Rotherham Metropolitan Borough Council

Rotherham Medication Support Guidance

Contracted Home Care and Support Services

Issued June 2023

Approved By	**Jacqueline Clark – Head of Prevention Early Intervention**
Target Audience	**RMBC Contracted Home Care and Support Providers** **RMBC Adult Social Care Staff** **TRFT Pharmacists** **Community Pharmacists** **General Practitioners** **Allied Healthcare Professionals**
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AMENDMENTS

Amendments to this Guidance may be issued from time to time. A new amendment history will be issued with each change.

New Version	Issued by	Nature of Amendment	Approved by & Date	Date on Internet

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Term	Definition/Interpretation
Adult	**the individual receiving support from the Home Care and Support provider.**
Advance care planning	**a voluntary process of discussion about what care a person would or would not want in the future, if they were unable to make decisions because of illness or a lack of mental capacity to consent; the person may also choose to involve their family members or friends in discussions.**
Assessor	**a person who is employed by the Home Care and Support Provider with the relevant skills to undertake an assessment and review of an adult's medication support needs.**
Care worker(s)	**a person who is employed by the Home Care and Support Provider to provide care and support (including support with medication) to people in their own home.**
Competency Assessor	**a person who is employed by the Home Care and Support Provider with relevant skills to carry out an assessment of competency of those with responsibility to administer medication.**
Compliance aid	**a non-tamper-proof system comprising unsealed units filled by the adult or their family.**
Covert administration	**when medicines are given in a disguised form without the knowledge or consent of the adult receiving them.**
'Fair blame' culture	**used in health and social care, to enable open and honest reporting of mistakes that are treated as an opportunity to learn to improve care.**
Health and social care practitioners	**the wider health and social care team of health professionals and social care practitioners (health professionals include, but are not limited to, GPs, pharmacists, hospital consultants, community nurses, specialist nurses and mental health professionals, and social care practitioners include, but are not limited to, care workers, case managers, care coordinators and social workers. When specific recommendations are made for a particular group, this is specified in the recommendation**
Home Care and Support Provider's Assessment	**an assessment of an adult's medicines support needs**
Home Care and Support Provider's Review	**A review of an adult's ongoing medicines support needs**
Medication Administration Record	**the record of medication support given. This can be in the form of an electronic record, written record, or MAR Chart.**
Medication Support	**any support that enables an adult to manage their medicines; dependant on their specific needs.**

Medicine(s)	**includes all prescription healthcare treatments, such as oral medicines, topical medicines, inhaled products, injections, wound care products, and vaccines.**
Monitored dosage system(s)	**a system for packing medicines, for example, by putting medicines for each time of day in separate blisters or compartments in a box. This activity is performed by the pharmacy.**
Original packaging	**the packaging in which the medicine is supplied by the pharmacy - this could be a manufacturers packaging or pharmacy supplied packaging after larger amounts of medicines have been decanted for individual patient use.**
Initial Assessment	**the assessment undertaken by a Social Care Assessor as part of a Care Act Assessment to establish medication support needs of an adult.**
Home Care and Support Provider	**a provider organisation registered with the Care Quality Commission and contracted under the Rotherham Joint Home Care and Support contract 17-156, to provide personal care and support in an adult's home.**
Social Worker /Social Care Assessor	**a social work professional who is employed by Rotherham Council who will carry out the initial assessment in order to refer the adult for medication support to the Home Care and Support Provider.**
Time-sensitive medicines	**medicines that need to be given or taken at a specific time, where a delay in receiving the dose or omission of the dose many lead to serious harm, for example, insulin injections for diabetes or specific medicines for Parkinson's disease.**
Unpaid Carer(s)	**an informal, unpaid carer – usually a family member or friend**

Contents:

Preface:

This policy has been produced by social care commissioners, pharmacists and home care and support providers and developed with input by representatives of the following organisations:

- **Rotherham Council ASC – Strategic Commissioning**
- **Home Care and Support Providers**
- **Rotherham Council ACS – Adult Care and Integration**

1. Introduction

1.1 Medicines are the most common intervention in healthcare. As people live longer, the number of adults with complex needs who live at home is increasing. Consequently, more people are taking multiple medicines to manage their complex needs.

The main responsibility for taking medicines for adults receiving care and support in the community lies with the adult themselves. Where people are able to take responsibility for administering their own medication, independence with this task should be enabled and maximised wherever possible. However there are situations where; adults are unable to take responsibility for the administration of their own medications, do not have an unpaid carer to rely on for this type of support and are receiving care and support in the community from a care worker.

For use prior to giving any support with medication and to meet the Regulator's registration requirements, Rotherham Council has developed this Medication Support Guidance with accompanying procedures, which reflects our organisational circumstances, contractual obligations, and indemnity cover.

Health and social care commissioners have reviewed the local governance arrangements to ensure that it is clear who is accountable and responsible for provision of medicines support.

1.2 The purpose of this Medication Support Guidance is to:

- Provide safe systems and processes for managing medicines for adults receiving care and support in the community.
- Ensure that adults who receive social care are supported to obtain, take and look after their medicines effectively and safely at home.

2. Scope

2.1 This Medication Support Guidance has been developed for contracted Home Care and Support providers with responsibilities for medicines support, it is based on current legislation and best available evidence and includes processes for:

- assessing an adult's medication support needs,
- supporting people to take their medicines,

- joint working with other health and social care providers,
- sharing information about an adult's medicines,
- ensuring that records are accurate and up to date,
- managing concerns about medicines, including medicines-related safeguarding incidents,
- giving medicines to people without their knowledge (covert administration),
- ordering and supplying medicines,
- transporting, storing and disposing of medicines,
- medicines-related staff training and assessment of competency

2.2 This Medication Support Guidance has been developed to help ensure that adults aged 18 years or over, who receive social care in the community get the support needed to manage their medicines safely and effectively.

Supporting adults to take their medicines may involve helping them to take their medicines themselves (self-administration) or giving them their medicines (administration).

Care in the community is defined as care and support in their own home for adults who:

- the local authority has to discharge a duty or responsibility under either the Care Act 2014 or Mental Health Act 1983,
- self-fund their own care and support.

2.3 This Medication Support Guidance is for adults receiving social care in the community and:

- their families and unpaid carers
- providers contracted by the Council delivering home care and support
- community pharmacies, hospital pharmacy, general practices, dispensing doctors, community health providers
- social care practitioners (for example, care workers, case managers, care coordinators and social workers)
- health professionals (for example, GPs, pharmacists, hospital consultants, community nurses, specialist nurses and mental health professionals)
- the commissioner of services (Rotherham Council)
- organisations that regulate or monitor how services are provided (for example, the Care Quality Commission [CQC] or any subsequent body).

2.4 This Medication Support Guidance will be implemented by Home Care and Support providers which are contracted by Rotherham Council under the arrangements of the Home Care and Support Dynamic Purchasing System in place from April 2020 and where there is an Individual Purchase Agreement in place.

2.5 This Medication Support Guidance replaces Rotherham MBC's Contracted Community and Home Care Services (Domiciliary Care) Medication Support Guidance on Medication (Amended 2014).

3. Context

3.1 Policy Context

The Medication Support Guidance has been developed in line with NICE Guidance NG67 – Managing Medicines for Adults Receiving Social Care in the Community: https://www.nice.org.uk/guidance/ng67/resources/managing-medicines-for-adults-receiving-social-care-in-the-community-pdf-1837578800581

The Council will ensure that it keeps up-to-date with changes to medication support in the community by taking note of regulatory guidance on medication issues, observing medication safety alerts and taking account of medication support in the community advice from organisations such as NICE, UKHCA, Royal Pharmaceutical Society, Department of Health and other Local Authorities.

The Better Care Fund (2013) requires NHS commissioners and local authorities to pool budgets and shift resources into social care and community services for the benefit of the NHS and local authorities, to promote integration across health and social care.

3.2 Legislative Context

The following legislation and regulations relating to these guidelines have been published by the UK Government, although this is not intended to be a comprehensive list:

- The Care Act 2014 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Health and Social Care Act 2012
- The Controlled Waste (England and Wales) Regulations 2012
- Care Quality Commission (Registration) Regulations 2009
- Health and Social Care Act 2008
- Mental Capacity Act 2005
- Data Protection Act 1998
- Equality Act 2010
- The Human Medicines Regulations 2012
- The Misuse of Drugs (Safe Custody) Regulations 1973
- Misuse of Drugs Act 1971.

3.3 The Mental Capacity Act 2005

The Mental Capacity Act makes it clear that decisions cannot be made about people aged 16 and over, based on their appearance, age, disability or diagnosis. The starting point every time is the assumption that the person can give consent unless proven otherwise. Guidance on how to assess mental capacity and make best interests can be found in the Mental Capacity Act 2005 Code of Practice.

Before any intervention or act to be carried out, the person must give valid consent for that treatment, which will include the support of the administration

of their medication. The person should be provided with the relevant information they need to make the decision.

The professional prescribing the medication should gain consent and inform the person and the professional (the social care provider) administering the medication should gain consent to support the person. If consent cannot be acquired because of an impairment of or disturbance in the functioning of the mind or brain, then it is likely a best interest's decision will need to be made and recorded.

For example, a GP (Prescriber) determines a person would benefit from a type of medication. The GP (Prescriber) will need to be sure the person is advised of the reasons for need for the medication, the benefits of taking the medication, the potential side effects. If the person can understand the relevant information provided to them in a way they will find easiest, and then retain that relevant information long enough to use or weigh it (e.g. see the reasons for the medical advice to take the medication and balance the consequences of taking or not taking the medication) and can communicate their decision then, regardless of any mental impairment, the person is the decision maker and can consent or refuse. It is their decision.

If the person cannot do the above, and the GP believes that on a balance of probabilities the inability to make the decision is caused by an impairment of or disturbance in the functioning of the person's mind or brain, then he or she can make the decision which must be in the person's best interests and be the least restrictive, unless the decision can wait and there is a possibility that the person might soon be able to make the decision.

It should be noted that if the person cannot make this type of decision and there is a valid Lasting Power of Attorney (LPA) for Personal Welfare decisions or a deputy appointed to make such decisions as ordered by the Court of Protection, then the attorney or deputy is the decision maker (to check if there is a valid LPA or court appointed deputy, the professional should complete form OPG100 to complete a free application for a search of the Public Guardian registers).

The person may also have made a valid advance decision to refuse medical treatment which must be respected. Again, guidance can be found in the MCA Code of Practice.

When administering medication, it is important for the care worker to continue to seek consent from the person, as mental capacity to make decisions is time specific. If the care worker, for example asks the person if they would like to take their medication and the person holds out their hand to take it, that could be seen as consent. But it is also important to be aware that the person may be consenting to a previous prescription; for example, the medication may have been reviewed by the GP (Prescriber) and doses changed without the person knowing. This then could represent a different decision and again the GP (Prescriber) will need to follow the process described above each time medication is reviewed as they would with any other patient.

Thus valid consent will be that which is given freely and without coercion, duress, or influence, even if well intentioned; will be informed in that the person

will be provided with the relevant information, and will be a capacity decision in that the person will be supported so far as is reasonably possible to make the decision.

Seeking consent before prescribing or administering medication in this way is likely to uphold the person's human rights, particularly Articles 3 and 8 of the Human Rights Act 1998 (that is, the right to freedom from torture, inhuman or degrading treatment or punishment and the right to respect for a private and family life, home and correspondence).

3.4 Stakeholder Context

The Medication Support Guidance identifies that each health and social care organisation and practitioner has their own duty and responsibility in relation to legislation.

3.4.1 Prescribers

Prescribers have a duty to prescribe, monitor and evaluate/review medicines. They also have a professional duty to communicate changes in an adult's medicines to the adult, their unpaid carer, care worker or other health professional as appropriate to the adult's individual situation. Prescribers are required to follow their own regulator's professional standards.

3.4.2 Supplying pharmacists

Supplying pharmacists have duties under the Medicines Act (1968) to ensure that medicines are supplied in accordance with the prescription and to take into account an adult's need for support with taking their medicines, for example, under the Equality Act (2010).

3.4.3 Providers

Providers have legal duties under the Health and Social Care Act (2008) (Regulated Activities) Regulations (2014), which include ensuring that the medicines support needs and preferences of an adult are assessed, reasonably met and reviewed when appropriate. They also have a duty to ensure that staff with responsibilities for medicines are suitably qualified, competent, skilled and experienced.

The Care Certificate is a recognised set of standards for non-regulated health and social care practitioners It is designed to ensure that this workforce have a core set of skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support, within an introductory period of their employment. The Care Certificate contains 2 standards in relation to medicines (standards 13.5a and 13.5c).

https://www.cqc.org.uk/sites/default/files/2015024%20Guidance%20for%20providers%20on%20meeting%20the%20regulations.pdf

3.4.4 Qualified nurses

Qualified nurses are accountable for their own professional practice and must adhere to the Code of Conduct of the Nursing and Midwifery Council (NMC).

Those managers who are themselves qualified nurses may be held professionally accountable for upholding the NMC code.

4. General Principles

4.1 Wherever possible, the adult requiring support will remain as independent as possible and will be responsible for administering their medication.

4.2 All medicines are potentially harmful if not used correctly and care must be taken in their storage, administration, control and safe disposal.

4.3 The adult's needs and preferences will always be considered and involve the adult and/or their family members/unpaid carers and the Home Care and Support provider in decision-making.

