent steroids have more side effects
- used intermittently (maximum 7 to 14 days depending on preparation) for acute flare ups of inflammatory skin problems like eczema when an emollient alone is not enough
- inappropriate use of steroid creams/ointments can cause thinning of the skin and can even be absorbed into the body where it can cause side effects
- products which contain antimicrobials should be used regularly for a short period (twice daily for 1 week) - longer use increases the chance of resistance and sensitisation.
- seek review for any resident on a long term steroid cream/ointment
- review of treatment is required as condition improves and especially if no improvement.
- if the client has been prescribed both a topical steroid and an emollient, the emollient should be applied first and then wait 30 minutes before applying the topical steroid

How to use creams and ointments.

1. wash your hands and put on a pair of disposable gloves and apron
2. once the seal is opened write the date on the tube/jar
3. make sure the area is clean and free from moisture
4. steroid creams and ointments need to be applied thinly to the amount absorbed through the skin
5. apply the cream or ointment to the skin and gently rub in
6. remove gloves and wash your hands
7. if more than one cream/ointment is to be applied, leave at least 15 minutes between applications - there are no standard rules which has to be applied first unless otherwise specified
8. record each application in the client's administration records

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

9. if the cream isn't applied for any particular reason the senior on duty must be informed and the correct code recorded on the mar

Over time, labels may fade or peel and essential information may be lost. In such cases advice must be sought from the supplying pharmacy and the product replaced if necessary. To assist in the life of the label, once the opening date has been written on clear plastic tape could be used to protect it.

Opened creams and ointment should **not** routinely be disposed of at the end of a monthly cycle. It is not necessary to order creams and ointments monthly.

## Transdermal Patches

Medication patches such as Fentanyl are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics, it works by changing the way the brain and nervous system respond to pain.

Transdermal fentanyl comes as a patch to apply to the skin. The patch is usually applied to the skin once every 72 hours and is changed at about the same time of day. Follow the directions on prescription label carefully, and refer to the PILs regarding possible side effects. Apply fentanyl patches exactly as directed and do not use a fentanyl patch that is cut, damaged, or changed in any way.

Press the patch firmly on to the skin for approximately 30 seconds to make sure that it sticks well, especially around the edges. It is important that you avoid touching the sticky side of the patch while you do this.

The area must also be indicated on a body map which must be kept updated as changes occur ([appendix 12b](#)).

Transdermal patches must be rendered unusable before disposal. This is done by folding the patch in half with the adhesive edges joined thus sealing the transdermal surface so that the drug could not be absorbed through the skin of anyone who may handle the patch. Dispose of following the double bagging system, which could be via a disposable glove followed by a bag and disposed of in the outside bin.

Try to make sure that any patch the client is wearing does not come into contact with a heat source such as a heating pad as this can increase the amount of fentanyl that is released from the patch, which increases the risk of overdose. Having long hot baths and sitting out in the sun for long periods is also best avoided. Let the health care professional know if the client develops a high temperature at any time, as this can also increase the amount of fentanyl absorbed from the patch.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

### 13. Disposal of Medicines

Medicines belong to the client for whom they were prescribed or supplied.

Home care staff should inform their manager if any excess medication is present in the home which may pose a risk. The removal of excessive quantities or out of date medicines may only be considered following agreement with the client. Stockpiling and excess of medication could be resolved via pharmacies which offer a prescription collection service. All unused, refused or out of date medication should be disposed of safely and in an environmentally friendly way.

It is recommended that that any unused medication should be put in an envelope or other suitable package and taken to the pharmacy at a convenient time where there is no collection service. Any disposal of medicines must be recorded.

Medicines, such as eye drops open longer than 28 days, may be disposed of by placing in household waste, although for environmental reasons a return to pharmacy is preferable.

If a client refuses a **single dose** of liquid medication which has already been poured this should not be returned back to the bottle but washed down the sink using plenty of running water.

To dispose of used morphine/hormone type patches:

1. fold the patch in half ensuring the side which attaches to the skin is folded in on itself
2. place the patch in a plastic bag or similar
3. dispose of the patch in the plastic bag in the outside household waste, although environmentally a return to the pharmacy is preferable
4. disposable gloves must be worn when performing the task

Unwanted topical preparations should be disposed of in the same way as the disposal of unwanted medicines and returned to the pharmacy.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## 14. Anticoagulant Medication

### Warfarin

Warfarin is an anti-coagulant drug commonly used to reduce the clotting power of blood in order to prevent venous thrombosis (clotting in veins) and pulmonary embolism (clotting in the arteries of the lungs). Warfarin is also used to prevent blockage of arteries in patients with rheumatic heart disease and atrial fibrillation (irregular heart beat).

It is important that clients who take warfarin have their prothrombin (clotting) time checked regularly by means of an INR test. This will involve a small blood sample being taken and sent for analysis. The result of the test will be used to confirm the dose taken or to adjust it if necessary.

The information and guidance with regards to administering the correct dose must be taken from the latest official documentation. If this documentation is out of date or the client has not received their up to date dosage information the prescriber must be contacted for advice on the correct dose to be taken. This must then be recorded on the MAR and detailed information written on the back in the 'carers notes'.

Many medicines and a number of foods interact with warfarin and may have the effect of reducing the effect of warfarin or of increasing it. This information can be gained via the Patient Information Leaflets (PILs) or from the dispensing pharmacist and it is important that this information is shared with the client and the staff team.

- **Administration of Warfarin**

When administering warfarin the home care worker must always refer to the correct dose within the client's NHS anti-coagulant documentation. Under no circumstances must this documentation be recorded on by anyone other than the relevant health care professional.

**Warfarin must only be administered from the original container** not from a compliance aid (blister pack).

The dose must **always** be checked against written instructions provided by the anticoagulant clinic or GP practice, usually found recorded in the 'yellow book' or on another official document.

- **Symptoms of Warfarin Over-dosage or Bleeding**

Regular monitoring of warfarin effect, (INR tests) should ensure that overdosing does not occur. However, it would be wise to be aware of the symptoms and signs of bleeding and, if these occur, to notify the GP immediately, or the out of hours service.

**Symptoms include:** Excessive bruising, nose-bleeds, blood in urine, blood in motions (black specks or sticky tarry motions), cuts bleeding excessively, purple blotches on ends of toes, 'coffee grounds' vomiting, changes in vision, client is pale, clammy, light-headed, has an abnormally

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

rapid pulse. Bleeding might not be due to a warfarin over-dose but any of these signs must be reported to the client's GP.

All falls must be reported and the relevant health care professional informed in case of any internal bleeding.

### **Novel Oral Anticoagulants (NOACs)**

These medications include apixaban, dabigtran, edoxaban and rivaroxaban. Compared to warfarin these new agents have fewer 'drug to drug' and 'food to drug' interactions. It is important to ensure that the specific PILs are available and that staff are made aware of the specific administration, monitoring and recording procedures. It is important that staff know what to do if doses are missed, too many doses taken, side effects, dental treatment, etc. for the specific medication being administered. The client should have been provided with a NOAC information booklet which must be kept in their working records.

