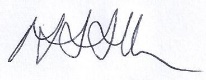


**Policy on ADMINISTRATING MEDICATION AND GUIDELINES**

Document Details

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1. Introduction and purpose
   1. The safe handling and management of medication at Spectrum Days is an essential part of ensuring the health and wellbeing of Members who receive medical treatment. The purpose of this policy is to provide a set of standards and procedures for staff at Spectrum Days which ensures that Members take their medication at the Centre in a safe manner and in line with best practice.
   2. The policy is adapted from the following guidance documents:

* “Medication Guidance and Standards” published by Worcestershire County Council (2016)
* “Medication Guidance and Standards” published by The Nursing and Midwifery Council (2007)
* “The Handling of Medicines in Social Care” published by The Royal Pharmaceutical Society of Great Britain (2007).

1. Scope
   1. The policy covers the supply, storage, transcribing, risk assessment, administration and disposal of medication at the Centre. Situations may arise that are not directly referred to within this document. When this happens, the senior team at Spectrum must be informed. The senior team are expected to use their professional knowledge and experience to decide on the best course of action and ensure the safety and well-being of the Member concerned. If the senior team are unable to decide upon a safe course of action, advice must be sought from the Member’s GP or pharmacist. Alternatively, NHS Direct helpline can be contacted if the prescriber/pharmacist is unavailable.
2. Roles

3.1 *The prescriber:*

The Member’s GP or Consultant will be the usual route for prescribing medicines. Alternatively, a non-medical prescriber - such as a Community Nurse Practitioner - may be responsible.

3.2 *Pharmacist/dispensing doctor:*

The pharmacist (or dispensing doctor) provide all the medicines and appliances used by the Member for their treatment. They also give advice to make sure they are used correctly.

3.3 *Authorised Staff at Spectrum:*

Management and staff must only make decisions appropriate to their qualifications, level of training and competencies.

3.3.1 Training:

The Service Lead,Service Co-ordinator and Activities Co-Ordinator will have completed a Level 3 training course in “Managing, Safe-handling and Administration of Medication”. Other staff will have completed a Level 2 training course in “Safe-Handling and Administration of Medicine”.

3.3.2 Service Lead

The Service Lead is responsible for the following tasks:

* Ensure the most up-to-date medication policy is accessible to all employees and agency staff.
* Provide written evidence to show that all employees have read the policy.
* Arrange training for staff in the administration, storage and disposal of medication.
* Ensure medication competency assessment is carried out at the Centre following the first training received by a staff member to administer medication received by a member staff (see proforma??)
* Ensure medication competency assessment is carried out for each staff member who is to administer medication after their initial medication training and after each annual medication training update.
* Maintain an up-to-date list of named employees responsible for medication management, along with their initials and signatures. Copies of training certificates to be kept in a central file and the original certificates in staff members’ personal files.
* Ensure auditing of medications stored permanently at the Centre takes place monthly (see proforma???)
* Submit an improvement plan to address any significant issues identified from audits. This must be actioned within a time frame set by the Service Lead.
* If a decision regarding medication needs to be made and the Service Lead and staff are not clear what action to take, the Service Leadand other senior members of staff are expected to make all reasonable attempts to take advice from the Member’s GP or pharmacist (see section 2.1).

3.3.2 Service Co-Ordinator and Activities Co-ordinator

The Service Co-ordinator and Acitivities Co Ordinator are responsible for:

* Transcribing all prescriptions to the Member’s Medication Administration Record (MAR) chart (see appendix … ?).
* Conducting medication competency assessments (see Section 3.3.1).
* Auditing of medications(see Section 3.3.1).

3.3.3 Other staff:

In addition to the training in Section 3.3.1, other staff must successfully complete the following:

* Induction from a senior member of staff about the medication system in use at the Centre.
* Medication competency assessment carried out by a senior member of staff following their first period of training to administer medication. This assessment must then be carried out annually following their annual medication training update.

Staff who have received the above training are able to administer medication in the form of tablets, capsules, liquid, cream/ointment, ear/nose/eye drops and inhaled medication. The administration must always be carried with a second member of staff to act as witness who is trained in the administration of medication.

