Unit 18

Support use of medication in social care settings
Unit purpose and aims

This unit assesses the support for use of medication in social care settings. It covers broad types, classifications and forms of medication, as well as safe handling and storage. It addresses practical support for the use of medication that reflects social care principles and values and includes the need for accurate recording and reporting.

The learner will:

1. Understand the legislative framework for the use of medication in social care settings
2. Know about common types of medication and their use
3. Understand roles and responsibilities in the use of medication in social care settings
4. Understand techniques for administering medication
5. Be able to receive, store and dispose of medication supplies safely
6. Know how to promote the rights of the individual when managing medication
7. Be able to support use of medication
8. Be able to record and report on use of medication
1.1 Identify legislation that governs the use of medication in social care settings

Legislation in relation to medicines

Legislation includes Acts of Parliament and government Regulations related to the Acts which are enforceable through the court system. Guidance produced by government and official bodies such as the Royal Pharmaceutical Society reflect best practice. Guidance documents are based on legislation and clarify the law by summarising the main points. There are various Acts, Regulations and Guidance relating to medication, as well as legislative controls that govern the manufacture, sale, distribution, prescribing, dispensing, storage, labelling, and administration and safe disposal of drugs.

The overall aim of this legislation and guidance is to:

- Protect service users from harm through the inappropriate use of drugs
- Provide all health care professionals with a comprehensive framework on which to base their clinical practice
- Reduce the risk of misuse of prescribed drugs which are addictive. These require extra safe prescribing, handling, storage and disposal and are called Controlled Drugs
- Protect the public and the environment from potentially damaging methods of disposal of medicines.

Although it is not essential for you to know the detailed content of all of the Acts, Regulations and Guidance it is important that you are familiar with the main ones which govern the supply, storage, administration and disposal of medicines - and that you comply with their requirements.

These are primarily:

- The Medicines Act (1968)
- The Misuse of Drugs Act(1971)
- The Misuse of Drugs Regulations(2001)
- The Hazardous Waste Regulations(2005)
- The Misuse of Drugs (Safe Custody) Regulations 1973 (as amended 2007)
- The Human Medicines Regulations(2012)
The Health and Social Care Act (2012)

The Care Quality Commission’s Fundamental Standards. The fundamental standards are based on The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part3).

The main ways these impact day to day work in health and social care is summarised in the table below. Useful Guidance documents which explain the legislation are included in the table. Your workplace medication policies and procedures should reflect this legislation and guidance.