All patients should have an anticoagulant alert card, similar to the yellow warfarin card. This card should have the name of the anticoagulant, the condition being treated and the length of treatment.

It is imperative that staff and clients are made aware of the importance of not missing doses of this medication as the client will have an increased risk of stroke and this will need reporting to their prescribing health care professional urgently.

Further information is available on the medicines management website at <http://www.derbyshiremedicinesmanagement.nhs.uk/>

## **15. Medication Audits**

It is a legal requirement to carry out regular medication audits. These audits will identify safe and unsafe practices including areas that need to be addressed.

Daily audits are:

- a visual audit of the MARs by the home care workers before administering the medication e.g checking for gaps on MAR
- all errors found must be reported following the guidance and completing the error report form

Monthly audits involve the following:

1. the DSO must carry out a visual audit of the MARs as they are brought to the office by the home care workers to monitor any gaps in recording - to do this the DSO must use the checks on the DSO Monthly MAR check sheet ([appendix 13a](#))
2. once they have done this the DSO must sign and date the MAR before it is scanned onto



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

the clients electronic system

3. the service manager must complete the 'Monthly Audit of Medication Administration Record' ([appendix 13b](#)) for 2 MAR per DSO each month
4. all errors found must be reported following the guidance and completing the error report form ([appendix 14a](#) & b)
5. the monitoring form must be completed following the completion of the error reports ([appendix 15](#)). Where there are no errors the monitoring sheet must still be completed to show that no errors have been made for the month
6. monitoring forms and errors forms must be emailed to [asch.dcm medicationreports@derbyshire.gov.uk](mailto:asch.dcm medicationreports@derbyshire.gov.uk)

## 16. Medication Errors

**Errors result from a number of cause's** e.g. distraction, fatigue, trying to rush, human error or a systems error, these may vary in seriousness. Identifying the cause of an error is important in deciding if any changes are needed to make the system safer and prevent a repetition of the same error. Staff must report any situation where things have or could have gone wrong. The full facts must be reported within 24 hours of the error occurring or being discovered and the root cause of the medication related incident must be determined.

In the event of an error occurring in the administration of a client's medication, the following procedure must be followed:

1. telephone the client's gp or pharmacy (or if out of hours helpline 111) with full details of the incident for a medical judgment of the significance of the incident
2. record and follow any advice given by the health care professional contacted; note the person's name, in case you need to refer back to them
3. complete all sections of the medication error form ([appendix 14b](#)) in detail - the form must be completed immediately by the person/s that made/found the error, supported by the line manager

Employees will ensure:

- that they report any instance of a medication error immediately to their dso and if required, seek medical advice from the clients' gp or out of hours health help line
- that they assist the dso with the completion of a medication error report form
- that they discuss regularly in supervision their medication training needs; such as if they require updating or refreshing

The DSO will ensure:

- that errors are reported. failure to do so could result in serious consequences for the client and for the individual employee
- that employees who report errors will be supported

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

- a copy will then need to be sent to the operational service manager, quality and compliance service manager for near misses and minor errors and for major errors the form also needs sending to the departmental health and safety adviser
- any major error resulting in a client being admitted to hospital the dso must notify the care quality commission (cqc)
- when errors are reported or identified, the appropriate manager will undertake a fact-finding audit with the intention of ensuring remedial action
- if it is found from the investigation that employees have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in line with Derbyshire Council's County disciplinary procedures
- reviewers of the medication error will use the Derbyshire County Council tool to identify the level of consequence and severity of the incident and subsequent actions that are required to be taken by the manager

For guidance and medication error form see **Appendix 14a and 14b.**

**N.B. Duty of Candour** –There is a legal duty upon care providers to inform clients and/ or relevant others, when something goes wrong and harm has occurred (harm thresholds are legally defined).

**\*\*\*Please refer to Safeguarding Policies and Procedures and where appropriate ensure a referral is submitted in the usual way\*\*\***

### **Monthly Medication Error Monitoring Form**

All medication error forms completed within the month must be recorded onto the monthly medication error monitoring form **(Appendix 15).**

This will highlight at a glance any trends in the errors occurring and enable the management team to monitor them effectively.

This form must be forwarded to the Adult Social Care & Health Quality and Compliance Team at the end of the month with the completed error forms to the email address:

[ASCH.DCmedicationreports@derbyshire.gov.uk](mailto:ASCH.DCmedicationreports@derbyshire.gov.uk)

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Appendices

Number	Appendix	Page
1	Letter to Relatives, Friends or other Carers Involved in Administration of Medication	
2	Staff Observational Competency Check Sheet (Care Worker Community)	
3a	Competency Form For Specialist Training (Individual Client)	
3b	Competency Form For Specialist Training (Generic)	
4	Medication Support Contact Details	
5a	Clients Requiring Medicines in Food or Drink	
5b	Covert Administration of Medicines in Food or Drink	
6	Health Professional Confirmation Tool	
7	Medication Administration Record (MAR)	
8	Medication Administration Check Sheet	
9	Home Care Medication Procedures – Easy Guide	
10	Emergency Rescue Medication Protocol	
11	Drugs in Transit Form	
12a	Creams Body Map	
12b	Transdermal Patch Body Map	
13a	DSO Monthly MAR Check Sheet	
13b	Service Manager Monthly Audit of Medication Administration Record	
14a	Error Reporting Guidance	
14b	Error Report Form	
15	Monthly Medication Error Monitoring Form	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Appendix 1. Letter to Relatives, Friends or Other Carers Involved in Administration of Medication

Address.....

Address.....

Address.....

Date.....

Dear (Name of family member/carers.....)

If you are involved in supporting (name of client.....) with their medication either prescribed or non-prescribed medicines, could you please inform the assessor or the home care workers so this can be recorded as part of the support plan.

All medication that's administered must be recorded on a Medication Administration Record (MAR), which in most cases is provided by the pharmacist upon request.

You must make sure that you fill in the MAR sheet every time you provide support with medication as agreed with the home care manager. This is to ensure that (name of client.....) does not miss a dose or receive a double dose of medication.

If you decide to give (name of client.....) any non-prescribed medicines that aren't in the support plan/ personal service plan you must check with the doctor or pharmacist first and clearly communicate this information to the Home Care Manager prior to the next home care visit. Non-prescription medicines include medication such as herbal remedies or medicines you can buy over the counter, for example cough syrup.

If you have any concerns about the medication, or any side effects (name of client.....) is having, please contact their doctor or pharmacist, and again communicate this conversation with the home care manager.

If (name of client.....) is having difficulty making decisions about taking their medication, contact the home care manager who will arrange a mental capacity assessment to be carried out. In such circumstances you will be consulted to ensure that any decisions made are in their best interests.

If you would like more information about medication administration, please contact the Home Care Manager (name and phone number.....).