4.4 A capacitated adult must give their authorisation to the Home Care and Support provider to administer medicines in writing before the care worker may assist with the administration of medication. Where the adult lacks the capacity to provide authorisation (and it is in the best interests of the adult to receive assistance) this must be noted on the Medication Administration Authorisation Form.

4.5 Home Care and Support providers WILL NOT take responsibility for managing an adult's medicines unless an assessment indicates this is a need, and it is documented as part of the Home Care and Support provider's medication support plan. Care workers will only provide medicines support that has been agreed and documented in the provider's medication support plan.

4.6 Home Care and Support providers must ensure that care workers are able to prioritise their visits for people who need support with time-sensitive medicines.

4.7 Care workers must not undertake any tasks that are the responsibility of the prescriber or nursing staff. As part of their induction staff must have adequate and relevant competence-based training on the basic knowledge of medication usage. They must not offer support with medication unless trained to do so and have been deemed competent, only working within the scope of their qualifications.

4.8 Home Care and Support providers will be obliged to have their own Medication Support Guidance or Medication Policy which will as a minimum refer to this Medication Support Guidance and have robust processes for care workers supporting people to take their medicines, including the 6 R's of medicines administration:

1. Right person
2. Right medicine
3. Right route
4. Right dose
5. Right time
6. Right to decline

4.9 Home Care and Support providers should seek advice about medicines from people with specialist experience e.g. prescriber, pharmacist, or another health

professional, when it is needed. There are many different reasons why a care worker might need to do this including:

- Advice about a possible medication reaction.
- Advice about a dropped dose of medicine from a medication compliance aid.
- Advice about missing or missed doses of medication.
- Refusal.
- An adult not being able to take a dose of medicine.
- New medication or change of medication.

Home Care and Support Providers and care workers should advise people and/or their family members/unpaid carers to seek advice from a health professional e.g. the prescriber or pharmacist if they have clinical questions about medicines.

4.10 When medicines related problems occur; Home Care and Support providers, prescribers and pharmacists will have robust processes in place to identify, report, review and learn from incidents and a 'fair blame' culture will be in place that encourages adults and/or their family members/unpaid carers/care workers to report their concerns.

5 Monitored Dosage System (MDS)

5.1 A monitored dosage system (MDS) (a tamper proof system **sealed** appliance), should be considered if packs and bottles are difficult to open or if the adult has difficulty remembering whether he or she has taken medicines. Using an MDS will only be considered when an assessment by a health professional e.g. a pharmacist has been carried out, in line with the Equality Act (2010), and a specific need has been identified to support medicines adherence.

5.2 This will take account of the adult's needs and preferences and involve the adult and/or their family members or unpaid carers and the Home Care and Support provider in decision-making. The adult may qualify for a free service to receive medications in a monitored dosage system or compliance aid from a community pharmacist such as a pill bob, pill cutter, large print labels, accessible and large eye dropper.

6. Limitations

6.1 This Rotherham Medication Support Guidance **does not permit** the following, considered to be healthcare tasks, to be undertaken by Home Care and Support providers

- Give injections
- Give any rectal medication/suppositories/enemas
- Give vaginal medication/pessaries
- Give insulin
- Administer variable doses (i.e. Warfarin)
- Administer through Percutaneous Endoscopic Gastrostomy ‘PEG’
- Apply creams other than moisturising products
- Apply any cream to broken skin

- Assistance with nebulisers and inhaler devices (including spacers) – inhaled medication
- Assistance with the administration of drops for instillation into the eye, ear, or nose
- Apply medication in patches to the skin (transdermal patches)
- Undertake treatment baths as part of wound care or where there is exacerbation of skin disease (where there is an obvious breach in otherwise intact skin)
- Administer medication via a syringe driver
- Administer Buccal Midazolam or other rescue medications
- Administer non prescribed medication or any other forms of medication, homely remedies or over the counter medication unless it is prescribed
- Purchase of General Sales List medicines and homely remedies on behalf of the adult accessing the service if shopping is a requirement of the package.
- Change stoma, colostomy, or ileostomy bags
- Insert catheters
- Apply or change any dressings
- Apply compression stockings/bandaging

6.2 Medication Compliance Aid

If the medication compliance aid (*Non-tamper-proof system **unsealed** units*) has been filled by the adult, their family or unpaid carer, care workers must **NOT** administer medication from these as they could be incorrect /unsafe**.**

Assistance must **NOT** be provided if the adult or their family member fill a compliance aid themselves – this is called secondary dispensing and is unsafe.

Care workers must **NOT** fill medication compliance aids as this involves transferring medicines from the original dispensed container.

6.3 Over the Counter (including homely remedies) Medication:

People who access home care services have as much right as anyone to choose whether to take a headache remedy or other 'over the counter' (OTC) medication. However, OTC medication may interact with prescribed medication and may cause an unknown allergic reaction. Care workers will therefore **NOT** administer OTC medication (including homely remedies) under this Medication Support Guidance **unless it is prescribed**.

6.4 Splitting/crushing of solid dosage forms

The Home Care and Support Provider must **NOT** administer unlicensed splitting or crushing of a solid dosage form or open a capsule or in any way alter the dose of a solid tablet (i.e. with a tablet cutter). Any medications that require splitting or crushing must be referred to the prescriber/dispenser to consider if an alternative formulation is available. If the medication is available in an alternative licensed formulation, for example in liquid form, then the alternative must be prescribed. If there is no alternative licensed formulation, then the

prescriber may wish to consider switching to a similar medication that is available in an alternative licensed formulation.

7. Assessment and Review

7.1 Initial Assessment

Prior to being referred for support with medication consideration will be given on whether the adult (or their family carer/unpaid carer) will be able to manage their medicines themselves. If there is an indication that the adult is unable or has no other support an RMBC Social Worker /Social Care Assessor will undertake an initial assessment and ask the following questions about medicines:

7.1.1 *Do you take any medicines, if so how many different medicines, including any tablets, creams, eye drops, inhalers, creams?*

7.1.2 *Do you have any problems taking or managing your medicines?*

For example:

- forgetting to order , collect or take your medicine(s)
- running out, or having too much, of your medicine(s)
- have difficulty opening, preparing, taking or applying your medicine(s)
- have any problems disposing of unwanted, unused or out-of-date medicines?

7.1.3 *Does anyone normally help you with your medicine(s), for example a friend or relative reminding or helping you to take your medicine(s)?*

7.1.4 *Does taking any of your medicine(s) cause you any problems (for example tiredness or makes you feel unwell)?*

7.1.5 RMBC Social Workers / Social Care Assessors who undertake initial assessments of medicines-related support have systems and processes in place to enable them to access necessary support from health professionals when addressing medicines related issues outside the scope of social care.

7.1.6 Where an adult has complex or specialist needs, adequate assessment of their medicines support needs will require input from both health and social care staff (multi-disciplinary team).

7.2 Home Care and Support Provider's Assessment

7.2.1 Home Care and Support Providers will employ an Assessor to undertake an assessment of an adult's medicines support needs as part of the overall assessment of their needs and preferences for care and treatment and will engage with the adult (and family members/unpaid carers if this has been agreed with the adult) when assessing an adult's medicines support needs.

The assessment will focus on:

- how the adult can be supported taking into account their needs and preferences, including social, cultural, emotional, religious, and spiritual needs
- their expectations for confidentiality and advance care planning
- their understanding of why they are taking their medicines
- what they can do and what support is needed e.g. reading medicine labels, using inhalers, or applying cream
- how they currently order, store and take their medicines
- whether they have any problems taking their medicines, particularly if they are taking multiple medicines
- whether they have nutritional and hydration needs
- whether they are allergic to any medicines
- who to contact about their medicines (ideally the adult themselves, if they choose to and are able to, or a family member/unpaid carer/care coordinator)
- the time and resources likely to be needed.

The Home Care and Support Provider's assessment will be recorded using a document *such as and as a minimum* refer to the items listed at **Medication Support Plan (Appendix A).**

Where an adult is prescribed external medication (e.g. ointments, creams, lotions). A **Body Chart** *such as and as a minimum refer to the one at* **Appendix B** denoting the location on the body on which to apply the medication will be kept with the Medication Administration Record.

7.2.2 Risk Assessment:

The Home Care and Support Provider will carry out a medication risk assessment, *such as and as a minimum refer to the one at* **Appendix C Fuller's Risk Assessment Screening Tool.** If it is assessed that medication support is required a risk assessment must be carried out to identify the possible risk to the adult and/or the care worker.

This screening mechanism helps to identify the level of support an adult is likely to require managing their medication safely and who may need assistance with their medication. The Home Care and Support Provider may need to refer the adult to a community pharmacist for accessible compliance aids such as a monitored dosage system, or 'pill bob', large print labels, and large eye dropper to assist them to manager their medications as independently as possible.

7.2.3 An adult requiring medication support should be referred to their GP for a full medication review to ensure medicine optimisation, the adult's understanding and support safe practice.

7.2.4 A copy of the medication risk assessment is kept with the medication support plan. Any identified changes in the adult's condition may require

a review of the medication current risk assessment and medication review to be undertaken.

7.3 Written Authorisation

Following a person-centred medicine assessment, the Home Care and Support Provider assessor will obtain written authorisation from the adult requiring support with medication if they are capacitated. Authorisation must be given by the adult in writing. This will be recorded on the **Medication Authorisation Form *such as and as a minimum to the one at* Appendix D** which will be kept in the medication support plan as a clearly documented agreement.

7.4 If the Home Care and Support Provider assessor has concluded, following an appropriate assessment, an adult appears to lack the mental capacity to give authorisation, the assessor will carry out the assessment of the adult's capacity to make this decision according to the Mental Capacity Act 2005 Code of Practice and record on the **Mental Capacity Assessment Form (Appendix E).** The Home Care and Support Provider must ensure that the adult and their family members or unpaid carers are actively involved in discussions and decision-making. The assessor will note the outcome of the mental capacity assessment on the Medication Administration Authorisation Form.

7.5 If consent cannot be acquired because of an impairment of or disturbance in the functioning of the mind or brain, then it is likely a best interest decision will need to be made and recorded The assessor will develop an appropriate Medication Support Plan to meet the need for assistance with medication in the best interests of the adult and keep records of the reasons and circumstances of the 'best interests' decision and who was involved in making this decision see **Best Interest Decision Record Form (Appendix F).**

7.6 Where the adult is assessed as lacking capacity to authorise the administration of medication, the assessor will seek to establish if any advance decisions have been made by the adult, if an Enduring Power of Attorney, Lasting Power of Attorney or Deputy is in existence and whether the adult's previously expressed wishes and feelings have been identified and recorded.

The assessor will state on the Medication Authorisation Form how it has been determined that the adult lacks capacity, and how it has been determined and that medication should be administered as prescribed.

7.7 If authorisation is refused, medication must not be administered by the Home Care and Support Provider.

If the Home Care and Support Provider considers that refusal to authorise support with medication will place the adult at risk, the refusal should be reported to the adult's GP.

Where it is felt that refusal of authorisation by an adult is not made of their own free will, it may be appropriate to refer to the Safeguarding Adults Procedures.

8. Levels of Medication Support

8.1 Following an assessment of medication support needs the Home Care and Support provider will reach a view on which level of support is required for the adult. There are 3 levels of support defined as:

- Level 1: General Support
- Level 2: Administering Medication
- Level 3: Administering Specialist Medication

Levels 1 and 2 may be undertaken by Home Care and Support Providers, Level 3 is currently NOT PERMITTED

8.2 The Rotherham NHS Foundation Trust are considering the development of a Delegation of Roles Policy. Home Care and Support Providers will be informed of any change to this Medication Support Guidance as a result.

8.3 Delegation of Healthcare Tasks – Future Development

The administration of specialist medicines and medication delivered by specialist techniques are the responsibility of a health care professional (e.g. a District Nurse). In some circumstances care workers will have undertaken advanced training to enable them to undertake some of the above tasks under the guidance of nursing staff. The health care professional remains responsible for the monitoring of such assistance with health care tasks and in some circumstances the appropriate health authority would need to fund such assistance.

When specific skills are needed to give a medicine e.g. using a percutaneous endoscopic gastrostomy [PEG] tube Health professionals will only delegate the task of giving the medicine to a care worker in accordance with the Delegation of Roles Policy and when:

- There is local agreement between health and social care that this support will be provided by a care worker
- The adult (or their family member/unpaid carer if they have lasting power of attorney) has given their consent
- Responsibilities of each person are agreed and recorded
- The care worker is trained and assessed as competent
- The care worker has written authorisation from the appropriate contact.

8.4 **Level 1: General Support**

General support is given when the adult still retains responsibility for their own medication. In these circumstances the care worker will always be working under the direction of the adult receiving care.

When included as a requirement in the Medication Support Plan, the **general support** given may include some or all the following:

8.4.1 Requesting repeat prescriptions from the GP / Pharmacy

8.4.2 Collecting medicines from the community pharmacy/dispensing GP surgery (ID will be required and care workers may be required to sign for receipt of medications by the Pharmacist). Medication received should be checked that it matches the medication and dosage prescribed and is listed on the appropriate documentation.

8.4.3 Disposing of unwanted, discontinued, unused or out of date medicines safely by returning them to the supplying pharmacy/dispensing GP practice (When requested by the adult or with their consent). A receipt should be obtained from the Pharmacist and a record made in the daily care record and **Medication Administration Record** *such as and as a minimum refer to the one at* **Appendix G** so that medication audits will be accurate.