<table>
<thead>
<tr>
<th>Issues in practice</th>
<th>Relevant Acts, Regulations and Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>General principles of safe handling of medicines in social care settings</td>
<td>These are covered by the Royal Pharmaceutical Society of Great Britain Guidance ‘The Handling of Medicines in Social Care’ (2016)</td>
</tr>
<tr>
<td>Consent and covert administration of medication (legal issues regarding hiding medicines in food and drinks)</td>
<td>The Mental Capacity Act (2005) is the main law regarding individual’s capacity to make decisions for themselves. This, and the amendment called the Deprivation of Liberty Safeguards underpin policies on how to manage medication for individuals who do not have capacity to consent, such as some people with advanced dementia (more on this below).</td>
</tr>
<tr>
<td>How medication is classified and how it can be obtained</td>
<td>For many years, almost all aspects of medication were determined by the Medicines Act 1968. Most of this Act has now been replaced by the Human Medicines Regulations 2012. The original classification of medicines as General Sales (can be obtained in general shops), Pharmacy (only available with a pharmacist overseeing the sale), Prescription only and Controlled Drugs (addictive drugs needing special control) continues.</td>
</tr>
<tr>
<td>Controlled Drugs classification</td>
<td>Controlled drugs were originally classified under <strong>The Misuse of Drugs Act (1971)</strong>. This was to protect the public from misuse of those medicines considered particularly dangerous as they are potentially addictive, such as morphine. More recently some controlled drugs were reclassified by the <strong>Misuse of Drugs Regulations (2001)</strong>.</td>
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<tr>
<td>Storage of medication</td>
<td><strong>The Royal Pharmaceutical Society guidance 'The Handling of Medicines in Social Care'</strong> describes the requirements for safe storage of medicines in different settings (such as a person’s own home, a care home or in children and young people’s settings). The correct storage of Controlled Drugs is determined by <strong>The Misuse of Drugs (Safe Custody) Regulations 1973 (as amended 2007)</strong>.</td>
</tr>
<tr>
<td>Handling of medication in healthcare settings (such as hospitals and care homes providing nursing care) is usually carried out by Registered Nurses. Care workers may be trained to handle medication in these settings but the Registered Nurse delegating this remains accountable too.</td>
<td>Detailed guidance for nurses and midwives on prescribing, obtaining medicines, administration, storage and disposal of medication is available from the <strong>Nursing and Midwifery Council (NMC) Guidance ‘Standards for Medicines Management’ (2015)</strong>.</td>
</tr>
<tr>
<td>Issues in practice</td>
<td>Relevant Acts, Regulations and Guidance</td>
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<tr>
<td>Recording the administration of medication correctly</td>
<td>Although the Commission for Social Inspection (CSCI) was abolished in 2009 and replaced by the Care Quality Commission, the <strong>CSCI guidance called ‘Professional advice: Medicine administration records (MAR) in care homes and domiciliary care’</strong> is still helpful. <strong>The Health and Social Care Act 2012</strong> requires health and social care settings to maintain accurate and up to date records regarding medication.</td>
</tr>
<tr>
<td>Confidentiality of medication records</td>
<td><strong>The Data Protection Act (1998)</strong> is the main legislation protecting the confidentiality of medical records including those relating to medicines.</td>
</tr>
<tr>
<td>Disposal of medication</td>
<td><strong>The Hazardous Waste Regulations 2005</strong> changed the way medicines are disposed of. Pharmacists must now hold a waste management license to dispose of medication legally. All medicines from social care settings requiring disposal must be returned to a suitably licensed pharmacist. Care homes registered for nursing care must denature controlled drugs in a special box prior to collection by a licensed waste company.</td>
</tr>
<tr>
<td>Inspection of medication records and practices</td>
<td><strong>The Health and Social Care Act 2012</strong> requires health and social care providers to follow correct procedures and make records of medication handling, storage, usage and disposal. Inspection of records and medication</td>
</tr>
</tbody>
</table>
Procedures by Care Quality Commission inspection teams helps ensure care settings meet legal requirements.

| Standards and dealing with medication errors | Previously, the Care Quality Commission (CQC) had an Essential Standard specific to medication. The Essential Standards have been replaced by the CQC’s **Fundamental Standards**. The fundamental standards are based on The **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**. None relate entirely to medication but several are relevant to the safe handling of medication. **The fundamental standard Duty of Candour** for example requires care settings to be honest and transparent about any errors made during treatment; this includes medication errors. |
Other legislation which affects the safe handling of medicines includes:

- **The Health and Safety at Work Act (1974)** and **The Control of Substances Hazardous to Health (COSHH) Regulations (2002)**. Both of these relate to health and safety in the workplace. As medicines are potentially harmful, they are classed as hazardous substances within the workplace.

- **The Controlled Drugs (Supervision of Management and Use) Regulations (2013)** tighten up the procedures regarding Controlled Drugs. These Regulations introduced the appointment of Controlled Drugs Accountable Officers to review the safety of procedures for the management and use of these drugs in organisations. This followed the Shipman Inquiry Fourth Report which investigated how the former doctor Harold Shipman was able to stockpile Controlled Drugs which he then used to murder some of his patients.

- **The Equality Act (2010)** requires service providers to think ahead, identify potential barriers and put procedures in place to eliminate these before they become an issue. When care workers are working with people in their own home, it is important they are aware of issues that might arise with administering medications, and also that they know what to do in these circumstances.