Yours sincerely (name of home care manager)

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Appendix 2 – Staff Observational Competency Check Sheet (Care Worker Community)		
Service:	Date:	
Observer:	Position:	
Observee:	Position:	
Observation Details	Compliant Y/N	Action Required
<b>Is the medication prepared safely prior to administration?</b> <ul style="list-style-type: none"> <li>Is there water, beakers, medic pots, spoons and any other equipment needed for the administration available?</li> <li>The information on the printed Pharmacy label is checked against the MAR.</li> <li>Where medication is dispensed in original boxes the name and strength of the medication on the back of the foil packs are the same as on the box.</li> <li>The batch number on the back of the foil pack is the same as on the box.</li> <li>Liquid medication is shaken and measured on a flat surface.</li> <li>“Pop and dot” system is used as each medicine is prepared.</li> <li>Medication is prepared according to the written instructions.</li> </ul>		
<b>Is the medication administered according to safe ways of working and following a person centred approach?</b> <ul style="list-style-type: none"> <li>Only prescribed or agreed over the counter medication is administered.</li> <li>The recipient is clearly identified.</li> <li>Obtain consent from the individual for the support required.</li> <li>Use effective communication with the client.</li> <li>Administer according to the identified support appropriate to the individual's needs.</li> <li>Administer as per instruction from the MAR.</li> </ul>		
<b>Are creams administered correctly?</b> <ul style="list-style-type: none"> <li>Follow infection control procedures.</li> <li>The MAR and the printed label have been checked.</li> <li>Body map has been checked.</li> <li>Expiry date and condition of cream has been checked.</li> <li>PRN protocol has been referred to where appropriate.</li> </ul>		

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

<ul style="list-style-type: none"> <li>• The cream is applied in the privacy of a safe environment in a dignified way.</li> <li>• The MAR is initialled/coded immediately after application.</li> </ul>		
<b>Are inhalers administered correctly?</b> <ul style="list-style-type: none"> <li>• Inhaler has been shaken.</li> <li>• Inhalers administered in the correct order.</li> <li>• One puff administered at a time.</li> <li>• Spacer is used correctly.</li> <li>• Drink is offered afterwards.</li> </ul>		
<b>Are eye drops administered correctly?</b> <ul style="list-style-type: none"> <li>• Follow infection control procedures.</li> <li>• Correct technique – one drop at a time.</li> <li>• Clear supportive communication.</li> <li>• Correct use of compliance aids.</li> <li>• Comfort, privacy and dignity is maintained.</li> </ul>		
<b>Are infection control precautions used?</b> <ul style="list-style-type: none"> <li>• Hands washed before and after medication is administered.</li> <li>• None touch technique.</li> <li>• Use of gloves when required.</li> <li>• Use of clean pots.</li> <li>• When the Spacer is washed, it is done in warm soapy water and left to air dry.</li> </ul>		
<b>Are MAR sheets signed appropriately and coded correctly?</b> <ul style="list-style-type: none"> <li>• The MAR is initialled/coded after administration.</li> <li>• Any gaps are identified, recorded and reported.</li> <li>• The correct codes used (not required is <b>not</b> the same as refused).</li> <li>• Where 'other' is recorded, this is clearly described on the back of the MAR.</li> </ul>		
<b>Are Error reports completed as applicable?</b>		
<b>Any other issues or comments:</b>		
Signed Observer:	Date:	
Signed Observee:	Date:	

### Appendix 3a – Competency Form for Specialist Training (Individual Client)

## Section A

Name of Client .....

Date of Birth: ...../...../.....

PIN: .....

Address: .....

Is Personal Service Plan Completed? Yes/No (If no, complete immediately)

Is Medication Assessment Completed?	Yes/No (If no complete immediately)

Task to be completed .....

## Section B

### Elements of the Task:

1. What Personal Protective Equipment is required
2. The steps to take to reduce the risk of cross infection
3. The correct use of the equipment
4. The correct procedure to administer
5. What to look for when monitoring and where to record this information

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Section C

I am satisfied that the worker/s listed below is/are competent to perform the specialist task at the time of assessment. All staff will require ongoing monitoring by managers and health professionals.

Name of Worker	Signature of Worker	Date

Name of Health Practitioner: .....

Signature of Health Practitioner: ..... Date: .....

Signature of Manager: ..... Date: .....

I agree to allow the above named carer/s to perform this task as part of my overall care package.

Signature of client, or their representative: .....

Date: .....



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

### Appendix 3b – Competency Form for Specialist Training (Generic)

#### Section A

Task to be completed .....

#### Section B

Elements of the Task:

1. What Personal Protective Equipment is required
2. The steps to take to reduce the risk of cross infection
3. The correct use of the equipment
4. The correct procedure to administer
5. What to look for when monitoring and where to record this information

I am satisfied that the worker/s listed below is/are competent to perform the specialist task at the time of assessment. All staff will require ongoing monitoring by managers and health professionals.

[illegible]

Signature of Manager: ..... Date: .....

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

#### Appendix 4 - Medication Support Contact Details

This form must be completed for all clients receiving any support with medication in their own homes so that all relevant people are aware of who is involved.

Once complete, copies of the form must be:

- kept in the clients file in the agency
- kept in the client held record
- sent to the GP and pharmacist along with the medication risk assessment

Any medication issues must be discussed with the GP/pharmacist/care worker/line manager as appropriate, where any changes or problems with medication occur.

The GP and/or pharmacist must inform the care agency of any changes to medication.

#### Medication Contact Details:

##### Client Details

Derbyshire County Council PIN.....

Name .....

Address.....

.....

Telephone.....

Email .....

##### Home Care Agency

Name .....

Address.....

.....

Telephone.....

Email .....

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Carer Details

Name .....

Contact Details.....

.....

Email .....

## GP Details

Name .....

Address.....

.....

Telephone.....

Email .....

## Pharmacy Details

Name .....

Address.....

.....

Telephone.....

Email .....

### Appendix 5a – Clients Requiring Administration of Medicines in Food or Drink

Name of client: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Reason for administration in this way: (e.g. client unable to swallow due to medical reasons).

.....

I am unable to take medicines in the form they are prescribed

I understand there are no alternatives to this method after discussion with the GP.

Clients signature .....

Date.....

Medicine Name and Strength	Method of Administration

(NB the medicine must be added to a small quantity of food/drink to ensure that the whole dose is taken by the client).

The suitability of these medicines to be given in this way has been verified by the GP/pharmacist.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

Pharmacist name..... Date.....

Signature..... Date.....

Name of the Health Care Professional.....

Job title.....

Signature..... Date.....

Domiciliary Service Organiser (Print) .....

Signature ..... Date .....

**This will be reviewed on ..... or at an earlier date if the client's situation or condition changes.**

To be stored on the clients electronic record and a copy in their personal held records alongside the Medication Administration Record (MAR)

**Appendix 5b – Covert Administration of Medicines in Food or Drink**

Name of Client: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Reason for administration in this way: (e.g. client unable to swallow due to medical reasons or does not have capacity).

.....

The client is unable to understand the necessity to take medicines prescribed for him/her. This matter has been discussed fully with the appropriate health care professional and representative. It has been agreed that it would be in the best interests of the client to administer medicine covertly in food or drink in order to maintain health and wellbeing.