Staff should not undertake the following unless they have satisfactorily completed additional training: rectal administration of midazolam (for epileptic seizure); injectable drugs such as insulin; administration through a Percutaneous Endoscopic Gastrostomy (PEG).

All medication administered at The Centre must be witnessed by another trained member of staff.

Trained staff are also responsible for signing medication in and out of the building.

1. Supply of medicines
   1. All medication given to members whilst they are at the Centre must have been originally supplied by a pharmacist. Most medications will be brought with the Member each time they come to the Centre and taken home again when they leave at the end of the day. Medications supplied by a pharmacist can be stored at Centre and not taken home with them - if this has been requested by the parent/carer.
   2. An accurate record of the receipt, storage, administration and disposal of medications is to be maintained within the Service.
      1. Medication that is brought to the Centre with a Member must be signed in by a trained member of staff using one of the following proformas:
         * Proforma ???: for medicines that are due to be taken whilst the Member is at the Centre and are taken home with them.
         * Proforma ???: for medicines that are due to be taken whilst the Member is at the Centre and the parent/carer wishes Spectrum to store them at the Centre.
         * Proforma ???: for medicines that are not due to be taken whilst the Member is at the Centre and but are to be taken by the Member at their respite venue.
   3. All signing in should be done promptly when the Member arrives at the Centre.
   4. All tablets and capsules must be individually counted and the total amounts recorded on the relevant proforma. Liquid and inhaled medication, as well as creams and ointments, are counted by the container only.
   5. All liquid medications (except insulin), creams and ointments that are administered to Members when they are at the Centre must have been opened and stored at the Centre. The medication must remain stored at the Centre and sent back to the parent/carer when the medication has been used up - or when it has exceeded its use by or expiry date (see Section 4.6). Insulin is the only exception since it requires refrigeration before it is opened.
   6. Any liquid medications (except insulin), creams and ointments that have not been opened can be kept and used up until their manufacturer’s expiry date. If they are opened in this time then staff must complete the following:
      1. Write the date when the medication was opened and when the medication must be discarded clearly on both the container and on any packaging in which the container is stored. All dates must be initialled by the staff member. The date to discard opened medication can be calculated using the following general guidelines:

|  |  |
| --- | --- |
| Dispensed bottles | 6 months |
| Manufactured bottles | Date on bottle |
| Eye products | 4 weeks after opening but always check label. |
| Tubs of cream/ointment | 1 month after opening |
| Tubes of cream | 3 months after opening |
| Insulin | 4 – 6 weeks (depending on brand) |

* 1. Medication for community visits
     1. Members who need to take medication when they are on a community visit must be accompanied during the trip by a member of staff with medication training (see 3.3.2). The staff member is responsible for taking the following items with the Member:
        + Medication that is due to be taken when the Member is on the visit;
        + Relevant MAR;
        + Any additional equipment which enables the Member to take the medication**.**
     2. A second member of staff who has medication training (see 3.3.2) must be present during the community visit to act as a witness in the administration of medication.
     3. All medications administered when off-site must be signed out and back into the Centre using proforma listed in Section 4.2.1.