- **The Deprivation of Liberty Safeguards (DOLS), 2009** were an amendment to the Mental Capacity Act. Like the Mental Capacity Act, people covered under DOLS must have a mental illness, dementia, learning disability or some other condition which impairs their ability to make decisions. They must be living in England or Wales, be over 18 years old and be in a care home or hospital, but unable to give their permission to be there. In relation to medication, DOLS would cover issues such as being given frequent medication to control their behaviour (which could be considered a form of restraint) or giving medication without the person’s consent. In 2017, the Law Commission proposed to replace the Deprivation of Liberty Safeguards with Liberty Protection Safeguards which would apply to all settings and to further amend the Mental Capacity Act.

- **The Mental Health Act 1983** (as amended 2007) is the main legislation relating to people with mental health difficulties which are severe enough to affect their safety. The Act allows the administration of medication against the person’s wishes in some circumstances to individuals who are detained under the Act (formerly called ‘sectioned’).
The Medicines and Healthcare Products Regulatory Agency (MHRA) is a government agency responsible for standards of safety, quality and performance and is concerned with the reporting of adverse medicine reactions using the Yellow Card system. Further information is available from www.mhra.gov.uk

Standards

Standards are statements written by the government or official bodies in line with legislation. In health and social care settings, standards set out the required minimum level of practice. With regard to medicines, various standards have been introduced. Examples include:

- **The National Minimum Standards for Domiciliary Care Agencies (2003)**

  These standards arose from the Care Standards Act (2003). They indicated whether an agency was providing care to the appropriate and laid-down minimum standards which were identified for all aspects of care, including medication handling. The National Standards aimed to ensure that an individual receives a good standard of care whilst being cared for in their own home. Domiciliary agencies must not fall below the standards which the government has set out.
**Appropriate training**

Minimum Care Standards 9.7 stated that:

‘In Residential Care Homes (i.e. Care Homes with personal care only) all medicines, including controlled drugs (except those for self-administration) are administered by designated and appropriately trained staff. Another designated appropriately trained member of staff witnesses the administration of controlled drugs.’

In relation to medications, the Minimum Care Standards stated that domiciliary carers must only assist with medication if they feel competent to do so and have received adequate training.

Any training that you undertake must be accredited and include:

- Basic knowledge of how medicines are used and how to recognise and deal with problems in use
- The principles behind all aspects of the organisation’s policy on medicines handling and recording.

Assistance must be given with the consent of the service user. All medications must be given in accordance with the care plan; a risk assessment must be in place and medications given in agreement with the line manager and not against the policies of the care organisation.

**Care Quality Commission Standards**

You may remember from Unit 03 that national minimum standards were replaced by the Care Quality Commission (CQC) essential standards. These included a standard specific to the safe handling of medication. In 2015 the essential standards were replaced by fundamental standards. As from 1st April 2015, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) came into force. The CQC consider the Fundamental Standards to be ‘clearer statements’ of the standards below which care should never fall. Rather surprisingly there isn’t a Fundamental Standard specifically about medication. However, several standards are relevant to medication issues, most notably the Duty of Candour which requires those working in health and social care to be transparent about any mistakes. This includes medication errors or side effects.
Legal responsibilities

There are many people, with differing responsibilities, involved in the handling of medication. Every health care professional who either prescribes, handles, supplies or administers any form of medication is responsible for working within current legislation and within the code of conduct of their professional body. This also includes social care workers, so it is important that you familiarise yourself with your code of conduct, in order to assist in protecting both yourself and members of the public for whom you provide care.