8.4.4 Manipulation of a container, for example opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the adult and when the care worker has not been required to select the medication.

8.4.5 Giving an occasional reminder to the adult to take their medicines. In doing so the care worker is checking that medication has been taken.

- If an adult is remembering to take medication before the reminder then no action is required.
- If by reminding the adult this leads to the adult taking their medication, the care worker will need to complete the daily record or Medication Administration Record (MAR).

NB: If this occurs for 3 consecutive days, or on a regular basis the care worker will inform their line manager who will arrange a medication review with the adult.

A persistent need for reminders or where an adult is forgetting to take his/her medication may indicate that they do not have the capacity (mental or physical) to take responsibility for their own medication and should trigger a review of the Medication Support Plan. This may require a full medication review by the prescriber and dispenser or both.

The care worker must notify their Line Manager immediately so that they can request that the Medication Support Plan be reviewed and record the notification in the communication record.

The Home Care and Support provider will then notify the Social Worker / Social Care Assessor directly if the adult has a worker allocated to them at that time or via the Council's First Contact service in situations where the adult is not currently allocated a worker.

The Home Care Provider should await confirmation that the Adult Care and Support service has reviewed and made alternative arrangements for support with medication and notified the Home Care and Support provider of these formally and in accordance with the agreed process.

8.5 Level 2: Administering Medication

Administering Medication is where the care worker is responsible for removing medication from the container and directly administering the medication.

8.5.1 Administration of medication may include some or all the following:

- Regular reminders to take medication
- Prompts to take medication because the adult would not take the medications otherwise.
- Selection and preparation of medicines for immediate administration
- Placement of oral medication into the mouth of an adult
- Selection and measurement of liquid medication

8.5.2 Medicines with a ‘when required’ dose (PRN)

Medicines with a ‘when required’ dose (PRN) can be prescribed to treat short term medical conditions (such as nausea and vomiting) or long-term conditions when people experience pain and indigestion, anxiety and insomnia.

The Medication Support Plan should contain enough information to support staff to administer PRN medicines as the prescriber intended. This should include:

- details about what the medicine is for
- the reasons for giving the 'when required' medicine
- symptoms to look out for and when to offer the medicine
- what the medicine is expected to do
- whether the person can ask for the medicine or if they need prompting or observing for signs of need, for example non-verbal cues
- the minimum time between doses if the first dose has not worked
- when the medicine should be reviewed and how long the person is expected to take the medicine
- where there is more than one option available, for example multiple painkillers the order in which they should be tried should be made clear. For example, paracetamol first, then codeine if pain not resolved.
- when to check with the prescriber if there is any confusion about which medicines or doses are to be given
- how to record 'when required' medicines on the MAR resident's care plan.

This information should be kept with the Medicines Administration Record (MAR) and the exact time the medication was given, and the amount given should be recorded.

If PRN medicine is given regularly then a referral to the GP should be considered to request a medicines review.

If medicines do not have the expected effects (such as effective pain relief) the GP should be contacted.

Responses from the GP about queries to medicines should be clearly recorded.

8.6 Level 3: Administering Specialist Medication

8.6.1 Occasionally an adult will require medication support beyond Level 2 and require specialist medication administered by a specialist technique such as:

- Apply medicated creams e.g. steroid based creams
- Inserts drops to ear, nose or eye
- Administering of inhaled medication
- Administering of oxygen
- Medication by pre-filled pen (NOT needle/syringe).
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Applying Transdermal patches

8.6.2 Care workers are **NOT permitted** to administer medication to an adult assessed to require Level 3 support.

The Home Care Provider should await confirmation that the Commissioning service has reviewed and made alternative arrangements for support with medication and notified the Home Care and Support provider of these formally and in accordance with the agreed process.

8.6.3 Where an adult has complex or specialist needs, adequate assessment of their medicines support needs will require input from both health and social care staff (multi-disciplinary team).

8.6.4 Where it is apparent that the adult receiving support with medication has become to require Level 3 support, the Home Care and Support provider will immediately notify the:

- The Social Worker / Social Care Assessor directly if the adult has a worker allocated to them at that time **or** the Council's First Contact

service in situations where the adult is not currently allocated a worker.

9. Home Care and Support Provider's Medication Support Plan:

9.1 Medication Support Plan

The Home Care and Support Provider will record discussions and decisions about the adult's medicines support needs and include:

- the adult's needs, preferences, and expectations for confidentiality and advance care planning
- how consent for decisions about medicines will be sought
- details of who to contact about their medicines (the adult or a named contact), support needed for each medicine and how it will be given
- who will be responsible for providing medicines support, particularly when it is agreed that more than one care provider is involved
- when medicines support will be reviewed e.g. 6 weeks.
- When a family member/unpaid carer gives a medicine e.g. during a day out, agree with the adult and/or their family member or unpaid carer how this will be recorded.

9.2 The above information **MUST** be recorded in a Medication Support Plan which must be accessible in the adult's home, or on request and focus on how the adult can be supported to manage their own medicines. The information must include:

- The level of support required i.e. Level 1, Level 2 or whether referred for Level 3 assessment
- Consent to support with medication and how consent is indication on a day to day basis
- The adult's preferences (person centred support)
- Details of supplying Pharmacy
- Details of supplying GP Practice
- Who is responsible for orders/delivery/collection/storage/disposal
- Times of day for support
- Storage of medication in the property
- An up to date list of medications (Medication Profile)
- Known allergies
- Any special requirements, e.g. time specific
- What to do if the adult is having a meal or sleeping
- What to do if the adult is going to be away for a short time e.g. visiting family
- How to give specific formulations of medicines e.g. liquids
- Instructions on using the correct equipment e.g. oral syringes for small doses of liquid medicines
- Directions about giving time-sensitive or 'when required' medicines
- What to do if the adult has declining or fluctuating mental capacity.

9.3 Home Care and Support Provider's Review of the Medication Support Plan

The Home Care and Support provider will review an adult's medication support plan at least annually or when carrying out an overall Home Care and Support Plan review or when required. This should be carried out at the time specified in the Home Care and Support provider's Medication Support Plan or sooner if there are changes in the adult's circumstances.

Once the review has taken place, any changes should be documented in the Medication Support Plan and communicated to care workers. A review might also take place for other reasons, such as:

- A change in the adult's condition
- Changes to their medicine's regime
- A concern is raised
- A hospital discharge
- A life event, such as bereavement
- A debilitating illness
- A change in the adult's capabilities.

If there is a change in an adult's condition or medication, they should be referred to their GP for a full medication review; to ensure medicine optimisation, the adult's understanding and support safe practice.

10. Communication and Joint Working

10.1 Joint Working

Joint working is crucial as it enables the adult to receive integrated, person-centred support. Health professionals working in primary and secondary care have a vital role in advising and supporting care workers and other social care practitioners.

It is important that information about medicines is shared with the adult and their significant others e.g. unpaid carer(s), and between health and social care practitioners, to support high-quality care.

10.2 Home Care and Support providers with responsibilities for medicines support will:

10.2.1 Notify an adult's general practice and supplying pharmacy when starting to provide medicines support, including details of who the general practice and supplying pharmacist should contact i.e. the Home Care and Support provider and the adult receiving medication support's name or their named contact.

10.2.2 Have robust processes for communicating and sharing information about an adult's medicines, that takes account of the adult's expectations for confidentiality. This includes communication with:

- the adult and their family members/unpaid carers,
- care workers and other social care practitioners,

- health professionals e.g. adult's GP or supplying pharmacist,
- other agencies e.g. when care is shared, or the adult moves between care settings.

10.2.3 Take into account the 5 rules set out in the Health and Social Care Information Centre's 'A guide to confidentiality in health and social care (2013) when sharing information.'

- Confidential information about people or patients should be treated confidentially and respectfully
- Members of the care team should share confidential information when it is needed for the safe and effective care of an individual.
- Information that is shared for the benefit of the community should be anonymised.
- An individual's right to object to the sharing of confidential information about them should be respected.
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.

10.3 Receiving Communication about Changes

Home Care and Support providers with responsibilities for medicines support receiving communication about changes to an adult's current medicines will have robust processes for handling changes to an adult's current medicines received verbally from a prescriber, including:

- Recording details of the requested change (including who requested the change, date and time of request and who received the request),
- Reading back the information that has been recorded to the prescriber requesting the change to confirm it is correct (including spelling the name of the medicine),
- Asking the prescriber requesting the change to repeat the request to someone else e.g. to the adult and/or a family member/unpaid carer.
- Inform the adult's supplying pharmacy, if this is needed and agreed with the adult and/or their family members or unpaid carers.
- Ensure the MAR chart/or medication instructions is updated to reflect the change of medication.
- Communicate the change to all the adult's care workers.

Any change in the dose of previously supplied medication should be communicated to the Home Care and Support Provider by the prescriber. Verbal instruction for dose changes may be acceptable **only if** the above procedures are in place to ensure the safety of the adult.

Verbal instructions from the prescriber which are given to the Home Care and Support provider's responsible person should be confirmed by a witness and a written confirmation should be given by the prescriber.

The Home Care and Support Provider **should not accept verbal instruction for new medications to be given.**

10.4 Hospital Appointments Admission and Discharge

10.4.1 Hospital Appointment

If an adult receiving support with medication attends an outpatient appointment, they should take a copy of the repeat prescription with them. Where a routine medication is recommended at an outpatient appointment the hospital will write to the GP of the adult receiving medication support outlining the reasons for this. The GP will consider the recommendation and prescribe any necessary medication if appropriate. The GP will then inform the Home Care and Support Provider that there is a new medication and supply a prescription. The normal procedure can then be followed.

10.4.2 Hospital Admission

If an adult receiving support with medication is admitted to hospital and the Home Care and Support Provider is aware, they should arrange for all medication to be sent with them. The original Medication Administration Record (MAR) should remain in the home of the adult receiving support with medication.

10.4.3 Hospital Discharge

A person receiving support with medication may be discharged from hospital with medication that differs from that which they had before admission. Where medication has changed the original MAR will be superseded by another. The newest version of the MAR should be used, and the superseded MAR returned to the Home Care and Support Provider's office in the normal manner.

All adults discharged with a package of care provided at home, which includes support with medication, **MUST** be reviewed in their home as soon as possible following discharge. The Home Care and Support Provider must prioritise a risk assessment *such as and as a minimum refer to the* Fuller's Risk Assessment and a review of their Medication Support Plan. An Authorisation form should be completed and provided to the patient's regular community pharmacy.

If the person did not receive assistance with their medication before admission but it is assessed that they will need this on discharge, the Home Care and Support Provider will complete a risk assessment *such as and as a minimum to refer to the* Fuller's Risk Assessment and produce a Medication Support Plan (see section 7).

11. Supporting someone to take medication:

11.1 Before supporting someone to take medication the following steps /measures must be taken /put in place:

11.1.1 Personal Protective Equipment (PPE) and Hygiene

Hand washing is the single most important practice needed to reduce the transmission of infection and is an essential element of standard infection prevention and control principles. Care workers must wash their hands before and after handling medication.

Care workers must wear the PPE and follow infection prevention and control measures in line with Government Guidance.

11.1.2 Package Information Leaflet (PIL)

Prior to administering medication Home Care and Support providers should ensure that an up-to-date Package Information Leaflet (PIL) for each prescribed medicine is kept in the adult's home.

11.1.3 Medication Administration Record (MAR)

Home Care and Support providers with responsibilities for medicines support should have robust processes to ensure that MARs are accurate and up to date e.g. changes must only be made and checked by people who are trained and assessed as competent to do so.

Ensure that MARs include:

- the adult's name, date of birth and any other available person-specific identifiers, such as the adult's NHS number
- the name, formulation and strength of the medicine(s)
- how often or the time the medicine should be taken
- how the medicine is taken or used (route of administration)
- the name of the adult's GP practice
- any stop or review date
- any additional information, such as specific instructions for giving a medicine and any known drug allergies.

Home Care and Support providers should record any additional information to help manage time-sensitive and 'when required' medicines in the adult's medication support plan.

11.2 Giving medication

11.2.1 Step One

Care workers should check:

There is authorisation and clear instructions to give the medicine e.g. on the dispensing label of a prescribed medicine, **AND** the 6 R's of administration have been met:

- Right person
- Right medicine
- Right route
- Right dose
- Right time
- Person's right to decline

11.2.2 Step Two

Before supporting an adult to take a dose of their medicine care workers should each time:

- ask the adult if they have already taken the dose and check written records to ensure that the dose has not already been given
- check the adult consents to receiving support in giving their medicines
- If the label has become detached from the container, is illegible, or has been altered, the medication **MUST** not be administered
- Ask the adult if they are ready to take their medicine, before removing it from its packaging, unless this has been agreed and it is recorded in the provider's medication support plan
- Check the medication record to see if the name on the label corresponds to the name listed on the Medication Administration Record
- Check the expiry date, do not give medication that has passed the expiry date, record on the Medication Administration Record that the medication has not be given and report to the line manager.

11.2.3 Care workers should give medicines directly from the container they are supplied in. They should not leave doses out for an adult to take later unless this has been agreed with the adult after a risk assessment has been completed, (*and they have capacity to make an informed decision)* and it is recorded in the Home Care and Support provider's medication support plan.