1. Storage of medication
   1. All medicinal products, when not in use, will be kept locked in a metal cabinet designed specifically for the storage of medication. The key must be kept on the team leader’s person at all time. Alternatively, if the team leader is unavailable the medication must given to a designated senior member of staff who has medication training (see Section 3.3). This key must then be stored in a secure cabinet at the end of the day. Copies of all drug keys must be kept in a safe place separate from the medication cabinet and staff must have access to these spare keys in event of an emergency.
   2. Staff should not store anything other than medicines in the medicine cupboard.
   3. Required conditions for the storage of medication - as stated on the packaging and in the accompanying instruction leaflet - must be followed. If this information is unavailable, the patient information leaflet or summary of product characteristics document for UK-licensed medicinal products may be found at [www.emc.medicines.org.uk](http://www.emc.medicines.org.uk).
   4. All medicines need to be stored a cool, dry place so that the products are not damaged by heat or dampness.
   5. Some medicines may require storage in a refrigerator. The Centre fridge (used for the storage of food) can be used – provided that it is placed in a container that is clearly labelled.
   6. All medicines administered at the Centre are to be stored in segregated, labelled compartments so that they are not mixed up with other people’s medicines.
   7. All liquid medications, creams and ointments that are administered to Members must be opened and stored at the Centre (see Section 4.5 and 4.6).
2. Infection Prevention & Control
   1. Staff should wash their hands prior to and after administering medication.
   2. All areas where medication is stored and administered must be kept clean and tidy, including cupboards, trollies, sink, waste bins and floor to reduce risk of contamination/cross infection.
   3. Staff must clean surfaces as soon as they become contaminated, e.g. as a result of split medicines, washing medicines spoons etc. after drug administration.
3. Transcribing
   1. The Service Lead, Service Coordinator and Activites Co-ordinator are able to transcribe.
   2. A separate MAR for each medication is created on a monthly basis using proforma (???) The MAR must contain the following information:
      * + name and date of birth of the Member for whom the medication is intended and up-to-date photograph (taken within the last 12 months)
        + home address and telephone number of member
        + known allergies
        + contact details of GP and pharmacist
        + name of substance to be administered, using its generic or brand name where appropriate and the form in which it is to be administered
        + strength of medication
        + dosage
        + timing of the medication
        + frequency of the medication
        + start and finish dates where stated by the prescriber
        + route
        + any extra instructions from the pharmacist on the label
        + start and finish dates of medication (where available)
        + codes for administration
        + MARs for creams must specify the site of application.
   3. Each MAR must be signed and dated by two senior staff to confirm that the details on the Pharmacist’s label matches the information on the MAR.
   4. Each Member who has medication at the Centre must have an identification sheet which should be available for staff in the MAR folder. This should contain the following information:

* name and photo, date of birth of Member and preferred name
* GP surgery name and details
* special instructions
* allergies
* method of administration, including known difficulties
* preferred drink and support required with medication.

Each identification sheet must be signed and dated by 2 senior staff and when any changes need to be made to take account of the changing needs of the Member.

* 1. Copies of any emails/letters used to transcribe should be filed alongside the MAR and identification sheet.
  2. The following sources of information can be used to complete the MAR:
     + - The pharmacist’s label on the medication packaging.
       - Original prescription chart (can only be used if current within 1 month of dispensing).
       - Email or letter from GP or pharmacist (used when the pharmacist’s label or original prescription chart in unclear or incomplete).
  3. When using the pharmacist’s label on the medication packaging the following checks must be made:
* The packaging must the one in which the medication was supplied by the pharmacist. The only exception to this is paracetamol which can be shop-bought (i.e. without a pharmacist’s label). This can only be used, however, if a written request has been supplied by the Member’s parent/carer. The MAR must be written according to the instructions on the leaflet accompanying the medication.
* The information on the pharmacist’s label must be clearly printed.
* The wording on the label must be unambiguous. Any medication label which states “give as directed” are not acceptable and must immediately be referred back to the prescriber requesting clear instructions regarding dose and times of administration
* The label must have the name and address of the pharmacy.
* Labels on dispensed medicines must not be altered by staff/parents/carers. If a manual change to the label has been made a fax or email from the prescriber must be obtained confirming this change before the medicine is administered
* If the medicine was dispensed more than six months ago check the GP should be consulted to verify whether the Member should still have it.
* Date-expired medicine cannot be given and a new supply must sought by the Member’s parent or carer.