1.2 Outline the legal classification system for medication

The Medicines Act 1968 divided medicines into three categories and the Human Medicines Regulations 2012 maintained this classification (although some individual drugs were reclassified). The classes are:

- **Prescription only Medicines (POM's)** - are medicines that can only be obtained with a prescription that is written by an appropriate practitioner for example a doctor, dentist or a nurse prescriber. Many other professionals can now train to be independent prescribers or supplementary prescribers, legally entitled to prescribe some medicines

- **Pharmacy only Medicines (P)** - are medicines that can be bought from a registered pharmacy provided that sale is supervised by the pharmacist

- **General Sales List Medicines (GSL's)** - are medicines that can be bought from any shop. These do not require a prescription or the supervision of a pharmacist.

The Misuse of Drugs Act 1971 was concerned particularly with controlled drugs and categorised them into five separate schedules and three classes. Schedules describe the circumstances in which a drug can be legally possessed and whether they can be prescribed for therapeutic use.

The Misuse of Drugs Act and its additional Regulations categorise controlled drugs into two lists, called classes and schedules. Classes describe the severity of the likely sentence or fine from a crime involving that drug. Schedules describe the circumstances in which a drug can be legally possessed and whether a doctor can prescribe it. Further details on the classes and schedules of a number of the most common substances are described in this section.
Classes A, B and C

There are three drug classes, with Class A drugs attracting the most severe penalties and Class C drugs attracting the least severe penalties. Note that the law has changed a number of times in recent years.

Class A Drugs

These are considered being the most harmful substances and include:

- Heroin (diamorphine) and various other opiates
- Methadone
- Ecstasy (MDMA)
- Magic mushrooms (or any fungus containing psilocin or an ester of psilocin)
- Cocaine and crack cocaine
- LSD
- Methylamphetamine (metamphetamine).

The maximum sentence for illegally possessing a Class A drug is currently: Seven years imprisonment and a fine.

The maximum sentence for illegally supplying/trafficking a Class A drug is: Life imprisonment and a fine.

Class B drugs

These are considered less dangerous than Class A drugs, but still having serious risks. These include:

- Amphetamines
- Cannabis
- Barbiturates
- Codeine
- Dihydrocodeine (DF118)
- Cathinones, which include Mephedrone (Meow), Methedrone & Methylone
- Ketamine.
The current maximum sentence for illegally possession of a Class B drug is: Five years imprisonment and a fine.
The current maximum sentence for illegally supplying/trafficking a Class B drug is: Fourteen years imprisonment and a fine.
However, preparing a Class B drug for injection automatically turns it into Class A.

Class C drugs

These are considered the least dangerous and include:

- Mild amphetamines
- Anabolic steroids
- Benzodiazepines (minor tranquillisers), such as:
  - Valium (diazepam)
  - Temazepam
  - Mogadon (nitrazepam).
- Rohypnol (flunitrazepam)
  - GHB
  - GBL (producing GHB once inside the body)
  - BZP.

The current maximum sentence for illegally possession of a Class C drug is: Two years imprisonment and a fine.
The current maximum sentence for illegally supplying/trafficking a Class C drug is: Fourteen years imprisonment and a fine.
Temporary Class Drugs (since 15 November 2011)

In response to the flood of new psychoactive substances in recent years, often referred to as ‘legal highs’, the Home Secretary now has the power to bring certain substances under a temporary class drug order under certain conditions. Such an order will expire at the end of twelve months or earlier, if the temporary class drug is brought under the permanent control of the Misuse of Drugs Act 1971 or the order for that specific drug is revoked.

Simple possession (i.e. for personal use) of such a controlled drug is not an offence, but police officers have the powers to seize and destroy the drug.
The maximum sentence for supplying/trafficking a temporary class drug is fourteen years imprisonment and/or an unlimited fine.

**Schedules 1 – 5 under the Misuse of Drugs Regulations**

The Misuse of Drugs Regulations creates five schedules, governing possession and supply of the drugs controlled under the Misuse of Drugs Act. The regulations also govern prescribing, safe custody, importation, exportation, production and record keeping.

When considering who can possess or supply Controlled Drugs (CDs), it is more important to look at the schedule of the drug, rather than the Class. The Class determines how dangerous a drug is perceived to be, and penalties relating to the drug. The schedule defines who may be in possession of, or supply each drug, and under what conditions.