11.2.4 When an adult decline to take a medicine, care workers should consider waiting a short while before offering it again. They should ask about factors that may cause the adult to decline their medicine, such as being in pain or discomfort. If the medicine is still declined, advice from a healthcare professional should be sought.

11.2.5 If a care worker believes that the adult receiving support is unable to give consent to taking a medicine, due to a lack of capacity, withdraws consent or refuses support then they must act in accordance with the requirements of the Mental Capacity Act 2005. The care worker must record the incident in the Medication Support Plan daily record and MAR chart and refer to their direct line manager immediately.

12. Record keeping

12.1 Home Care and Support providers are required by law (The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014) to securely maintain accurate and up-to-date records about medicines for each adult receiving medicines support. This includes details of all support for prescribed medicines.

Home Care and Support providers with responsibilities for medicines support should have robust processes for recording an adult's current medicines and

ensure that records are accurate and kept up to date, accessible, in line with the adult's expectations for confidentiality.

12.2 Care workers must record the medicines support given to an adult for each individual medicine on every occasion, in line with Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance including details of all support for prescribed medicines, such as:

- reminding an adult to take their medicine
- giving the adult their medicine
- recording if the adult has taken or declined their medicine

12.3 Care workers should use a Medication Administration Record to record any medicines support that they give to an adult. This will be a printed record provided by the supplying pharmacist, dispensing doctor however, there may be occasions when the Medication Administration Record will need to be produced by the provider.

For medicines administered from a monitored dosage system a Medication Administration Record will be used to record medicines administered.

The Medication Administration Record must be accurate and up to date and the provider should have robust processes to ensure this. Any new records, additions or changes should only be made and checked by people who are trained and assessed as competent to do so.

A Medication Administration Record will be kept in the adult's home with the support plan when administration is required. The Medication Administration Record can be in a variety of formats, including electronic and written documentation. The Medication Administration Record must be made available to any visiting clinician or others who are authorised to administer medication e.g. paramedic. Where electronic records are used, a copy of the electronic record provided upon request.

A Medication Administration Record must be maintained by the care worker for each person who is receiving administration of their medication. Where a Medication Administration Record is not available, the care worker should inform their appropriate contact before administering any medication and arrangements can be made to provide a Medication Administration Record.

12.4 Effective record keeping must be:

- Factual, consistent and accurate
- Abbreviations and jargon should not be used
- Accessible, in line with the adult's expectation for confidentiality
- Recorded as soon as possible after the event, recording current information on the condition of the adult
- Written clearly, legibly and in a way that cannot be erased, using black ink

- Alterations or additions should be signed and dated; the original entry must still be legible.

12.5 The Care Worker must confirm that a dose has been administered by observing that the medication has been taken and only then entering their initials or signature in the appropriate administration record box on the chart.

- Medication administered to a person must be recorded at the time of the administration.

- For time specific medication, the time of administration must be recorded on the MAR.

Any alterations to the MAR that cannot be shown as coming from an authorised medication source will not be administered without clarification. These alterations should be signed and dated by the clinician or alternatively written authorisation should be provided.

13. Covert administration

13.1 Every adult is assumed to have the capacity to consent to whatever care and treatment is offered. This also extends to withdrawing this consent even if everyone else thinks this decision might be detrimental to the adult's health and well-being. Consent is therefore required prior to supporting with medication and likewise adults can withdraw their consent to take medication any time it suits them.

13.2 If consent is withdrawn, the Home Care and Support Provider must seek advice from a GP. Ensure that covert administration of medicines only takes place in accordance with the requirements of the Mental Capacity Act 2005 and good practice frameworks (Mental Capacity Act 2005: Code of Practice) to protect both the adult and care workers.

13.3 Giving medication covertly could be interpreted as an infringement of a person's human rights. Care workers must not give, or make the decision to give, medicines by covert administration, unless there is clear authorisation and instructions to do this in the provider's Medication Support Plan, in line with the Mental Capacity Act 2005. Decisions to administer medication covertly is made by the prescriber (see section 21). Home Care and Support Providers will ensure that; covert administration of medication is only carried out as authorised by the prescriber and clearly communicated to the care worker and recorded in the Medication Support Plan.

Appendix E - Record of a Mental Capacity Assessment in respect of being given medication

14. Medication Administration Record and Transcribing:

14.1 Medication Administration Record should ideally be a printed record provided by the supplying pharmacist; however, there may be occasions when the Medication Administration Record will need to be produced by the provider.

Circumstances when transcribing is required include:

- The person's pharmacy does not supply a Medication Administration Record.
- There has been a planned discharge from hospital and the medication has changed (current Medication Administration Record does not reflect changes).
- Medication has been prescribed during an interim visit e.g. the service user has been prescribed antibiotics.

14.2 Medical advice must be sought before medicines are transcribed or administered if there are concerns about the safety of transcribing:

- Due to the quality of the information available
- A discrepancy between the information and the medication provided
- Any additional medicines (e.g. bought over the counter or herbal medications) not listed in the medication source.

This should be documented in the person's Medication Support Plan.

14.3 Transcribing Process:

The appropriate, competent member of staff should carefully transcribe the details onto the Medication Administration Record using one of the following, listed medication sources:

- An original prescription signed by a prescriber from primary care, which may be the right-hand side/counterfoil of the current prescription.
- A secondary care discharge prescription or outpatient prescription.
- A printed or written record obtained from the service user's GP detailing current prescribed medication.
- The pharmacy label on the current medicine container/box.
- A copy of the current Medication Administration Record from the previous care setting.

14.4 Where the pharmacy label on the medicine container/box is used there must be a check to ensure that the medicines are current and fit for purpose. The label on the packaging must be clear and unambiguous and includes all the following:

- The service user's name (checking that this is the correct person)
- The name of the medicine inside the packaging (also checking that it matches the medicine named on the label)
- The expiry date of the medicine (checking that this has not been exceeded)
- All directions are clear and legible.

14.5 The above medication details must be transcribed onto the Medication Administration Record.

All information must be printed or handwritten legibly in ink or accurately entered into the electronic medication record and must meet the following requirements:

- The person's full name and date of birth should be clearly written on all Medication Administration Records.
- All medicine names and instructions must be written in full as printed on the label or from other source. Any ambiguity in the instructions must be checked.
- The following medication details must be stated:
    - Name of the medicine
    - Form e.g. tablets, capsules
    - Strength (NB pay attention to milligrams/ micrograms)
    - Dose and frequency
    - Route of administration
    - Time of administration
    - Duration of treatment (if known or applicable)
    - Any special instructions and advice labels e.g. take with or after food, disperse in water, may cause drowsiness, should be included
    - Any advice label or warnings, that cannot fit on the Medication Administration Record should be highlighted, for example, by adding **see advice on the pharmacy label**
    - The transcriber must sign and date against each item and print their name along with their signature on the back of the Medication Administration Record
    - If a service user needs more than one Medication Administration Record, they should be clearly marked sequentially on the front 1 of 2, 2 of 2 etc.
    - Details of any allergies or intolerances must be stated in the space indicated. If none are known record 'Not known'.
    - The quantity of each medication received should be recorded.

14.6 Attach the medication source, where applicable, to the Medication Administration Record to allow the GP or others to check. The person's Care/Support Plan must be documented identifying that the Medication Administration Record has been transcribed, listing the medicine sources used and the date of the source. Alternatively, document the source, for the GP to check, saving a hard copy in the patient's file.

14.7 If informed verbally by the prescriber of any dose change or if a medication is stopped, then the Medication Administration Record must be altered accordingly and checked by another member of staff. The changes must be recorded as a new entry. The original entry must not be altered, instead it should be crossed though (with a single line) stating "See new entry" and include the date of the change. Furthermore, the pharmacy label will need to be marked "See new directions on Medication Administration Record".

Written confirmation of the change must be requested from the prescriber to verify this and retained with the person's records.

14.7.1 Checking

The transcription must be checked by a second competent member of staff as soon as possible. The ‘checker’ must ensure that the original source of information matches the transcription. The ‘checker’ must sign and date against each item and print their name along with their signature on the back of the Medication Administration Record. Medical advice must be sought if any discrepancy cannot be resolved between the transcriber and checker.

14.7.2 Remote Checking

It may not always be possible for a member of staff to witness ‘live’ the transcribing such as when the Medication Administration Record is being amended in the adult’s home by a care worker working alone. In such cases the care worker can use a work mobile phone or tablet device to photograph the amendments and the listed source. The consent of the adult should be obtained. This evidence can be transmitted to the person witnessing the accuracy of the transcribing, and who may be based at the office.

Note that any information stored on a mobile device must be deleted as soon as possible.

14.8 Care Worker Administering Transcribed Medicines

If there is any uncertainty regarding accuracy or appropriateness of transcribed medicines, then clarification should be sought immediately. The care worker must seek clarification from the transcriber. If there is still uncertainty, advice must be sought from the GP or the dispensing pharmacy. If none are available, the unpaid carer should contact 111 for advice.

Recording the Medication Profile:

The Medication Profile will be created by the Home Care and Support provider using the information provided by the prescriber/dispenser. This will be updated every review or as and when the Home Care and Support provider is notified of any changes to the adult’s medication.

The Home Care and Support provider relies on receiving this information from the GP and is only expected to keep the medication profile up to date in accordance with the notifications received from the Prescriber.

15. Ordering prescribed medicines

15.1 Home Care and Support providers should agree with the adult and/or their family members/unpaid carers who will be responsible for ordering medicines and record this information in the provider's medication support plan. This should be the adult, if they agree and are able to, with support from family members/unpaid carers/care workers (if needed).

When Home Care and Support providers are responsible for ordering an adult's medicines, they:

- must ensure that the correct amounts of the medicines are available when required, in line with Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- should not delegate this task to the supplying pharmacist (or another provider), unless this has been requested and agreed with the adult and/or their family members/unpaid carers.

15.2 When Home Care and Support providers are responsible for ordering an adult's medicines, they should ensure that care workers:

- have enough time allocated for checking which medicines are needed, ordering medicines and checking that the correct medicines have been supplied,
- are trained and assessed as competent to do so.

15.3 When ordering an adult's medicines, care workers should:

- Order medication using the method agreed with the adult and detailed in the Medication Support Plan
- Place the order in good time to allow time for the prescription to be generated and the items to be dispensed. There should be 7 – 10 days' supply remaining when the medication is ordered
- Wherever possible use the adult's preferred regular pharmacy this means that the pharmacy has a complete record of the adult's medication
- Record when medicines have been ordered, including the name of the medicine
- When medicine is received or collected, staff should update the Medication Administration Record, detailing the name strength and form of the medicine supplied, the date of supply and the quantity supplied. The member of staff making the record should sign and date it.
- Check for any discrepancies between the medicines ordered and those supplied and notify their line manager of any discrepancies.

Home Care and Support providers should ensure that care workers know what action to take if a discrepancy is noted between the medicines ordered and those supplied.

16. Transporting, storing, and disposing medicines

16.1 Transporting

Home Care and Support providers should agree with the adult and/or their family members or unpaid carers who will be responsible for transporting medicines to or from the adult's home. They must encourage the adult to take responsibility for this, if they agree and are able to, with support from family members, unpaid carers or care workers only if needed. The Home Care and Support Provider must record this information in the medication support plan.

16.2 If a care worker is involved, the Home Care and Support provider must carry out a risk assessment of transport arrangements.

Controlled Drugs

Care workers collecting controlled drugs (CD's) prescriptions from the pharmacy/dispensing doctor practice will need to provide personal identification, such as an ID badge with photo.

Once a Controlled Drug is in the adult's own home, the safe storage and recording requirement for Controlled Drugs does not apply. However, care should be taken with storage to minimise any risk of inappropriate access to the medicines.

16.3 Storing:

When Home Care and Support providers are responsible for storing an adult's medicines, they should ensure that all medication is stored in the original packaging that they were dispensed in and ensure they are stored away from heat and light sources and out of the reach of children. Some medication may need to be stored in the fridge. If this is necessary, it will be indicated on the medication label. If in doubt, the dispensing pharmacist must be contacted to clarify. Home Care and Support providers should have robust processes to ensure safe access to medicines, particularly for Controlled Drugs (see). NICE pathway; Controlled drugs: safe use and management - https://pathways.nice.org.uk/pathways/controlled-drugs-safe-use-and-management

NB: - Where concerns are raised involving controlled drugs, Home Care and Support Providers are required to report the matter to their NHS England area team Controlled Drugs Accountable Officer (CDAO).

16.4 Secure Storage:

When an adult is assessed to be at risk because of unsecured access to their medicines, they may agree that secure storage is in their best interests and this should be documented in the medication support plan. If an adult lacks capacity this decision should only be made after a mental capacity assessment has been conducted and a best interest decision made, and this decision is recorded in the Medication Support Plan. Where a secure home storage unit is needed, such as a lockable cupboard. The Home Care and Support Provider must:

- identify who should have authorised access to the medicines
- seek advice from a health professional about how to store medicines safely, if needed
- ensure there is a safe storage place or cupboard for storing medicines including those supplied in Monitored Dosage System
- assess the need for secure storage e.g. in a lockable cupboard
- identify the need for fridge storage

- review storage needs e.g. if the adult has declining or fluctuating mental capacity.