**Where the client does not have capacity you must ensure a Mental Capacity Assessment is in place or refer to it.**

Medicine Name and Strength	Method of Administration

(NB the medicine must be added to a small quantity of food/drink to ensure that the whole dose is taken by the client).

We are not aware of any previous instructions given by the client that medicines should not be given in this manner.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

The suitability of these medicines to be given in this way has been verified by the GP/pharmacist.

Pharmacist Name..... Date.....

Signature..... Date.....

Name of the Health Care Professional.....

Job Title.....

Signature..... Date.....

Client's Representative Name.....

Signature..... Date.....

Client Signature (Where applicable) .....

Domiciliary Services Organiser (Print) .....

Signature ..... Date .....

Service Manager (Print) .....

Signature ..... Date .....

Social Worker (Print).....

Signature..... Date.....

**This will be reviewed on ..... or at an earlier date if the client's situation or condition changes.**

To be stored on the clients electronic record and a copy in their personal held records alongside the Medication Administration Record (MAR)



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Appendix 6 - Health Professional Confirmation Tool

The purpose of this tool is to fulfil the requirement that the directions for our client's medication are explicit and unambiguous. Employees and carers are not trained nurses; they make no claim to have clinical skills and they are not covered by current protocols to undertake such decisions. Please return within 48 hrs of receipt.

GP Surgery Practice Stamp

Date.....

Client.....

DoB.....

Name and email of Home Care Service

.....

.....

Name of medication to be administered 'as required'

.....

For what condition or situation is this to be administered?

.....

How much should be given? .....

How long after the first dose can a further dose be given? .....

Maximum dose to be given in 24 hours?.....

Signature of Prescriber .....

**NB: If this is a repeat medication please make sure that the directions are amended in the patient records**

☐

**(Tick to confirm)**

To be stored on the clients electronic record and a copy in their personal held records alongside the Medication Administration Record (MAR)

### Appendix 7 - Medication Assessment Record

Name:			Address:						DOB:						Doctor:					
Allergies:									Start Date:						Start Day:					
Medication Details			Week 1				Week 2				Week 3				Week 4					
		Date Time																		
Label																				
Label																				
Label																				

O – Offered but not required (PRN)

N - Nausea/vomiting

R - Refused

C - See notes overleaf.

A – Assist e.g. Opening the bottle of  
medicine/s/creams and passing to client

P – Prompt/remind  
e.g. verbally asking if meds have been taken



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2021
---	--	--

## Appendix 8 - Medication Administration Check Sheet

The following is a list of checks you must have made before you initial/code the MAR each time of administration:

All checks below refer to the “6 Rights” within the Home Care Medication and Health Related Activities Policy

**Right Person**

**Right Medication**

**Right Strength**

**Right Dose**

**Right Time**

**Right to refuse**

### IMPORTANT:

If you make/notice an error/recording error, it is your responsibility to report this to your manager as soon as possible.

### MAR Sheet/Pharmacy Printed label

- start date of mar sheet
- date of administration on mar sheet
- name of client
- name of medication
- strength of medication
- dose (amount of medication to be given and when)
- specific directions
- statutory warnings

### IMPORTANT:

The information on the pharmacy printed label must be the same as the information recorded on the MAR sheet

### Medication

- all prescribed medication must be dispensed into pharmacy filled containers
- if medication is dispensed into foils packs inside a box, the batch number on the foil pack must match the batch number on the box
- you have observed the client swallow their medication – if not, the correct code must be used

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

Appendix 9 Home Care Medication Procedures – Easy Guide			
Procedure	Will we do it?	What will we do?	What we won't do:
Tablets/Capsules	<p>Yes</p> <ul style="list-style-type: none"> <li>include as part of a care package</li> <li>appropriate assessments are in place</li> <li>mar sheet in place</li> <li>medication is dispensed into pharmacy filled compliance aids or in original containers</li> <li>medication is clearly labelled by the pharmacist</li> </ul>	<ul style="list-style-type: none"> <li>hand the container to the client to self-administer</li> <li>prompt the client to remind them to take their medication</li> <li>administer the dose when the client is unable to self-administer</li> <li>place the dose into a container</li> <li>dissolve tablets in water as per instructions on the original container</li> <li>if agreed, cut tablets in half using a proper tablet cutter</li> <li>its good practice to use a health professional confirmation method if additional directions are required</li> <li>refer to main policy if a prn protocol is required</li> </ul>	<ul style="list-style-type: none"> <li>accept any change to medication unless it is clearly identified on the MAR sheet, and signed by a health care professional or home care manager - this must be double signed by a suitable witness</li> </ul> <p>Crush tablets unless:</p> <ul style="list-style-type: none"> <li>there is no suitable alternative</li> <li>it is carried out with the written authority of a relevant health care professional</li> </ul>
Liquid/powdered medicines	<p>Yes:</p> <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place.</li> </ul>	<ul style="list-style-type: none"> <li>hand the medication to the client to self-administer</li> <li>administer the dose when the client is unable to self-administer</li> </ul>	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

Procedure	Will we do it?	What will we do?	What we won't do:
	<ul style="list-style-type: none"> <li>medication is clearly labelled by the pharmacist</li> </ul>	<ul style="list-style-type: none"> <li>measure out the dose into a measuring utensil</li> <li>prepare a powdered medicine as per instructions on the original container</li> </ul>	<ul style="list-style-type: none"> <li>accept any change to medication unless it is clearly identified on the MAR sheet, and signed by a health care professional or home care manager - this must be double signed by a suitable witness</li> </ul>
Eye, ear and nose drops/ointments	<p>Yes</p> <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>generic training by an agreed provider</li> <li>Individual specific training by a relevant health care professional and staff have been signed off as competent.</li> </ul>	<ul style="list-style-type: none"> <li>prompt to remind client to self-administer</li> <li>place drops into compliance aids for client to self-administer</li> <li>administer the drops when all other options have been explored</li> <li>leave sufficient time between each dose</li> </ul>	<ul style="list-style-type: none"> <li>provide assistance with any drops that are over the counter/herbal medicines unless advised by the relevant health care professional and appropriate assessments are in place</li> </ul>
Patches (including pain relief such as Morphine)	<p>Yes:</p> <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place.</li> <li>in the original container and clearly labelled by the pharmacist</li> <li>body map in place</li> </ul>	<ul style="list-style-type: none"> <li>take out of the package for the client to apply</li> <li>apply the patch</li> <li>dispose of the patch</li> </ul>	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