1. Administration of Medicines
   1. Members of Spectrum are usually unable to self-administer medication due to having PMLD. However, where possible, Members should be enabled to participate in the administration of their medication. The level of their participation is based on their Capacity Assessment for the administration of medication.
   2. All members must have a Capacity Assessment for the administration of medication completed and recorded before they take start taking medication at the Centre. This is to assess their level of understanding of their medication and how it is administered.
   3. If a member is deemed - as a result of their capacity assessment - to be able to self-manage their medication, a risk assessment is carried out to determine the risks involved of doing this while they are at the Centre (see section ???). This must ensure the Member is able to administer their medicine safely - and in line with the medical advice given - on a consistent basis. The risk assessment must take into account the environment where the medication is to be administered. An individualized care plan is then created (based on the risk assessment) which involves carers and professionals who work with the member, to specify what (if any) support the Member needs to administer their treatment.
   4. If a Member is deemed, as a result of their capacity assessment, not to be able to self-manage their medication, then a Best Interest decision can be made. This decision is made by a multi-disciplinary team and must be recorded in the individual's support plan. This will involve the administration of their medication by two staff member who are appropriately trained (see Section 3.3).
   5. General procedure for administration of medication to Members:
      1. One of the staff members prepares and administers the medicine and the other must act as a witness. Both members of staff are equally responsible for all aspects of administering the medication.
      2. Every effort should be made to preserve the dignity and privacy of individuals when administering medication. This means being tactful and sensitive; for example, when discussing bowel and bladder function staff should always be handled discreetly. Personal medical information should remain confidential, for example each member’s MAR should not be left where everyone can see it.
      3. Staff administering medications should not be disturbed, unless there is an unavoidable emergency situation. All employees have a responsibility to ensure staff administering medications are not disturbed inappropriately and are supported to concentrate on administering medications safely.
      4. The over-arching principles of medicine administration are to ensure the “5 rights of medicine administration”:

1. Right person

2. Right drug

3. Right dose

4. Right time – check that the dose has not already been given by someone else.

5. Right route, i.e. method of administration.

* + 1. In addition, the expiry date must be checked if the medication is unopened. If the medication has been opened - and is inthe form of a liquid, creams and ointment - the use-by date must be checked (see 4.5 and 4.6).
    2. Do not leave the trolley when it is unlocked.
    3. Select the correct MAR for the Member and check the following:

Member’s identification sheet

* name and photo, date of birth of Member and preferred name
* GP surgery name and details
* special instructions, including support required to take medication.
* allergies
* method of administration, including known difficulties
* preferred drink to take the medication.

Member’s MAR

* name of member
* any known drug allergies
* name of medication
* dose of medication
* route of medication
* frequency and time of administering each dose.
  + 1. Before administering any drugs the following checks should be made:
* Check the name of the Member against the MAR and the medication label.
* Check the Member is ready to take their medication.
* Check that the medication has not already been administered.
* Check that if amendments are made to the label/MAR that they are authorised by the prescriber.
* Employees administering medication must be aware of the Member’s mental capacity in relation to their consent in taking medication (see Section 8.1 – 8.4). Where a Member has capacity to consent to medication, their consent must be sought.
* Check the label on the container against the information on the MAR and the medication label.
* Check the expiry date (or use by date) on container.
* Prepare the medication handling it as little possible. Medicines must be prepared using a ‘clean’ technique — i.e. pushing a tablet or capsule out of the blister directly into a medicine pot. If applying medicine in the form of cream directly to the skin gloves must be worn.
* Check correct route of administration on the MAR and on the medication label.
* Check that the medication is going to be given at the correct time according to the MAR and the medication label.
* Consider any personal preferences of how the Member likes to take their medication (see Member’s identification sheet).
* Staff must witness the Member swallow of the medication. Only when both members of staff are confident that the medication has been taken, can the MAR be signed. The initials of both support workers are needed in the relevant part of the MAR to indicate the medication has been taken.
* All signatures and codes are to be clear and precise.
  + 1. Medicines, once poured or removed from container, should not be put back in the container.
    2. Refusals/declining:
       - Where a Member refuses to take medication, and has capacity to understand the reasons for taking their medication, staff are expected to discuss with the Member the importance of continuing with their treatment and find out the reason why they don’t wish to take it. If the Member does not capacity to understand why they take the mediation, staff must try to find out the reason for the Member declining based on their knowledge of the service user. Where possible, staff must try to resolve the reasons for refusing medication before documenting the refusal.
       - The staff member must not force any Member to take medicine and staff must be aware that all Members have the right to refuse treatment if they repeatedly refuse to take it.
       - If the Member does not take the medication prescribed for them, staff must do the following:
* The appropriate code should be recorded and, where appropriate, the reason specified on the back of the MAR.
* A team leader must be notified of refusal who will then ensure that the parent/carer is notified. A record of the episode must also be made in the Member’s communication book.
  + - * Should the Member refuse medication on more than one occasion, e.g. 3 consecutive occasions for the same medication, staff should discuss with the parents/carers the need to approach the Member’s GP.
      * Where a Member is having difficulty swallowing tablets or capsules, the family should be informed. If the problem persists, staff should discuss with parents/carers the possibility of a SALT referral and arranging for a liquid version of the medication to be prescribed as an alternative.
    1. Contra-indications, side effects and reactions
       - An adverse drug reaction is when a member has an unintended reaction to a drug when no error has occurred in administration. All medication may produce unwanted or unexpected adverse reactions.
       - It is the responsibility of staff to monitor the well-being of each member they visit. If staff have concerns for the welfare of any Members due to a suspected adverse drug reaction, then the following steps are taken:

1. Immediately inform the Service Lead or senior member of staff on duty.

2. Family members / representatives are informed of the concern.

3. The Service Lead or senior member of staff will seek immediate medical advice from the members GP, Consultant or pharmacist and may have to call the local Accident and Emergency department and / or poisons unit (see Section 2.1.)

5. The Service Lead or senior member of staff must record the event using incident form (proforma ???)

6. The Service Lead will discuss initiating a review of the Member’s medication with the GP, Consultant or Nurse Practitioner

* 1. Withholding medication:
     1. Staff can only withhold medication when clear written instructions are given by the Member’s GP.
  2. PRN (Pro re nata) or 'as needed / when required' administration of drugs
     1. This form of medication is given only when the Member is experiencing symptoms for a specific problem (e.g. pain management, constipation, etc.) The medicine must always be prescribed (except paracetamol – see Section 7.7) All PRN medication must be transcribed and recorded onto a separate MAR and must be clearly marked as PRN.
     2. General procedure for administering PRN medication (an addition to steps listed in Section 8.5):
        + Before administering any PRN medication, staff must find out if the medication has been given earlier in the day by checking the MAR and asking the Member’s parent/carer whether it was given before they arrived at the Centre. If it has been given before they came to the Centre, staff must ensure that sufficient time has elapsed before the medication is given again, according to the advice from the pharmacist on the medication label on the container).
        + Staff must always seek permission from the Member’s parent/carer before administering the medication.
        + Staff must always record when PRN medication is given on the MAR – indicating the dose and time, as well as monitor response to the treatment. Staff must communicate to the parent/carer when the medication was given, the dose and the outcome of the treatment.
  3. Over-the-Counter Medicines:
     1. Simple household remedies (or “over-the-counter medicines”), such as cough linctus, which aren’t prescribed by a Prescriber cannot be administered to a Member at any time when they are at the Centre.
  4. Complementary and alternative therapies:
     1. These can only be administered with both a written request from the carer and written confirmation from the Member’s GP/consultant that is safe to be carried out. Staff must have successfully undertaken training and be competent to practise the therapy before the therapy can be carried out at the Centre.
  5. 'Special Measures' Drugs:
     1. Certain controlled Drugs, such as Lithium, Methotrexate, and Warfarin are deemed to be 'special measures' drugs that require additional training because of their potential to cause harm if not administered correctly. Staff at Spectrum do not have the required training to administer these medications.

* 1. Administration of other forms of medicine
     1. As a general principle, care staff do not undertake invasive procedures. However, there may be exceptional circumstances, such as the administration of rectal diazepam, when it might be appropriate to undertake such personal tasks providing the following criteria apply:
        + - The doctor / nursing practitioner gives clear instructions
          - Staff to carry out the procedure are clearly identified
          - Members of staff are appropriately trained and have demonstrated their competencies to carry out the procedure
          - A suitable and sufficient risk assessment is carried out by an appropriately qualified member of staff for each member
          - The relevant service supervisor has agreed to the procedure being carried out based on the assessment
          - A procedure, review and recording process is agreed
          - The administration is fully recorded.
  2. Administration of medicines through an enteral feeding tube (PEG/NG feed)

Administration of medicines through an enteral feeding tube is permissible. Only dispersible and medicines in liquid form can be administered through the tube.