16.5 Disposing of medicines

When Home Care and Support providers are responsible for disposing of any unwanted, damaged, out-of-date or part-used medicines, they must have robust processes, in line with The Controlled Waste (England and Wales) Regulations 2012. Including:

- obtaining agreement from the adult (or their family member/carer),
- how medicines will be disposed of, usually by returning them to a pharmacy for disposal,
- any special considerations e.g. for disposal of CD's, needles and syringes, what information needs to be recorded e.g. the name and quantity of medicine, the name of the adult returning the medicine, the date returned and the name of the pharmacy.

17. Managing concerns about an adult's medicines

17.1 Care workers should raise any concerns about an adult's medicines with the Home Care and Support provider to be escalated to the appropriate health professional, prescriber, community pharmacist, etc if required. These concerns may include:

- the adult declining to take their medicine
- medicines not being taken in accordance with the prescriber's instructions
- possible adverse effects (including falls after changes to medicines; see NICE pathway: Falls in older people)
- the adult stockpiling their medicines
- medication errors or near misses
- possible misuse or diversion of medicines
- the adult's mental capacity to make decisions about their medicines
- changes to the adult's physical or mental health.

17.2 Home Care and Support providers with responsibilities for medicines support must have robust processes for:

- medicines-related safeguarding incidents, in line with Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Also see NICE pathway: Home care for older people.
- Medicines-related contract concerns in line with the Home Care and Support - 17-156.
- identifying, reporting, reviewing and learning from medicines-related problems.

These processes should support a person-centred, 'fair blame' culture that actively encourages people and/or their family members/unpaid carers/care workers to report their concerns.

17.3 Drug Interactions

There is a possibility that two medicines taken at the same time may interact with each other. Both the GP and the dispensing pharmacist should be aware of this risk with prescribed medicines. However, there is also a risk of an interaction with non-prescribed medicines, certain foods (e.g. grapefruit) and alcohol. Therefore, care workers should remind the person of the potential for adverse effects of alcohol consumption whilst taking some medication. Where a known interaction exists between a medicine and alcohol, a warning should appear on the label of the medicine container.

17.4 Side Effects

Some medication causes side effects and the care worker should be alert to this possibility and report any concerns to their manager.

17.5 Adverse Drug Reactions – Yellow Card Reporting

An Adverse Drug Reaction (ADR) is an injury caused by taking a medication. ADRs may occur following a single dose or prolonged administration of a drug or can result from the combination of two or more drugs. The **Yellow Card Scheme** is the UK system for collection information on suspected ADRs to medicines. The scheme is intended to improve the safety of the medicines.

When necessary, the appropriate contact of the care worker, or their manager should discuss any concerns relating to a person's medication with the supplying Pharmacist or the GP.

18. Medication errors and incidents:

18.1 All medication errors and incidents will be referred to Rotherham Council as a Safeguarding Alert to be screened to assess if the incident constitutes abuse or neglect, including gross negligence or intentional misuse of medication.

Examples of Medication Errors and Incidents where the cause is Home Care and Support Providers with responsibility for supporting people with medicines are:

18.1.1 Preparation and Administration Errors:

- Administered the wrong medication / dose / route
- Adult administered an out of date medicine
- Medication administered to the wrong adult
- Medication incorrectly prepared
- Unauthorised administration i.e. disguised in food without an agreed covert medication support plan
- Medication administered late / early
- Administration of medication recorded incorrectly or not recorded
- Failure to ensure staff competence in medication administration
- Failure to manage changes in an adult's prescribed medication (for example Medication Administration Record not updated at time of transfer of care).

18.1.2 Incident

If the incident has resulted in an administration error (i.e. the adult has received the wrong medication, wrong dose or at the wrong time):

- Seek immediate medical advice from a pharmacist or doctor
- Ask about any immediate actions needed and about potential side effects of error. Monitor the adult's condition according to advice from pharmacist or doctor
- **Call 999** if the adults' condition deteriorates
- Preserve any evidence and contact the police immediately if you think a crime has been committed (**999 for emergencies or 101 for situations that do not need an immediate emergency police response**).
- Take any immediate steps you can to prevent the abuse or neglect continuing. Consider any immediate actions needed to protect others at risk of abuse and neglect.

18.1.3 For all medication incidents

If an error involves another agency e.g. GP or pharmacists, contact them to rectify the issue and make them aware (to help learning and prevent future incidents).

- Take any other immediate action you can to reduce risk of incident happening again
- Report the incident through your line manager or through your organisation's procedures
- Contact the Community Pharmacist or Medicines Management teams for advice and support around medication systems.
- For a medication review contact the Community Pharmacist.

19. Training and competency

19.1 Home Care and Support providers with responsibilities for medicines support, should have robust processes for medicines-related training and **Medication Administration Competency Assessment *as a minimum include the detail of* (Appendix H)** for care workers, to ensure that they:

- receive appropriate training and support, have the necessary knowledge and skills,
- are assessed as competent to give medicines support being asked of them, including direct observation,
- have an annual review of their knowledge, skills and competencies,
- follow the Home Care and Support – Service Specification on recruiting, training, and supporting home care workers.

The Competency Assessor undertaking the competency assessment must themselves be trained and competent in the administration of medication and authorised to assess others by the Registered Manager of the Home Care and Support Service Provider.

19.2 Essential training and assessment of knowledge and skills should include:

- Awareness of and abiding by the Rotherham Council Medication Support Guidance and procedures regarding the adult's medication, in line with CQC and NICE guidance
- Understanding best practice guidance on the day to day handling and levels of support required with medication within the organisations agreed ways of working
- Understanding how medicines are used and are aware of the safe procedures for handling medication and demonstrating appropriate hygiene and infection control
- Having a basic awareness of the most common side effects of medication and contra-indications
- Understanding types and routes of medication and knowing how to support specific formulations of medicines, for example, liquids
- Using the correct equipment, for example, oral syringes for small doses of liquid medicines
- Understanding the purpose of monitored dosage systems and individual compliance aids and how to use effectively
- Administering medicines safely for adults who are unable to self-administer.
- Supporting adults who self-administer
- Supporting time-sensitive or 'as and when required' medicines
- Recognising and dealing with medication problems
- Knowing who to contact for appropriate advice concerning medication, including refusal of medication, medication incident reporting and safeguarding
- Knowing what to do if the adult has declining or fluctuating mental capacity.
- Knowing the requirements and maintaining accurate and factual medication records

- Ordering, transporting, storing and disposal of medication
- Training for any specialist medication, practices or health conditions of adults supported with medication.

19.3 Support with medication

- Understand the importance of gaining consent and how the adult gives their consent.
- Understand the adult's needs and preferences including cultural, emotional, religious and spiritual needs.
- Check the adult understands why they are taking their medicines.
- Know what the adult is able to do and what support is needed.
- Know how the adult currently manages their medicines, how they order, store and take their medicines.
- Check if the adult has any problems taking their medicines, particularly if they take multiple medicines.
- Check if the adult has nutritional and hydration needs, including the need for nutritional supplements.
- Know who to contact about the adult's medicines, ideally the adult themselves, if they are able, or a family member, unpaid carer or other named adult.

19.4 The Home Care and Support provider must ensure that staff are competent to support with medication. Assessment of competence to be done by a combination of simulation, direct physical observation of work practice, and appropriate questioning techniques, which must then be fully documented.

All staff to have a review of their knowledge, skills and competencies every 6 months or as required (i.e. if they make an error).

20. Role of the supplying pharmacists and dispensing doctors

20.1 Supplying pharmacists and dispensing doctors should supply medicines in their original packaging. They must make reasonable adjustments to the supplied packaging to help the adult to manage their medicines e.g. child proof tops, in line with the Equality Act 2010.

20.2 Supplying pharmacists and dispensing doctors will supply printed MARs for an adult receiving medicines support from a Home Care and Support provider and ensure that MARs include:

- the adult's name, date of birth and any other available person-specific identifiers, such as the adult's NHS number
- the name, formulation and strength of the medicine(s)
- how often or the time the medicine should be taken
- how the medicine is taken or used (route of administration)
- the name of the adult's GP practice
- any stop or review date

- any additional information, such as specific instructions for giving a medicine and any known drug allergies.

20.3 Written directions: prescriptions and dispensing labels

Prescribers, supplying pharmacists and dispensing doctors should provide clear written directions on the prescription and dispensing label on how each prescribed medicine should be taken or given.

20.3.1 All medicines

- what the medicine is for
- what dose should be taken (avoiding variable doses unless the adult or their family member/unpaid carer can direct the care worker).

20.3.2 Time-sensitive medicines

- what time dose should be taken, as agreed with the adult.

20.3.3 'When-required' medicines

- minimum time between doses
- maximum number of doses to be given e.g. in a 24 hour period.

20.4 Prescribers, supplying pharmacists and dispensing doctors will consider using a MDS only when an assessment has been carried out in line with the Equality Act 2010, and a specific need has been identified to support medicines adherence

Supplying pharmacists and dispensing doctors must:

- Supply a Package Information Leaflet (PIL) for all medicines supplied, in line with The Human Medicines Regulations 2012. This includes medicines supplied in an MDS.
- Will provide a description of the appearance of each individual medicine supplied in an MDS.

21. Role of the prescriber

21.1 General practices should record details of the adult's medicines support and who to contact about their medicines (the adult or a named contact) in their medical record, when notified that an adult is receiving medicines support from a Home Care and Support provider.

Prescribers should always follow advice in NICE pathway: Medicines optimisation. https://pathways.nice.org.uk/pathways/medicines-optimisation

21.2 Prescribers should communicate changes to an adult's medicines (e.g. when stopping or starting a medicine) by:

- informing the adult or their named contact
- providing written instructions of the change or issuing a new prescription
- informing the adult's supplying pharmacy, if needed and agreed with the adult and/or their family members/unpaid carers.

21.3 The Prescriber will

21.3.1 Provide ongoing advice and medicines support. Check if any changes or extra support may be helpful e.g. by checking:

- If the adult's medicines regimen can be simplified,
- information shared about time-sensitive medicines,
- if any medicines can be stopped,
- if the formulation of a medicine can be changed,
- any support needed for problems with medicines adherence,
- if a review of the adult's medicines may be needed.

21.3.2 Review an adult's medicine support to check whether it is meeting their needs and preferences. This should be carried out at the time specified in the providers' medication support plan or sooner if there are changes in the adult's circumstances, such as a:

- change to their medicine's regimen,
- concern is raised,
- hospital admission,
- life event such as a bereavement.

21.3.3 Encourage and support people and/or their family members/unpaid carers to raise any concerns about their medicines. They should explain how to seek help or make a complaint, including who to complain to and the role of advocacy services (if needed) and record this information in the adult's provider's medication support plan.

21.3.4 Ensure that people and/or their family members/unpaid carers, and care workers know how to report adverse effects of medicines, including using the Medicines and Healthcare products Regulatory Agency's yellow card scheme.

21.4 Covert administration of medication

The process for covert administration is managed by the prescriber and involves:

- Assessing an adult's mental capacity to make a specific decision about their medicines
- Seeking advice about other options, for example, whether the medicine could be stopped
- Consult with others, including the pharmacist, in line with s5.13 of the MCA Code of Practice to consider whether giving medicines covertly is in the adult's best interests
- Recording any decisions and who was involved in decision-making
- Agreeing where records of the decision are kept and who has access
- Planning how medicines will be given covertly which should include seeking advice from a pharmacist

- When the decision to give medicines covertly will be reviewed
- Providing authorisation and clear instructions for Home Care and Support provider, documented in the Home Care and Support provider's medication support plan
- The Home Care and Support provider needs to ensure the care workers are trained and assessed as competent to give the medicine covertly.

22. Role of the prescriber dispensing doctor or pharmacist – Medicine related error or incident

22.1 A medicine related incident is any event that may lead to an adult getting the wrong medication, or in the wrong dose, the wrong route or at the wrong time. Although this can occasionally lead to serious harm or even death, most medication incidents to do not lead to any significant harm or distress. All medication incidents, including 'near misses' need to be recognised and acted upon to help prevent future errors and make sure the adult gets any medical attention they may need.

22.2 The following list gives examples of scenarios where medicines related incidents can occur. Near misses in any of the sections below should also be considered. This list is not definitive.

22.2.1 Prescribing Errors

Adult prescribed the wrong medication/dose/route/rate:

- Incomplete information e.g. no strength or route specified.
- Medication omitted from prescription.
- Medication prescribed to wrong patient.
- Transcription errors.
- Prescribing without taking into account the adult's clinical condition.
- Prescribing without taking into account the adult's clinical parameters e.g. weight.
- Prescription not signed.

22.2.2 Dispensing Errors

Adult dispensed the wrong medication / dose / route:

- Medication dispensed to the wrong adult.
- Adult dispensed an out of date medicine.
- Medication is labelled incorrectly.

22.2.3 Errors in Monitoring Medication

Adult known to be allergic to medication but the medication was prescribed and/or dispensed and / or administered:

- Failure to provide the adult with correct information regarding their medication; e.g. when to take, what it is for, side effects.
- Know where to access information about the medicines; e.g. the patient information leaflet rather than expecting the staff to know?

- Failure to recognise or react appropriately to signs of ill health, pain, change in an adult's needs or requests for help due to being un-well – associated with medication administration.

22.2.4 Errors in Assessment and Communication of Need

Other medication issues may include:

- Inadequate assessment of an adult's needs in relation to medication.
- Poor or inadequate communication or not sharing of information about an adult's medication.
- Poor, inadequate or incorrect recording / documentation.
- Inappropriate or inadequate disposal of medicines.
- Deviation from local guidance relating to Medicines management.