Procedure	Will we do it?	What will we do?	What we won't do:
Tens machine	In exceptional circumstances when it has been prescribed by the GP or other relevant professional: <ul style="list-style-type: none"> <li>included as part of a package</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional has been provided and staff have been signed off as competent</li> </ul>	<ul style="list-style-type: none"> <li>we will provide assistance to support the client to apply the pads where required</li> </ul>	<ul style="list-style-type: none"> <li>make any judgements where the pain relief will be set</li> <li>provide support where clients have purchased the machine themselves</li> </ul>
Catheter care (In-dwelling) (Supa-pubic)	Yes <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>monitored by DN</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional has been provided</li> <li>staff have been signed off as competent.</li> </ul>	<ul style="list-style-type: none"> <li>keep the area clean where the catheter enters the body</li> <li>attach the night bag to the day bag</li> <li>empty the bags</li> <li>flush out the empty catheter bag</li> <li>change the day bag</li> <li>report any change in appearance of condition/bodily fluids no matter how small to the dn/manager</li> </ul>	<ul style="list-style-type: none"> <li>provide personal care where there is evidence of infection or soreness to the entry site</li> <li>insert or remove catheters</li> <li>make judgements on a person's health</li> </ul>
Sheath catheters	This is not a preferred method of managing continence: <ul style="list-style-type: none"> <li><b>staff must be happy to assist</b></li> </ul>	<ul style="list-style-type: none"> <li>If this is a request the manager must complete a risk assessment and refer to Adult Care or health and safety for further guidance.</li> </ul>	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

Procedure	Will we do it?	What will we do?	What we won't do:
Stoma care / Colostomy bags	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>monitored by DN</li> <li>appropriate assessments are in place</li> <li>training by a relevant health care professional has been provided</li> <li>staff have been signed off as competent</li> </ul>	<ul style="list-style-type: none"> <li>we will promote a person's independence in the management of stoma /colostomy care</li> <li>we will support with the removal of the bag, cleaning the area and applying the new bag</li> <li>report any change in appearance of the site and bodily fluids no matter how small to the DN/manager</li> </ul>	<ul style="list-style-type: none"> <li>provide assistance where there is evidence of infection or soreness to the site</li> <li>make judgements on a person's health</li> </ul>
Insulin injection	No	<ul style="list-style-type: none"> <li>we will hand the syringe/pen to the client</li> <li>we will pass the sharps bin to the client to deposit the used syringe</li> </ul>	<ul style="list-style-type: none"> <li>draw up the syringe</li> <li>test/monitor the client's glucose/sugar levels</li> </ul>
Open wounds	No		
Pressure area care/Tissue viability	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>monitored by DN</li> <li>appropriate risk assessments are in place</li> <li>staff have completed DCC Tissue Viability training</li> <li>provide health and safety cards for guidance</li> </ul>	<ul style="list-style-type: none"> <li>we will clean the pressure area and apply prescribed creams where the skin is not broken</li> <li>we will record and report to the DN/manager any changes in the appearance of pressure areas</li> </ul>	<ul style="list-style-type: none"> <li>make any judgements on the care required</li> <li>provide assistance when the skin is broken</li> <li>apply dressings to the affected area</li> </ul>



Procedure	Will we do it?	What will we do?	What we won't do:
	<ul style="list-style-type: none"><li>• MAR sheet in place</li><li>• record on PSP</li></ul>		<ul style="list-style-type: none"><li>• apply creams purchased by the clients to the affected areas</li></ul>
PEG feeding	<p>Yes:</p> <ul style="list-style-type: none"><li>• included as part of a care package</li><li>• appropriate assessments are in place</li><li>• MAR sheet in place where Medication is fed into the PEG</li><li>• training by a relevant health professional has been provided</li><li>• staff have been signed off as competent.</li></ul>	<ul style="list-style-type: none"><li>• ensure tubes are clean and running free</li><li>• attach a feed</li><li>• insert drinks into the tube using the correct utensils provided</li><li>• insert medication into the tube as per MAR sheet using the utensils provided</li><li>• detach and dispose of the empty feed container</li><li>• clean the site area when required</li><li>• report to the DN/manager any problems identified with any aspect of the PEG feed</li></ul>	<ul style="list-style-type: none"><li>• make judgements on a person's health</li><li>• make decisions about the quantity, content and speed of the feed provided</li><li>• rectify any faults identified with the feed apparatus</li></ul>

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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Procedure	Will we do it?	What will we do?	What we won't do:
Thickeners (drinks)	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional has been provided.</li> </ul>	<ul style="list-style-type: none"> <li>make up the drink as specified by clear instructions on the box, container label or the relevant health professional</li> <li>assist the individual to drink from a cup or spoon if required</li> </ul>	<ul style="list-style-type: none"> <li>supplement the drink on advice from anyone other than a relevant medical professional which must be recorded</li> </ul>
Support stockings	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate risk assessments are in place</li> <li>training by a relevant health professional specific or generic as required</li> </ul>	<ul style="list-style-type: none"> <li>assist individuals to apply the stockings with or without the use of compliance aides as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>apply stockings where there are areas of broken skin</li> </ul>
Anal medication including suppositories.	No	<ul style="list-style-type: none"> <li>assist the DN by supporting the client during the procedure</li> </ul>	
Vaginal creams	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place</li> </ul>	<ul style="list-style-type: none"> <li>apply external cream as directed on the pharmacist label</li> <li>record and report any change in condition of the treated area to DN/manager as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>apply internal creams</li> </ul>
Pessaries	No	<ul style="list-style-type: none"> <li>assist the DN by supporting the client during the procedure</li> </ul>	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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Procedure	Will we do it?	What will we do?	What we won't do:
Contact lenses	This is not a procedure we would undertake without prior discussion: <ul style="list-style-type: none"> <li><b>staff must be happy to assist</b></li> </ul>	<ul style="list-style-type: none"> <li>if this is a request the manager must complete a risk assessment and refer to Adult Care or Health and Safety for further guidance</li> </ul>	
Trusses	Yes <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate risk assessments are in place</li> <li>training by a relevant health professional specific or generic as required</li> </ul>	<ul style="list-style-type: none"> <li>assist the client to apply the truss as per direction of the health care professional</li> <li>ensure the client is comfortable with the appliance</li> <li>report and record any difficulties experienced by the client or staff member in applying the truss</li> <li>monitor for any sore areas and report to DN/manager</li> </ul>	<ul style="list-style-type: none"> <li>adjust the truss or change the application without direction from health care professional</li> </ul>
False limbs	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional specific or generic as required</li> </ul>	<ul style="list-style-type: none"> <li>assist the client to apply the false limb as per direction of the health care professional/client</li> <li>ensure the client is comfortable with the limb</li> <li>report and record any difficulties experienced by the client or staff member in applying the limb</li> </ul>	

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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Procedure	Will we do it?	What will we do?	What we won't do:
Callipers	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional specific or generic as required</li> </ul>	<ul style="list-style-type: none"> <li>assist the client to apply the calliper per direction of the health care professional/client</li> <li>ensure the client is comfortable with the calliper</li> <li>report and record any difficulties experienced by the client or staff member in applying the calliper</li> </ul>	
Oxygen	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>training by a relevant health professional specific or generic as required</li> </ul>	<ul style="list-style-type: none"> <li>assist the client to fit the mask/tube</li> <li>switch the machine on or off as required</li> <li>notify line manager/dso when pressure gauge indicates the contents of the cylinder are running low</li> </ul>	<ul style="list-style-type: none"> <li>make any decision as to when the oxygen is or is not required</li> <li>set any controls to regulate the flow of oxygen</li> <li>change oxygen cylinders</li> </ul>