Care workers are not permitted to crush tablets and administer the powder through the tubes as crushing tablets can change the properties of the medicines. All medication administered must be transcribed and recorded onto the members current MAR.

The safe procedure for administering medicines through a tube is:

1. Stop the infusion of feed.

2. To prevent blockage, the enteral feeding tube is flushed before and after feeding of administrating medicines. Flush the feeding tube with at least 30mls of water. Use freshly boiled and cooled at home, or sterile water in hospital (use 1 litre sterile water bottles, start a new bottle every 24 hours. Each member has their own bottle). Enteral feeding tubes for members who are immunosuppressed are flushed with either cooled boiled water or sterile water from a freshly opened container).

3. Administer the dose in an appropriate syringe via the feeding tube.

4. Draw up 10mls of water in the same syringe and administer via the tube to flush.

5. If more than one medication, flush between each drug with a least 10ml of water then repeat steps 2-4 (Each medication requires a separate syringe).

6. Flush the tube with at least 30ml water following administration of the last drug.

* 1. Covert meds
     1. Covert medication is the administration of a medicine without the knowledge or consent of a member e.g. disguising a medication or hiding it in food or drink. Medication is not be administered in this way.

1. Stock control
   1. Auditing of all stored medication takes place on a monthly basis.
   2. Any discrepancies to be reported to the Service Lead and actioned, which must include completion of the following:
      * An incident form completed
      * An investigation is to be undertaken promptly.
      * Submit an improvement plan to address any significant issues identified from audits. This must be actioned within a time frame set by the Service Lead.
2. Disposal of Medications:
   1. Medicines are disposed of when:

* If the medicine has been removed from its container, but has not been taken.
* The medication has been damaged.
* The expiry or use by date has been reached - whichever is the sooner. When a supply of medication is running low or is approaching its use by date, arrangements should be made with the Member’s member or carer to ensure continuity of supply.
* A course of treatment is completed or the prescriber stops the medication.
* The Member for whom the medication is prescribed dies. The medication is kept for at least 7 days after the death because details may be required by the Coroner.
  1. The support worker must arrange to return all unused medicine to the parent/carer. A signature of receipt (using proforma???) is to be obtained from the parent/carer and a full record of all medicines disposed kept (using proforma ???), including date medicine was returned, name and strength of the medicine, quantity returned and the Member for whom the medicines were prescribed. It is then the responsibility of the parent/carer to dispose of medication in line with legislation. In no circumstances is medication to be disposed of by flushing down a sink or toilet into the sewage system.

1. Medication errors
   1. A medication error is defined as any preventable event that may cause or lead to inappropriate use of medicine or harm to a member while the medication is in the control of social care staff. It is the Service Lead’s responsibility to provide an environment where care workers feel comfortable and confident enough to report any errors without fear of prejudice or recrimination. An error may be:

* A transcribing error
* Loss or wastage of a medicine
* An administration error:
* Omitting to administer medication
* To the wrong person
* Via the incorrect route
* At the wrong time
* Of the wrong medication
* Of the wrong dose
* Poor storage or handling.
  1. On discovery or in the event of an error the following steps are taken:

1. The service supervisor of the service or senior member of staff on duty is immediately informed of the error.
2. The Service Lead or senior member of staff will provide the staff member reporting the error with instructions on the actions to be taken.
3. The Service Lead will need to contact GP, Consultant, Nurse Practitioner or NHS Direct for advice.
4. The Service Lead will need to contact the family members carers to inform them of the error.
5. If required, it may be necessary to dial 999 for the emergency services
6. The Service Lead ensures that the medication error is investigated and appropriate actions to prevent recurrence are taken. If the error was thought to be deliberate and intended to cause harm a safeguarding notification will need to be made to CQC / WCC Safeguarding team.
7. For a serious medication error the Service Lead will commission an investigation and make recommendations on how to reduce the likelihood of incident happening again
8. Provisions will be made to support the staff member making the medication error
9. It is advisable for registered services to maintain a system of monitoring all medication errors that can be viewed by the CQC during an inspection.
10. If the error involved a controlled drug, the PCT Controlled Drug Accountable officer is informed.