23. Ongoing governance arrangements

23.1 Home Care and Support provider responsibilities - Audit

23.1.1 The practice of all staff undertaking medication support will be subject to systematic monitoring and review to ensure the adults they work with are supported with their medication as prescribed, safely and effectively.

This Includes:

- Ensuring that records are accurate and up to date
- Managing concerns about medicines, including but not exclusive to prescribing, dispensing, administering, monitoring errors and medicines-related safeguarding incidents
- Medicines related staff training and assessment of competency
- Frequency and sample of monitoring/ example audits
- Governance for managing medicines safely and effectively.

Each member of staff will have a representative sample of their practice audited at least twice yearly using both an audit tool and by direct observation.

The Home Care and Support provider will undertake the audit of staff medication administration practice using a tool *such as and as a minimum to the one at* **Appendix J** – Medication Audit Tool

23.1.2 Home Care and Support providers will also undertake audits which assess their performance against NICE Guidance 67 (NG67) both at an individual level and at a team level using the tools provided at **Appendix K** and **Appendix L.**

23.1.3 These audits should be undertaking every 6 months against the records of all the people receiving complex medication support and each of the teams providing the support.

23.2 Medication Support Guidance Review Group

A Medication Support Guidance Review Group will oversee the implementation and operation of the Medication Support Guidance throughout its application.

The objective of this group will be to

- continuously ensure medicines are managed safely and effectively in the community.
- review the Guidance at regular intervals
- revise in line with emerging issues which require either an urgent or longer-term solution.

23.3 Social Care Commissioners will review:

- the local governance arrangements to ensure that it is clear who is accountable and responsible for providing medicines support
- review any medicines-related issues.

Their review findings will be reported to the Medication Support Guidance Review Group who will share this learning with people:

- working across the health and care system
- receiving medicines support, their family members/unpaid carers
- and those directly working in related services e.g. GPs, supplying pharmacies and community health providers.

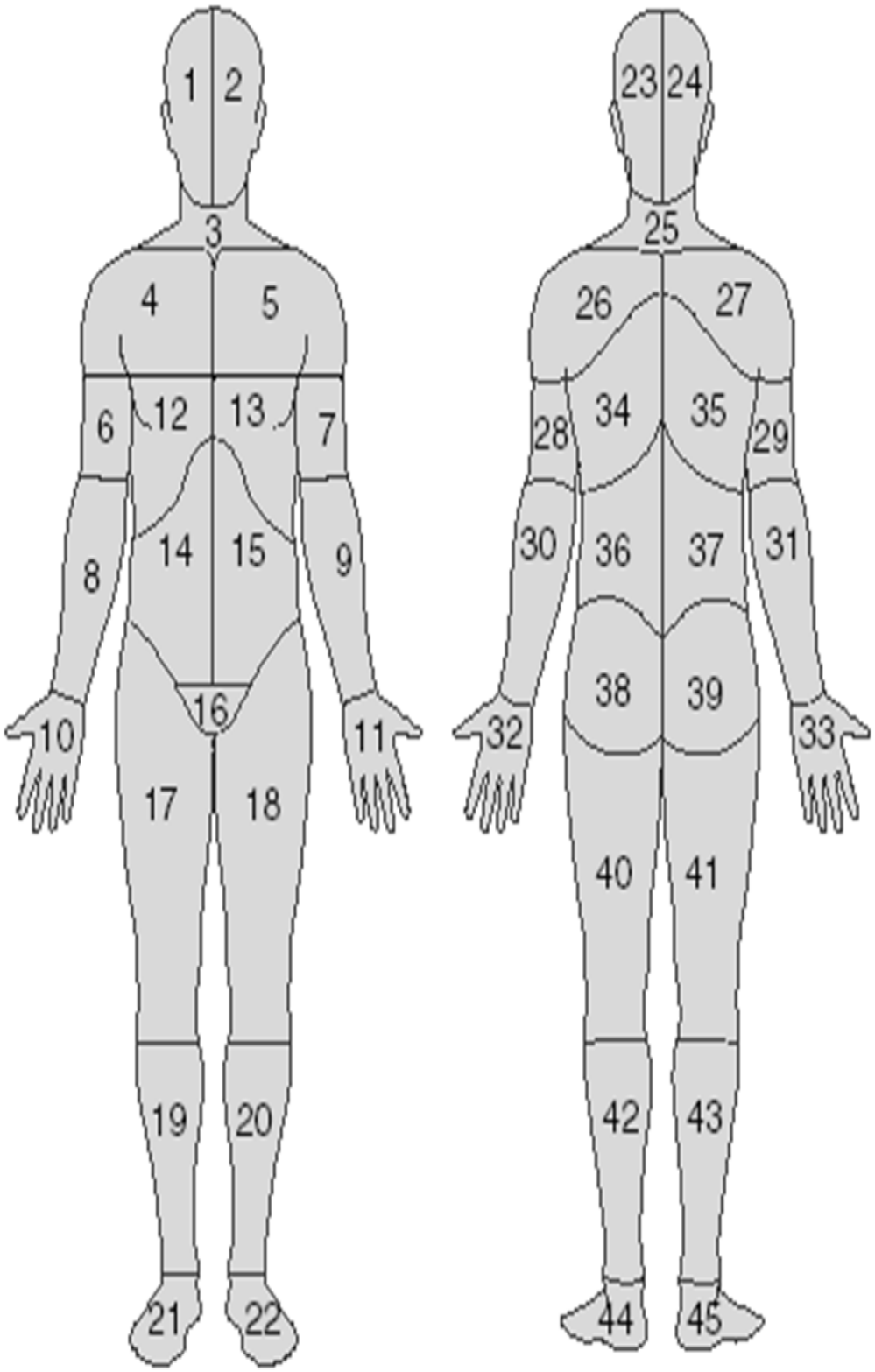
Appendix A - Home Care and Support Provider - Medication Support Plan

A Medication Support Plan must as a minimum refer to and record the following items:

Communication:	Name and contact details of: • GP • Chosen pharmacist • District Nurse • Other Allied Professional (i.e. Stoma Nurse, Tissue Viability Nurse, etc)
Record dates and signatures:	• Date of assessment undertaken • Date of review undertaken • Date of review due
Assessment in line with Section 7.2 of the Rotherham Medication Support Guidance:	• Known allergies • Whether support is needed • What support is required • Risk Level • Medication support level – Level 1, Level 2, Level 3 • The frequency of medication • Best Interest decision been made for clients receiving covert medication • Body Map – to identify point where topical creams to be applied
Identify hazard:	• Anticoagulants • Issues with storage • One or more PRN medicines • Controlled medication • One or more of medicines are for pain relief • One or more of medicines are time-sensitive • One or more of medicines are covert
Instruction:	• Who is responsible for ordering/delivery/collection/storage/disposal of medication • Instructions for ordering/delivery/collection/storage/disposal of medication • compliance aids to be used from community pharmacist • Other pertinent instructions for carers (i.e. compliance aids) • Special Instructions (i.e. application area to be rotated)
Storage Information:	• Where medication stored i.e. locked cupboard, cupboard, fridge, etc.

Medication Details:	• Oral • Inhaled • Liquid • Topical • Patches • Controlled drugs
Whether medication is administered from:	• Tubs, bottles, original packaging • Monitored dosage system.

Appendix B – Body Chart



Appendix C - Fullers Risk Assessment – Screening Tool

Name of person: Enter Score Below:				
Number of prescribed medications	**1** 1 Drug	**2** 2 Drugs	**3** 3 Drugs	**4** 4 Drugs
Mental State	**1** Alert and orientated	**4** Orientated but sometimes forgetful	**8** Confused, muddled/disorientated/very forgetful	**12** Very confused
Vision	**1** Can see to read with no aids	**2** Needs glasses/aids to read and print	**4** Difficult to read print with glasses/aids	**6** Unable to see
Social Circumstances	**1** Living with others who can fully support medication needs	**2** Living with others who usually/sometimes support medication administration	**3** Living with others with some support from paid carers or family/friend	**4** Living alone with no support
Physical Condition	**1** Can manage to open bottles/packets independently	**2** Weakness of hand/poor coordination, but can manage to open bottles/packets with difficulty	**3** Disabled. Requires some help to open packages	**4** Severely disabled unable to manage
Attitude and knowledge about medications	**1** Interested about prescribed medications and knows all about them, believes they are important	**2** Fairly interested about prescribed medications and knows enough about them to administer them safely/believes they are important	**8** Not very interested about prescribed medications. Does not believe they are important/unable to recall medication regime	**12** Disinterested and or unwilling to take prescribed medication
TOTAL SCORE				

Minimum Score: 6 Maximum Score: 42
Total your score and please see guidance for Risk Management 6-13 Low Risk, 14-16 Medium Risk, 17-22 High Risk 23-42 Very High

Name of the Person Completing the Form:	
Position:	
Signature:	
Date:	

RISK ASSESSMENT GUIDANCE

LOW RISK:

1. Give full explanation/information to service user about prescribed medications.
2. If carer/family will be giving medication, give full information about the drug regime.
3. Service User or carer may benefit from a personal medication chart with written information and advice about medication regime.

MEDIUM RISK:

As above plus:
1. May need support or need someone else to administer medication safely.
2. Inform local pharmacist and service user's GP of concerns including memory aids, easy open bottles, large print labels.
3. Keep medication regime simple.
4. Consider referral to pharmacist/GP for more in-depth medication review.

HIGH RISK:

As above plus:
1. Activate a system to administer medications.
2. Refer back to prescribing GP and dispensing pharmacist if this is not possible.
3. Recommend a regular medication management review by the service user's GP or pharmacist.
4. Keep prescribing to a minimum.

VERY HIGH:

As above plus:
The strongest elements that contribute to risk are those related to mental state, the individual's attitude and beliefs about their medications and visual impairments.
The risk is further increased for individuals with more than one of the three strongest risk elements, especially when living alone.

Appendix D – Medication Authorisation Form

Medication Authorisation Form		
	Signature	**Details**
I have discussed and I agree to the Medication Support Plan.		Name: _____ Adult Date: _____
The Medication Support Plan has been discussed with _____ Adult who has indicated their consent _____		Name: _____ Position _____ Date: _____
_____ (Adult) is unable to communicate informed consent. However, the following action has been taken to involve them in discussions about the Medication Support Plan: _____ _____ _____ In addition, the plan has been discussed with _____ as a result of which it has been agreed that the Medication Support Plan is in the best interests of _____ (Adult)		Name: _____ Position _____ Date: _____

To be completed in addition to the above section		
I authorise XXXXXXX Care Workers to support me by performing the tasks outlined in the Medication Support Plan.		Name: _____ Relationship*: _____ Date: _____

Relationship *

- Enduring Power of Attorney
- Lasting Power of Attorney
- Deputy or
- If other state nature of relationship.

Appendix E: Record of a Mental Capacity Assessment in respect of being given medication

Guidance:

This is not a statutory form and nothing in it should be considered legal advice which should be sought if in any doubt as to how to proceed.

You are completing this form because you are uncertain if the person identified below has the mental capacity to make the decision as to whether they take their medication with or without support from the Home Care and Support Provider's care worker. The assessor is not likely to be medically trained; this assessment is about taking the medication not prescribing it. If in any doubt as to the consequences of the decision, the opinion of the prescriber should be sought beforehand.

This record could be completed when establishing or reviewing the person's support plan. The decision - whether one made by the capacitous person or a best interests decision made if the person lacked capacity at the time of the assessment - should be reviewed regularly. The assessment should be completed at the time the decision needs to be made.

The person must be provided with the relevant information in a way they will find easiest to understand and you should do all that is practicable to help the person to understand this information, retain it for sufficient time to make the decision and use or weigh that information as part of the decision making process. The person does not need to know every detail, but rather have a general understanding of the kind expected of the general population at large making such a decision.

If the person is considered (on a balance of probabilities) by the assessor to lack the mental capacity to make the decision, it will still be necessary for care staff supporting the person thereafter to check each time with the person, as people can regain mental capacity to decide. Equally if the person has capacity and has asked for staff support, they could change their mind later. The MCA Code of Practice in Chapter 4 gives guidance stating that care workers *"…do not have to be experts at assessing capacity"* but that they must have a reasonable belief at the time that the person lacks capacity. In this they must take 'reasonable' steps to determine the person's consent to take medication or have it given to them.

Please refer to the MCA Code of Practice for guidance on assessing mental capacity. It will be noted that efforts must be taken to enable the person to make the decision. For example, a person might not know that they take a certain type of medicine. This may not mean the person lacks capacity simply that they have forgotten over time or had not been advised of changes to their prescription. Only if the person cannot understand the salient information, retain, or use or weigh that information or communicate the decision <u>because of</u> a mental impairment, is the person considered to lack capacity to decide.

If the person's mental capacity to make the decision may fluctuate, consider completing the assessment at the time at which the person is most likely to be able to make the decision, for example if the disturbance impairment of the mind or brain is temporary, can the assessment wait? Consider also the person who should be completing the assessment (MCA Code of Practice 4.38) and ask the person if they want anyone present (e.g. family members) to support them. The guidance in the comments sections are just suggestions, these will be different for each person of course.

A valid decision is one which is capacious and made voluntarily without coercion or duress.