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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Procedure	Will we do it?	What will we do?	What we won't do:
Anticoagulants e.g. Warfarin	yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place.</li> </ul>	<ul style="list-style-type: none"> <li>adjust the dose following instruction recorded in the 'yellow book'</li> <li>place the dose into a container</li> <li>hand the container to the client to self-administer</li> <li>we will administer the dose when the client is unable to self-administer</li> <li>prompt the client to remind them to take their medication</li> </ul>	<ul style="list-style-type: none"> <li>offer support from any compliance aid</li> <li>write any information regarding dosage in the 'yellow book'</li> </ul>
Controlled drugs (tablets, medicine or patches)	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place.</li> </ul>	<ul style="list-style-type: none"> <li>controlled drugs are treated in exactly the same way as all other forms of medication</li> </ul>	
Medication applied to gums/inside of mouth	Yes: <ul style="list-style-type: none"> <li>included as part of a care package</li> <li>appropriate assessments are in place</li> <li>MAR sheet in place</li> <li>training by a health professional where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>support the client to self-administer</li> <li>rub medication onto the affected/appropriate area of the mouth</li> </ul>	<ul style="list-style-type: none"> <li>administer the medication where there is a risk of harm to the employee due to behavioural difficulties</li> </ul>

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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#### Appendix 10 – Emergency Rescue Medication Protocol

<b>Client Name:</b>	<b>Pin Number:</b>
<b>Establishment Name:</b>	<b>DOB:</b>
<b>Name of Prescriber:</b>	
<b>Name and strength of prescribed rescue medication:</b>	

<b>Seizure Classification (if known)</b>
<b>Description of seizures which may require rescue medication: (Record all known physical and psychological symptoms of each seizure eg: Sudden drop, loss of consciousness, convulsions down both sides of body etc.</b>
<b>Usual duration of seizure:</b>
<b>Other useful information: (This could include: triggers for seizures, warning signs and potential allergies etc)</b>

<b>When should the rescue medication be administered? (Identify if after a certain length of time or after a number of seizures)</b>
<b>Initial dosage? (Prescribed number of mg/mls)</b>
<b>What is the usual reaction/s to the prescribed rescue medication?</b>

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

<b>If there are difficulties in administration, what action should be taken?</b>
<b>Can a second dose of the rescue medication be administered? (If so provide details)</b>
<b>When should (9)999 be called?</b>
<p><b>Immediately after initial administration    YES/NO</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>After..... minutes post initial dose of prescribed rescue medication</b></p> <p><b>Other (provide details below)</b></p>
<b>Under what circumstances should the prescribed rescue medication not be used? (eg – other medication might have already been administered which could have contra indications)</b>
<b>Maximum dose of the rescue medication to be administered in a 24 hour period:</b>
<b>Who needs to be informed post recovery?</b>
<b>Prescribing Doctor</b>

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

**Family/carers**

**Other**

**Recovery Plan:**

**Prescriber Name (Block capitals):**

**Signature:**

**Date:**

**Clients Signature (if able to consent):**

**Date:**

**Family/Carer Name( if in clients best interest) (Block capitals):**

**Signature:**

**Date:**



## Appendix 11 - Drugs in Transit Form

[illegible]

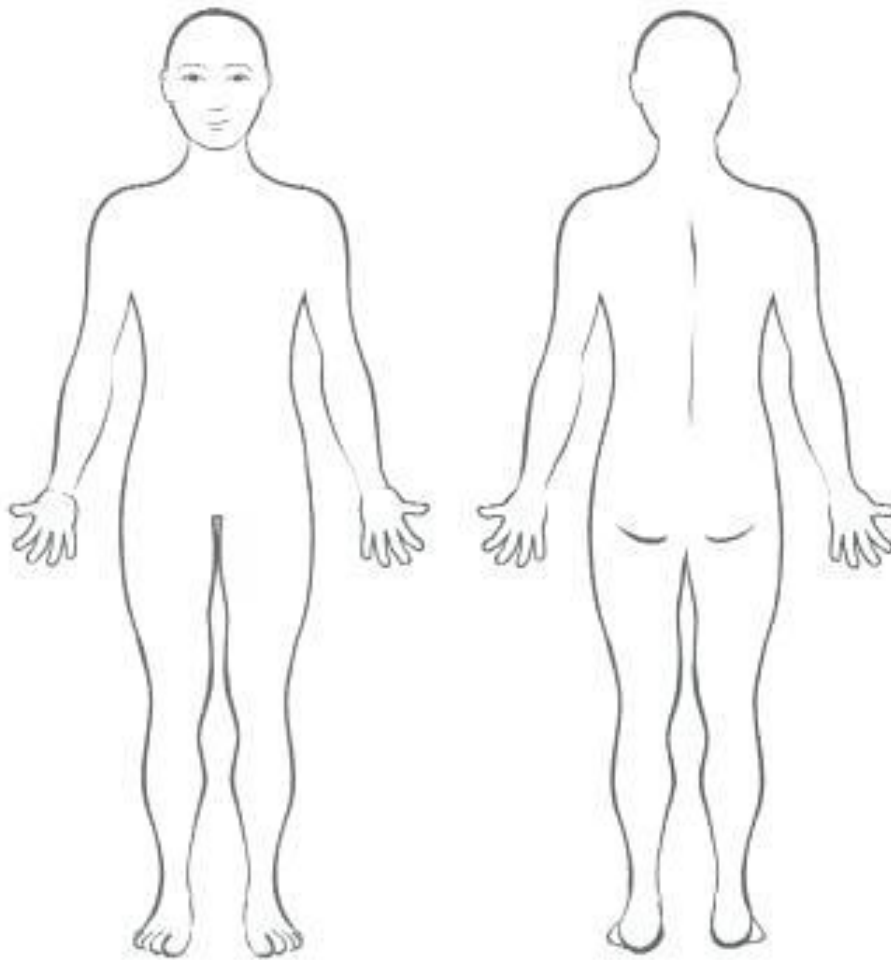
**Appendix 12a – Creams Body Map**

Client's name..... Name of cream: .....

Directions of application:

.....  
 .....  
 .....  
 .....

Completed by: .....Date: .....