Guidance notes to support completion of this form:

Can the person decide whether to be supported to take their medication?

This is not a question as to what should happen as a result of this assessment, but simply can the person make the decision or not?

Q1. Is there an impairment of, or disturbance in the functioning of the person's mind or brain?

For example, symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term effects of brain damage, confusion etc. There does not need to be a formal diagnosis.

Include sources of information, e.g. the medical diagnosis if there is one, and where you read it or who advised you, or the person's presentation which led you to believe there was an impairment of or disturbance in the mind or brain)

Q2. Can the person understand the information they require to make the decision?

The relevant information should include that the person has medication prescribed and takes it regularly, does the person know that and know why? Assessors should advise the person of their medication list and what it is for. The relevant information should include what might happen as a result of not taking the prescribed medication but the person does not need to be able to understand everything, only the salient details This might mean the person understands that not taking their medication as prescribed could result in illness, hospital admission etc. A broad explanation will usually be enough so long as the important detail is provided. The impact of making the decision one way or the other should be provided. If in doubt, consult with the prescribing clinician as to the information the person needs to know.

What you have done to enable the person to understand the information?

E.g. considering their cultural / language needs, sensory needs, support from family members or people who know how best to enable communication, providing information in written form, using non-verbal communication techniques, picture cards, meeting the person when he or she is most able to make the decision. Is an interpreter needed? Consider documenting conversations verbatim to convey the person's wishes and understanding of the decision to be made. Ask the person the actual question, ask them to explain in their own words their understanding of the decision to be made.

Q3. Can the person retain the information long enough to make the decision?

It does not matter if a person forgets later on, the person needs only to retain the relevant information long enough to understand it and use or weigh it to make the decision.

What have you done to enable the person to retain the information long enough to make the decision?

e.g. Repeating information, putting things in writing, considering choice of language, using open and closed questions, returning at a different time if possible. Can the person paraphrase what has been put to them?

During this process, the assessor could ask the person to say what the decision is they are being asked to make?

Q4. Can the person use or weigh the information?

What have you done to enable the person to use or weigh the information necessary to make their own decision?

e.g. How have you supported the person to understand and balance the risks / advantages of taking their meds themselves or having others provide medication to them? How did you present the options for the person? Explain how the person assessed the risks of the options including not making the decision at all, use a balance sheet with the person if it will help the person to see the consequences. The person will be able to balance the consequences of taking medication without support, for example, if they take their own medication is there a possibility they might forget to do so? If they forget, what are the likely consequences of that? What are the consequences of being given medication by care staff, e.g. loss of autonomy / reliance on others to give medication.

Q5. Can the person communicate their decision?

This section of the test assumes that the person has been able to decide: i.e. can understand, retain, use and weigh the relevant information and the problem relates to a difficulty or inability to communicate the decision, This means it is a section of the test which only applies to a very limited group of people, for instance those with locked-in syndrome who may, despite all practicable steps, be unable to communicate. If you consider that the person is unable to understand, retain, use or weigh relevant information but it is clear that they are communicating something, then the record of your assessment should not say that they are unable to communicate their decision but that they are unable to make a decision, and what they are communicating are wishes and feelings. You should take into account what they are communicating for the purpose of reaching the best interest decision.

What have you done to enable the person to communicate their own decision?

e.g. Preferred Communication for the person could be verbal, nonverbal through facial expressions or hand movements, or in the written form etc. Consider the person's preferred language and need for interpreter.

Name of the person	
Name and occupation of assessing officer:	
Date(s) and time(s) assessment undertaken.	
Where did the assessment take place?	

Please use this space to give reason why mental capacity was being assessed e.g. was there a concern about the person's ability to make the decision to decide on taking their medication and if so, who raised the concern?

Or was there something in the person's presentation that led you to question the person's capacity to decide this?

Please also provide the name, status and contact details of anyone who assisted with or was present during this assessment. Did the individual ask for anyone else to be present? If so, were they present?

Name	Status and contact details

The specific decision the person is being asked to make is.

Can the person decide whether to be supported to take their medication?

Mental Capacity Act 2005 - Principles 1 to 3 of 5.

1) **A Person must be assumed to have the mental capacity to make the decision unless it is established that they lack capacity to make the decision**
2) **A person is not to be treated as unable to make a decision unless all practicable steps to help the person to do so have been taken without success**
3) **A person is not to be treated as unable to make a decision merely because they make an unwise decision.**

The diagnostic assessment	**Response**		
	Yes	**No**	***Please Describe Below.***
Q1. **Is there an impairment of, or disturbance in the functioning of the person's mind or brain?**			

If you have answered **YES** to Question 1 please proceed with Questions 2 to 5.
If you have answered **NO** to Question 1, the diagnostic requirement is not met, thus the person cannot lack capacity as defined by the Act. The person may still want and need support. Sign/date this form, record the outcome within the person's records (with their consent) and proceed no further with the assessment.
Is the impairment as described above such that it is affecting the person's ability to make the decision at the time it needs to be made?

The functional assessment	**Response**		
	Yes	***No***	**Please describe.**
Q2. **Can the person <u>understand</u> the information they require to make the decision?**			**What you have done to enable the person to <u>understand</u> the information?**
Q3. **Can the person <u>retain</u> the information long enough to make the decision?**			**What have you done to enable the person to <u>retain</u> the information long enough to make the decision?**
Q4. **Can the person <u>use or weigh</u> the information?**			**What have you done to enable the person to <u>use or weigh</u> the information necessary to make their own decision?**
Q5. **Can the person <u>communicate</u> their decision?**			**What have you done to enable the person to <u>communicate</u> their own decision?**

If you have answered **YES** to **<u>all of questions</u>** Q2 to Q5, then, on a balance of probabilities, the person has the mental capacity to make the specific decision at that time. If you have answered **NO** to **<u>any of the questions</u>** Q2 to Q5, then, on a balance of probabilities, the person did not have the mental capacity to make the particular decision at the time the decision needed to be made.
If you have concluded that on a balance of probabilities the person does not have the mental capacity to make the decision, you are signing here to say you are satisfied that the person's inability to make the decision was caused by the impairment of or disturbance in the functioning of the person's mind or brain**. Please sign and date this form and record the outcome within the person's records**.

Signature and Print name, job title,	**Date assessment completed**

Appendix F: Best Interest Decision Record Form regarding support to take medication

Record of actions taken to make a best interest decision regarding support to take medication. This document will be used after a capacity assessment, specifically about taking medication, has been completed and the person was considered unable to make the decision because of a mental impairment. This is not a statutory form.

Name of Person:			
Name of Decision Maker:			
Role:			
Date:			
Please give the name and status of anyone who assisted with making this best interest decision:			
Name	**Status**		
Description of the decision to be made:			
Can the person decide whether or not to be supported to take their medication?			
PART 1 – MENTAL CAPACITY TO MAKE THIS DECISION AT THIS TIME **Every adult should be assumed to have the mental capacity to make the decision at the time it needs to be made unless it is proved that they lack capacity.**			
Has the person been deemed to not have the mental capacity to make the decision as to whether they want support to take their medication at this time?	**YES** ☐	**NO** ☐	If yes please comment on the mental capacity assessment (e.g. who did the assessment and when, that it was about taking medication and that the outcome was that the person does not have mental capacity to make this decision)

PART 2 – DETERMINING BEST INTERESTS	
Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition, or behaviour.	**Please provide your comments below**
Relevant Circumstances: Identify the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity. As part of the capacity assessment, the decision-maker should already have identified all the relevant details of the decision.	

The Person's Wishes: What are the person's past and present known wishes, feelings, and values? E.g. does the person have any known views about medication, in general or anything specific? Or have they previously expressed any views? How have these been taken into account?	
Written statements: Have you considered any written statements about taking medication made by the person when they had capacity?	
Encourage Participation: What have you done to enable the person to take part in making the decision?	
Regaining Capacity: Is the person likely to have the mental capacity to make this decision at some date in the future – this could be a matter of hours or days etc - and if so can the decision be delayed until then?	
Views of Others: What are the views of other people who know the person best, e.g friends and relatives, care staff who regularly help the person, independent advocate etc?	
Least restrictive option: How have you given consideration to the least restrictive options for the person? E.g. can the person be reminded to take the medication using telecare technology? If the person is objecting to taking the medication, is the opinion of the prescribing clinician that the medication is essential?	
Disagreement or challenges: Is there any objection from anyone to this decision, including the relevant person? Is a best interests meeting required?	
The decision: Having considered all the relevant circumstances, what decision / action do you intend to take regarding the person being supported with medication? How is this decision in the best interests of the person, e.g. what might happen if the person is not supported? Describe any other options and explain why this one is the best for the person.	

Signature:		Date:	
Print name:			
Job title:			

Appendix G – MEDICATION ADMINISTRATION RECORD

*Right Person *Right Medication *Right Route *Right Dose *Right Time *Right to Refuse

Date: **Client Name:** **D.O.B:**

Address: **GP or Surgery:**

ALLERGIES

MEDICATION ADMINISTRATION RECORD	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication Route?		S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
	Breakfast																															
	Lunch																															
	Tea																															
	Bed																															
Short Course Quantity?	**Key: R= refused N= nausea H= hospital C= cancelled visit NR= not required S= self administered O= other**																															
Medication Route?																																
	Breakfast																															
	Lunch																															
	Tea																															
	Bed																															
Short Course Quantity?	**Key: R= refused N= nausea H= hospital C= cancelled visit NR= not required S= self administered O= other**																															
Medication Route?																																
	Breakfast																															
	Lunch																															
	Tea																															
	Bed																															
Short Course Quantity?	**Key: R= refused N= nausea H= hospital C= cancelled visit NR= not required S= self administered O= other**																															
Medication Route?																																
	Breakfast																															
	Lunch																															
	Tea																															
	Bed																															
Short Course Quantity?	**Key: R= refused N= nausea H= hospital C= cancelled visit NR= not required S= self administered O= other**																															
Medication Route?																																
	Breakfast																															
	Lunch																															
	Tea																															
	Bed																															

Short Course Quantity?		**Key: R= refused N= nausea H= hospital C= cancelled visit NR= not required S= self administered O= other**

Date	O = Other reasons and Comments	Signature

Appendix H – Medication Administration Competency Assessment

This document outlines the minimum required in the assessment of competency after medication administration training has been undertaken. It relates to all care workers, assessors and staff employed by the Home Care and Support Provider with responsibilities to administer medication in line with the Rotherham Medication Guidance and who must be trained and competent to undertake this task.

This competency assessment does not include competency of invasive or specialised techniques (Level 3). This is the responsibility of healthcare professionals.

It is the responsibility of the Home Care and Support Provider's Registered Manager to ensure those with such responsibilities have received appropriate training and have been assessed as competent.

Care workers, assessors and staff employed by the Home Care and Support Provider MUST NOT be asked or allowed to administer medication unsupervised unless this has been completed and they have been assessed as competent.

The Competency Assessor undertaking the competency assessment must themselves be trained and competent in the administration of medication and authorised to assess others by the Registered Manager of the Home Care and Support Service Provider.

The assessment of competency should be done by direct physical observation. i.e. when the assessor is physically present observing the assessed.

Competency will include discussion – where this is done it should be clearly indicated as such.

The administering of medication should only be undertaken when assessed as competent to administer the form of medication prescribed (see Section 7)

The Home Care and Support Provider's Competency Assessor MUST assess competence:

- On more than one occasion to develop confidence and to demonstrate competence over time.

- Following a medication incident, assessing competence on more than one occasion.

- Involving several people accessing the service to demonstrate competence in as many situations as possible.

- Annually and in response to medication incidents.

The Home Care and Support Provider will document the competency assessment for each assessed member of staff which will as a minimum contain the following detail:

- Home Care and Support Provider's CQC Registration Number
- Name/Designation of person being assessed
- Date of Medication Training
- Name of Competency Assessor
- Date and Time of:
- Assessment 1
- Assessment 2
- Reason for Assessment (i.e. annual, medication incident, etc)
- Date of final sign off

EXAMPLE:

1st ASSESSMENT
Demonstrating competence at this assessment to administer medication unsupervised
Requiring further assessment/training/supervision at this stage to demonstrate competence to administer medication unsupervised. (See action plan) [insert name of staff member] has been assessed as delete as appropriate
Demonstrating competence at this assessment to administer medication unsupervised with the exceptions identified (See action plan)
Signed Assessor:
Full name / designation:
Date:
Signed Trainee:
Full name / designation:
Date:

2nd ASSESSMENT
Demonstrating competence at this assessment to administer medication unsupervised with the exceptions identified (See action plan)
Demonstrating competence at this assessment to administer medication unsupervised
Requiring further assessment/training/supervision at this stage to demonstrate competence to administer medication unsupervised. (See action plan)
Signed Assessor:
Full name / designation:
Date:
Signed Trainee:
Full name / designation:
Date:

CRITERIA:

The Competency Assessor will assess under the following criteria set out 1 through to 14.

The Competency Assessor MUST clearly document whether:

- The criteria have been met
- The criteria have not been met
- Not assessed at this time (i.e. Forms of Medication)
- Assessed by method of questioning (Q)
- Assessed by method of Direct Observation (DO)
- NA = not applicable to this person's job role.