NB one body map per cream

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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### Appendix 12b – Transdermal Patch Body Map

<b>Name of Client</b>			
<b>Name of Patch</b>		<b>Strength</b>	

**The patch should be checked on a daily basis to make sure it is still in place.**

**Below is a guide to rotating of sites but it does not replace your responsibility in ensuring you have all the information needed to use the patch correctly**

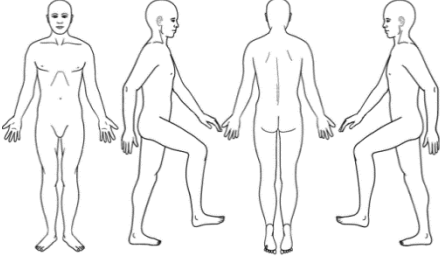
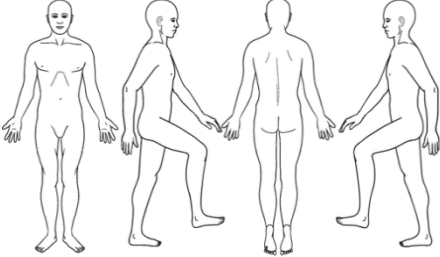
	<b>Fentanyl</b>	<b>Butrans/Butec</b>	<b>Transtec</b>	<b>Hyoscine</b>	<b>Rivastigmine</b>	<b>Rotigotine</b>
Duration of use	72 hours	1 week	4 days	72 hours	24 hours	24 hours
Interval before reusing a site	1 week	3-4 weeks	1 week	72 hours	14 days	Use only the specific chart for rotigotine.
Number of sites on rotation	3 sites	4 sites	2 sites	2 sites	14 sites	

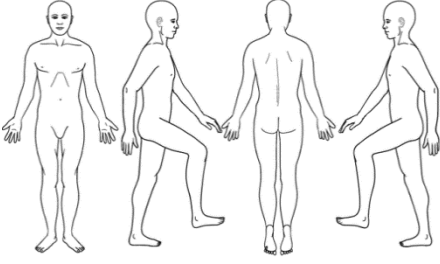
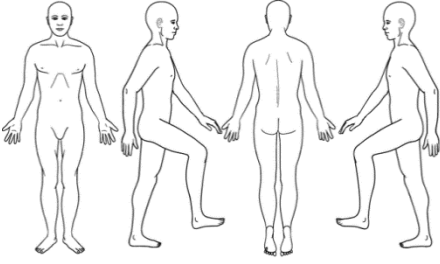
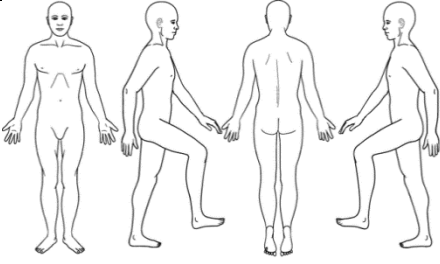
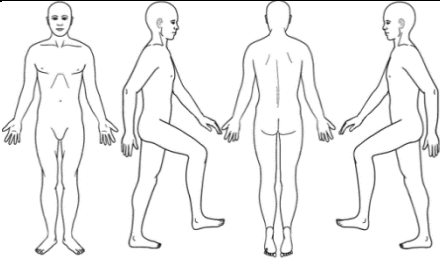
Patches should not be applied to bony prominent parts of the body and Hyoscine should be place behind the ear.

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

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

#### **THIS DOES NOT REPLACE THE NEED TO RECORD ADMINISTRATION ON THE MAR**

	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			
	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			

	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			
	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			
	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			
	<b>Date new patch applied</b>			<b>Time</b>	
	<b>Applied by</b>				
	<b>Date patch removed</b>			<b>Time</b>	
	<b>Removed by</b>				
	<b>Witnessed by</b>	Only required for CD's			

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

<b>Appendix 13a – DSO Monthly MAR Check Sheet</b>
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All DSOs must carry out the following checks on each MAR before they are scanned onto MOSAIC. Once the following checks have been made you must sign and date each MAR. This confirms that the following checks have been completed.

You are ensuring that:

- drug allergies correctly recorded
- all directions are clear
- there is a prn protocol in place where needed and fully completed
- any hand written alterations have been made following health care professional advice
- any mid-cycle changes are clear, accurate, initialled and dated
- handwritten additions are clearly written, initialled, dated and countersigned
- initials are clear so that staff members can be identified
- gaps present on the mar sheet are supported by error report forms
- for variable doses, the amount administered is recorded appropriately
- the reason for non-administration is recorded using the correct code and details recorded on the back of the mar if this is required

<p><b>If there are any concerns with particular MAR sheets, it is the DSOs responsibility to discuss with the staff involved, record outcome and carry out observation/s of practice.</b></p>
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Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

### Appendix 13b – Service Manager Monthly Audit of Medication Administration Record

#### Instruction:

- 1) Conduct audit upon receipt of the MAR sheets, before they are scanned onto Mosaic.
- 2) Collect a sample of 2 MAR sheets per DSO a month. These must be different ones each time.
- 3) All concerns must be recorded in the 'Findings' column in detail.
- 4) Complete the "Action Required" column in detail with realistic target dates.

List PIN numbers and DSO for MARs that have been audited:

DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2
DSO	Client 1
	Client 2

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

	<b>Findings (include pin number with details)</b>	<b>Action Required</b>
1. Drug allergies correctly recorded		
2.All directions are clear		
3.There is a PRN protocol in place where needed and fully completed		
4.Any mid-cycle changes are clear, accurate, initialled and dated		
5.Handwritten additions are clearly written, initialled, dated and countersigned		
6.Initials are clear so that staff members can be identified		
7.Gaps present on the MAR sheet are supported by error report forms		
8.For variable doses, the amount administered is recorded appropriately		
9.The reason for non-administration is recorded using the correct code and details recorded on the back of the MAR if this is required.		

**Completed by:** .....

**Job Role:** .....

**Signed:** .....

**Date:** .....

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

## Appendix 14a – Error Reporting Guidance

Part A to be completed by the person who discovered the error.

Part B to be completed by the person identified as making the error.

Part C to be completed by the line manager.

**Please type or write clearly. Report all incidents within 24 hours of the error occurring or being discovered.**

Copies of this form **MUST** be sent on a monthly basis or sooner to:

- the Quality and Compliance Team by email to  
ASCH.DCmedicationreports@derbyshire.gov.uk
- Service Manager for your area

The completed and signed medication error form is to be saved with the staff member's supervision records and a copy scanned onto the electronic record for the client involved. When the form is scanned and sent through to the relevant person the document must be named as initials of resident, date error occurred and establishments name e.g. DF 15.10.16 Brook Bank Home.

### General Principles:

- staff must report any situation where things have or could have gone wrong
- the full facts must be reported within 24 hours of the error occurring or being discovered and the root cause of the medicine related incident must be determined
- medication errors must be monitored on a monthly basis

### Employees will ensure:

- that they report any instance of a medication error immediately to their manager and if required, seek medical advice from the residents' gp or out of hour's health help line
- that they assist the manager with the completion of a medication incident report form - a copy will then need to be sent to the service manager for the area, quality and compliance service manager for near misses and minor errors and for major errors the form also needs sending to the departmental health and safety adviser
- that they discuss regularly in supervision their medication training needs; such as if they require updating or refreshing

### Unit Manager/Domiciliary Service Organisers will ensure:

- errors are to be reported using the medication error report form
- employees who report errors will be supported



Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

- that when errors are reported or identified, the appropriate manager will undertake a fact-finding audit with the intention of ensuring remedial action
- that actions carried out or planned are recorded on the medication error report form
- that error report forms are monitored on a monthly basis by the manager with any trends identified and action agreed alongside the service manager.
- all completed medication error forms are sent to the relevant individuals on a monthly basis if not sooner
- if it is found from the investigation that employees have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in line with Derbyshire County Council's disciplinary procedures
- that CQC notifications are completed if the cause or effect of a medicine error met the criteria to notify one of the following:
  - a death
  - an injury requiring medical treatment
  - abuse or an allegation of abuse
  - an incident reported to or investigated by the police

<http://www.cqc.org.uk/content/notifications>

Copies of these **MUST** be sent to Health and Safety Section.

- where relevant, they are able to evidence that a medicine error was a known or possible cause or effect of these incidents or events being notified
- reviewers of the medication incident will use the Derbyshire County Council tool to identify the level of consequence and severity of the incident and subsequent actions that are required to be taken by the manager

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

## How to use the Consequence/Severity Tool

Address the **Impact** of the error first followed by the **Likelihood** of the error occurring second.

### Explanation of the examples given on the above tool:

#### Example 1: Low Risk: Score 1

Worker fails to sign for one medication as is interrupted by a colleague. The worker has always signed the MAR sheet correctly before. The client received medication and no harm occurred.

#### Example 2: Moderate Risk: Score 5

Worker fails to sign for several medications on the current MAR sheet. The client received their medication. They have a history of not signing MAR sheets and have attended training previously. This will undoubtedly reoccur again if their practice does not change.

#### Example 3: High Risk: Score 9

A dose has been incorrectly transcribed by a manager onto the MAR sheet. Due to the employee not cross checking the information on the MAR against that on the medication label, the client is repeatedly given an overdose of medication. Checks made by GP, antidote prescribed and administered to correct the consequences of the overdose.

This incident identifies a catalogue of errors made, therefore more than one form will need to be completed; the manager for the initial wrong transcription of the information and for each staff member who continued to administer the medication without checking the information on the MAR against that on the pharmacy label.










#### Example 4: Extreme Risk: Score 15

Controlled drug arrives at the care home, is booked in by two staff and entered into the CD register. The staff fails to notice that the actual medication strength is stronger than was prescribed (the label states 10mg the medication is actually 60mg). Three doses are administered; the client dies as a result. The home has a poor record of managing controlled drugs.

Again this incident identifies a catalogue of errors made by different people; GP/pharmacist and the staff who didn't notice the error when booking in the medication and those administering it.

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

## Guidance to completing the Consequence/Severity Tool

Likelihood 		1	2	3	4	5
Actual harm to person (s)		Rare	Unlikely	Possible	Likely	Definitely
Impact 		This will probably never happen/recur	Do not expect it to happen/ recur but it is possible it may do so unless practice is altered	Might happen or recur occasionally unless practice is altered	Will probably happen/ recur OR history of incidents/ repeated errors	Will happen/ recur, possibly frequently AND history of repeated errors
1	Negligible(No harm)  Near miss or harm prevented	Example 1  $1 \times 1 = 1$				Example 2  $1 \times 5 = 5$
2	Minor (minimal harm)  Person(s) required extra observation or minor treatment					
3	Moderate (short-term harm)  Person(s) required further treatment or procedure			Example 3  $3 \times 3 = 9$		
4	Major (permanent or long-term harm)  Person(s) required permanent or long-term treatment					
5	Fatality  Person died as a direct consequence of the error/ incident			Example 4  $5 \times 3 = 15$		

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

MULTIPLY THE TWO NUMBERS TOGETHER TO GET A FINAL SCORE WHICH WILL INDICATE GUIDANCE ON ACTION TO BE TAKEN. Record this on the Medication Error Report Form.

### **Risk Scoring Action Plan**

- 1 - 3: Low risk:** Discussion one to one with line manager and recorded on the error form.
- 4 - 6: Moderate risk:** Line manager to complete the 'Staff Observational Competency Check Sheet'  
Documented discussion one to one with line manager  
Consider need for attendance on medication training course  
Consider safeguarding referral
- 8 - 12: High risk:** Line manager to complete the 'Staff Observational Competency Check Sheet'  
Documented discussion one to one with line manager  
Consider need for attendance on medication training course  
Systems review by manager  
Consider safeguarding referral  
Managing Individual Capability  
Consider immediate suspension from administration of medicines until competency restored.  
Consider whether a CQC notification is completed and referral made to safeguarding
- 15 - 25: Extreme risk:** Line manager to complete the 'Staff Observational Competency Check Sheet'  
Documented discussion one to one with line manager  
Attendance on medication training course  
Systems review by manager Managing Individual Capability  
Consider immediate suspension from administration of medicines until competency restored.  
CQC notification completed and referral to safeguarding

**The consequence/severity rating outcome MUST be completed in Part C of the Medication Error Form**

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
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### Appendix 14b – Error Report Form

Please type or clearly write all information in appropriate section. Completed forms sent to [ASCH.DCmedicationreports@derbyshire.gov.uk](mailto:ASCH.DCmedicationreports@derbyshire.gov.uk)

#### **PART A: TO BE COMPLETED BY THE PERSON DISCOVERING THE ERROR**

<b>Client Name</b>
<b>PIN Number</b>
<b>Date of birth of client</b>
<b>Establishment/Service where the error occurred</b>

<b>Name of person who discovered the error</b>
<b>Job Title</b>
<b>Date error was discovered</b>

<b>Name of the person identified as making the error</b>	
<b>External e.g. pharmacy/prescriber</b>	
<b>Internal Job Title</b>	
<b>Date of error</b>	<b>Time of error</b>

<b>What was the error? Tick box</b>			
Recording error		Omission of dose	
Wrong client		Wrong time	
Wrong amount/dose		Other	
Wrong medicine			

<b>This incident relates to which medicine(s)</b>	<b>Dose(s)</b>

**PART A continued: How was the incident discovered and what action was taken at the time of discovery (Inc. medical advice sort)?**

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

**PART B: TO BE COMPLETED BY THE PERSON WHO MADE THE ERROR**

**Describe in detail the circumstances of the event as they happened (use extra sheet if needed)**

Version: 3 FOI Status: <b>Public</b>	Home Care Medication and Health Related Activities Policy	Issued: August 2019 Review Due: August 2019
---	--	--

**PART C: MANAGEMENT ACTIONS**

**Risk Scoring (refer to the tool in appendix of policy or guidance and MUST be completed):**

Likelihood rating and score (1 to 5)	x	Impact rating and score (1 to 5)	=	Risk Rating score (1 to 25)	Risk Rating (low, mod, high, extreme)
	<b>x</b>		<b>=</b>		

Risk Scoring will identify the selection of actions to be taken (see guidance)

**Action taken to prevent a reoccurrence:**

Remedial action taken?	Yes	No	Give reasons
Client informed			
Family/Carers informed			
CQC have been informed if appropriate			
Safeguarding form completed and sent if appropriate			
Discussed with person who made the error and recorded			
Service Manager informed			

Signature/name of person who made the error

.....Date.....

Line Manager's signature/name

.....Date.....

Service Manager name

.....



1. Complete along with monthly medication audit
2. Use as cover sheet for monthly error forms
3. Scan and send to Quality and Compliance  
(ASCH.DCmedicationreports@derbyshire.gov.uk)
4. Discuss with Service Manager

[illegible]

[illegible]