CRITERIA

1. PREPERATION PRIOR TO ADMINISTRATION

Washes hands
Donning doffing PPE (if required)
Checks person's records to see what support is required with medication (if any)
Checks where person's medication is stored.
Collects all equipment together including jugs of water
Has correct records available
Prepares a clean and tidy work area

CRITERIA

2. CONSENT AND IDENTIFICATION:

Checks and confirms person's identity appropriately
Checks consent obtained as per Medication Support Plan

CRITERIA

3. MEDICATION ADMINISTRATION RECORD (MAR)

Checks and confirms person's identity appropriately
Checks consent obtained as per Medication Support Plan
Checks it is for the correct person
Checks all information is clear and legible
Checks that previous doses have been signed or coded for
Resolves any identified issues appropriately

CRITERIA

4. SELECTION OF MEDICATION

Reads MAR carefully
Uses the MAR to select the correct medication for the time of day
Checks medication has not already been given
Checks timing in relation to food (if appropriate)

Checks the name on the MAR and label match
Checks name, strength, and form of the medication with the MAR
Checks directions on label with MAR
Clarifies any differences appropriately
Checks that the medication is within its useable shelf life

CRITERIA

5. PREPERATION OF EQUIPMENT

Uses clean equipment
Uses appropriate measure for liquid doses
Pops tablets/capsules directly into an appropriate container.
Avoids handling medication with bare hands
Checks the correct dose of each medication is prepared
Follows any special instructions or protocols for that person

CRITERIA

6. GIVING MEDICATION

Confirms identity of the person appropriately including that it is the same as the MAR and dispensing label.
Offers the medication in accordance with the Medication Support Plan
Provides explanation and support appropriate to the person
Administers medication correctly
Discretely confirms that medication has been taken
Only offers as required medication in accordance with the information/protocol in the Medication Support Plan for that person
Left for later medication handled in accordance with Medication Support Plan

CRITERIA

7. FORMS OF MEDICATION i.e.

	1st Assessment		2nd Assessment		
FORMS OF MEDICATION		Tick*		Tick*	COMPETENCY ASSESSOR COMMENTS
Forms of medication correctly administered on this occasion Please tick the items you have witnessed being administered.	**Medicine Form**		**Medicine Form**		
	Tablet/capsules		Eye Drops		
	Inhaler devices		Nose Drops		
	Ear Drops		Sachet/Powder		
	Creams and Ointments		Transdermal Patches		
	Liquids		Eye ointment		
	Nasal Sprays		Other please specify		
	Other - please specify				

CRITERIA

8. REFUSAL OF MEDICATION OR REGULAR MEDICATION NOT GIVEN

Checks (or knows) any relevant information in the Medication Support Plan for the individual
IF APPROPRIATE for refusal
• Reoffers medication after a short time
• Tries to establish the reason for refusal with the person
Respects the right of a person to make an informed choice to refuse medication.
Seeks appropriate advice and shares information with the person
Reports needs for any ongoing monitoring for any potential ill effects resulting from the refusal or dose not given.
Ensures correct documentation made including reason the dose was not taken.

CRITERIA

9. AFTER ADMINISTRATION OF A PRESCRIBED DRUG

Correctly signs for the medication on the MAR chart OR on supplementary record if appropriate
Records the actual time the medication is given where appropriate e.g. minimum time between doses or as required medication
If the dose is variable records the actual dose given
Uses correct code for any regular medication not administered
Separates used equipment correctly
Ensures that any relevant information is correctly documented.
Completes the whole process for one person at a time including making appropriate records
Always treats the person with respect and dignity
Maintains hygiene standards e.g. regular washing of hands, use of clean gloves when appropriate
Ensures all equipment is left clean
Single use equipment is disposed of
Equipment which is for single person use is kept separately for each individual
Medication is returned to the appropriate place and stored tidily
Final check of MAR Charts done to ensure that they are all completed correctly, and no medication has been omitted by mistake.
Ensures all information is handed over appropriately
Arranges for any outstanding issues to be followed up

CRITERIA

10. MEDICATION SUPPLY

Identifies if supplies are running low
Takes appropriate actions to ensure supplies are replaced as per the Medication Support Plan.
If necessary is aware of correct action to take if supplies are needed urgently
Encourages person to store medication correctly including cold storage.
Reports concerns with storage
If medication is in locked storage, ensures that security is maintained.

CRITERIA

11. RECEIPT OF MEDICATION

Medication received is recorded correctly.
New supplies are stored correctly e.g. new supply behind older supplies.
Checks the storage requirements of a medication before putting it away

CRITERIA

12. DISPOSAL OF MEDICATION

Person alerted to medicines which are out of date or no longer required.
If staff organising disposal, returns medication to pharmacy/dispensing GP
Records are completed correctly including the person's consent to disposal.

CRITERIA

13. ACCESSING ADVICE AND INFORMATION

Knows who to contact if needs advice
Knows actions to take if person is unwell
Directs client to patient information leaflet or health care professional if they want information or advice on medication.

CRITERIA

14. DEALING WITH ERRORS

Can describe correct process to follow if they make an error.
Can describe correct process to follow if they discover an error.

ACTION PLAN:
Where issues are identified during the competency assessment the Competency Assessor MUST complete an Action Plan to address training needs prior to Reassessing competency.

Action	Detail	Identified at Assessment Number	Assessment Date	To be completed by

Appendix J: Medication Audit Tool

Completed by (block caps):	Designation:	Date:

Name of Person (whose records are being audited):

		Yes	No
1	Are the charts archived in date order?		
2	Is the person's name, address, date of birth, allergy status and GP clearly stated on each MAR chart?		
3	Is the start date including the year clearly identified on each MAR chart?		
4	Do all medicine entries show the name, strength, form of medicine and full directions for use? (where medicine is taken from a dosage system there must be a medication record available)		
5	Have all relevant entries been signed by the member of staff making the entry?		
6	Are there any gaps in entries?		
7	If a medicine has not been given has an appropriate code been recorded on the chart?		
8	Does each MAR chart clearly identify when 'as required' medicine is given and when it is refused?		
9	Does each MAR chart correspond with the medication record?		
10	There are Patient Information Leaflets (PILs) in the person's home?		

Where the answer to any of the above questions is 'no' (except Q6 – if Yes) please identify the action needed, who by, when by and when completed :

Action	Who By	When By	Completed date	Signed

Having reviewed each MAR chart are there any patterns or trends that require addressing e.g. regularly refusing certain medicine, regular nausea? If yes, identify the actions needed, who by, when by and when completed:				
Action	**Who By**	**When By**	**Completed date**	**Signed**

Registered Manager's Comments	
Signed :	Date:

Appendix K

Practice Audit of NICE NG67:

Managing Medicines for Adults receiving Social Care in the Community

Person - Questionnaire

People receiving social care in the community may be at greater risk of medicine – related problems as a result of having multiple physical and mental health long term conditions known as 'Multimorbidity' and/or the need to take multiple medicines known as 'Polypharmacy'.

Please answer the following questions for **EVERY** customer to be included in the audit					
Ref	**Question**	**Yes**	**No**	**NA**	**Comments**
1.	Does the customer have a documented statement to assess their needs and preferences for support with medicines as part of their overall assessment?	☐	☐		
2.	Is there evidence in the customer support plan that the following people were engaged when assessing their need for medicine support:				
2a.	• Customer	☐	☐		
2b.	• Family/Carer (if applicable)	☐	☐	☐	
3.	Is there a medicines support review date documented in the customers support plan?	☐	☐		
4.	Is there evidence in the customer support plan that the following professionals have been notified that the customer is receiving medicines support:				
4a.	• GP	☐	☐		
4b.	• Supplying Pharmacy	☐	☐		
4c.	• Prescriber				
5.	Is there evidence in the customer support plan that the customers health care professional (prescriber) continue to monitor the safety and effectiveness of the medicines? **Guidance:** This could include evidence of patient attending appointments with GP/Psychiatrist	☐	☐		
6.	Has the customer had any changes to their medicines that has been received **verbally** from the prescriber? (If no please go to question 8).	☐	☐		
7.	If yes, have the following details been recorded:				
7a.	• Name and profession of the person who requested the change?	☐	☐		
7b.	• Name and designation of the person who received the request?	☐	☐		

Please answer the following questions for **EVERY** customer to be included in the audit					
Ref	**Question**	**Yes**	**No**	**NA**	**Comments**
7c.	• Date and time of the change request?	☐	☐		
8.	Is there evidence in the customer documentation that instructs support workers what to do in the following circumstances:				
8a.	• If the customer is having a meal?	☐	☐		
8b.	• If the customer is sleeping?	☐	☐		
8c.	• If the customer is not in the building e.g. visiting family?	☐	☐	☐	
8d.	• If the customer has declining or fluctuating mental capacity?	☐	☐	☐	
8e.	• If the customer requires administration of specific medicines that are not in tablet form? (E.g. inhalers, patches, eye drops, creams, and liquid medicines).	☐	☐	☐	
8f.	• If the customer requires administration of *'time sensitive'* medicines? (E.g. Warfarin/Insulin).	☐	☐	☐	
8g.	• If the customer requires administration of *'As Required/PRN'* medicines? (E.g. Pain relief).	☐	☐	☐	
9.	If the customer is prescribed *'As Required/PRN'* medicines does the customer support plan document the minimum and maximum doses that can be administered?	☐	☐	☐	
10.	Are there up to date *'Patient Information Leaflets (PILs)'* available for the customer if requested? **Guidance:** This includes medicines supplied using a monitored dosing system (dossette box).	☐	☐		
11.	Does or has the customer ever required their medication to be administered covertly? (If no, please go to question 13)	☐	☐		
12.	If yes, is there evidence documented within the customer support plan that gives clear authorisation and instruction in line with the Mental Capacity Act 2005 to give medicines covertly?	☐	☐		
13.	Is there evidence within the customer support plan that the customer is in agreement to allow the following:				
13a.	• The team to order their medicines?	☐	☐	☐	
13b.	• The team to transport, store and dispose of their medicines?	☐	☐		
14.	Has the customer had any unwanted, damaged or out of date medications that required to be disposed of?	☐	☐		

Please answer the following questions for **EVERY** customer to be included in the audit					
Ref	**Question**	**Yes**	**No**	**NA**	**Comments**
	(If no, please go to section 2)				
15.	If yes, is there evidence that the team have completed the following:				
15a.	• Obtained agreement from customer to dispose of medicines?	☐	☐		
15b.	• Disposed of medications in accordance to agreed method of disposal? **Guidance:** Usually return to pharmacy	☐	☐		
16.	When disposing of medicines have the following been recorded:				
16a.	• Name/s of the medicine?	☐	☐		
16b.	• Quantity of the medicine?	☐	☐		
16c.	• Name and profession of the person who returned the medicines?	☐	☐		
16d.	• Date medicines were returned?	☐	☐		
16e.	• Name and profession of the person who received the medicines?	☐	☐		

Appendix L

Practice Audit of NICE NG67:

Managing Medicines for Adults receiving Social Care in the Community

Team - Questionnaire

People receiving social care in the community may be at greater risk of medicine – related problems as a result of having multiple physical and mental health long term conditions known as 'Multimorbidity' and/or the need to take multiple medicines known as 'Polypharmacy'.

Please answer the following questions **ONCE** only for each team					
Ref	**Question**	**Yes**	**No**	**NA**	**Comments**
17.	Is there evidence that the team have robust processes for managing medicines related problems (incidents/errors)?	☐	☐		
18.	Has the team experienced any medicines related problems (incidents/errors) within the last 6 month? If no, please go to question 21.	☐	☐		
19.	Is there evidence that the team have reviewed their medicines related problems to identify and address causes/trends within the last 6 month?	☐	☐		
20.	Is there evidence to support that the learning from reviewing the medicines related incidents has been shared with the following people:				
20a.	• Colleague's working within the organisation	☐	☐		
20b.	• Customer receiving the medicines support	☐	☐		
20c.	• Customers family/Carers	☐	☐	☐	
20d.	• GP and/or Supplying Pharmacy	☐	☐		
21.	Is there evidence that the team has robust processes for support workers who administer/provide medicines support that follows the *'6 rights of administration"*? **Guidance:** Right person, medicine, route, dose, time and right to decline.	☐	☐		
22.	Is there evidence that the team use a medicines administration record (MARs) chart?	☐	☐		
23.	If yes, does the team/Registered Manager take part, as a minimum, in a monthly MARs chart audit to ensure accuracy?	☐	☐		
24.	Have any discrepancies occurred within the team between medications ordered and medications supplied within the last 6 month?	☐	☐		

Please answer the following questions **ONCE** only for each team					
25.	If yes, is there evidence in the team that support workers know what action to take if a discrepancy is noted? **Guidance:** Contact the supplying pharmacist	☐	☐	☐	
26.	When the team is responsible for storing customer medicines are the medications stored in a lockable cupboard?	☐	☐	☐	
27.	Is there evidence that the team, when storing medicines have robust processes in place including the following:				
27a.	Is there an accurate log book that records medications fridge temperature?	☐	☐	☐	
27b.	Is there a record available stating who has authorisation to access medicines?	☐	☐	☐	
28.	How many colleagues from your team/service **are required to complete** the following (please enter a number in the first column):				
28a.	Medicines management training				
28b.	Competency assessed by direct observation				
28c.	An annual review of knowledge, skills and competency				
28.	How many colleagues from your team/service **have completed** the following (please enter a number in the first column):				
28a.	Medicines management training				
28b.	Competency assessed by direct observation				
28c.	An annual review of knowledge, skills and competency				