The following is an extract of the (very extensive) list.

**Schedule 1** – Drugs under this schedule are thought to have no therapeutic uses and cannot be prescribed by a doctor. Possession and supply are prohibited except in accordance with Home Office authority (i.e. for research purposes). Includes:

- Cannabis
- MDMA (ecstasy)
- Rawopium
- LSD.
Schedule 2 – These drugs can be supplied on prescription by a doctor but are subject to strict regulations of safe keeping, stock registration and prescription requirements. However, only a few specially licensed doctors can prescribe heroin and cocaine for the treatment of addiction.

Includes:
- Diamorphine (Heroin)
- Methadone
- Morphine
- Cocaine
- Amphetamines
- Methylamphetamines.

Schedule 3 – Drugs under this schedule are illegal to possess without a prescription but are subject to less strict controls but still have the special prescription requirements. Also, further regulations apply for import, export and production – as with Schedule 2.

Includes:
- Barbiturates
- Buprenorphine
- As well as the tranquillisers temazepam and flunitrazepam (Rohypnol).

Schedule 4, part i – Are now also illegal to possess without a prescription but are subject to minimal controls. Includes:
- Most benzodiazepines (apart from temazepam and Rohypnol, which are Schedule 3)
- GHB (Gamma HydroxyButyrate).

Schedule 4, part ii – These drugs can be prescribed by a doctor and are not illegal to possess for personal use without a prescription, provided that they are in a medicinal form (i.e. tablets not having been crushed and prepared for injection). Includes:
- Anabolic steroids.

Schedule 5 – This schedule covers ‘over the counter’ compound preparations which may contain small amounts of controlled drugs, such as cough mixtures and anti-diarrhoea medicines.
Examples are:
- Gee’s Linctus (cough medicine)
- Kaolin and Morphine in preparations for diarrhea treatment.

1.3 Explain how and why policies and procedures or agreed ways of working must reflect and incorporate legislative requirements

Policies and procedures

The National Minimum Standards (2003) defined a policy as:

‘An operational statement of intent which helps staff to make sound decisions and take actions which are legal, consistent with the aims of the home and in the best interest of the service users’.

Procedures are defined as: ‘The steps taken to fulfil a policy’.

Put simply, any aspect of care requires policies and procedures which should guide us in:

- What we should be doing
- How we should be doing it
- What issues we should take into account.

In relation to the safe handling of medicines, the registered person and/or manager of your establishment must ensure that there are policies in place for the receipt, recording, storage, handling, administration and disposal of medicines.

The purpose of these policies is to promote the safety and wellbeing of staff and service users, and to enhance safe practices within your health care establishment. It is absolutely essential that policies and procedures are developed and updated in line with current legislation, and that you are familiar with their content.

The ‘Handling of Medicines in Social Care Guidelines’ were produced by the Royal Pharmaceutical Society of Great Britain. Although the guidelines are not a law or an Act of Parliament, they are currently seen as the best example of good practice. The guidelines state that the following should be included in a care provider’s policy for the Administration of Medicines:

1. How you should confirm the identity of the service user
2. The way in which you should check the service user’s name, medicine and dosage
3. The way in which you should check that the Medicine Administration Record (MAR) sheet and the medicine label match the name of the medicine, strength, dose, frequency and route

4. The way in which you should manage discrepancies

5. The way in which a medicine is given

6. The way in which MAR sheets should be signed immediately after administration of medicines

7. The way in which medicines should be identified and confirmed when using Monitored-Dose Systems (MDS) containing more than one type of medicine, and be aware of any special instructions e.g. give one hour before food

8. The way in which records should be made if the medicine is refused or omitted, including the reasons why

9. The way in which ‘as required’ medicines are recorded, and their dosages.

2.1 Identify common types of medication

Brand and generic names

<table>
<thead>
<tr>
<th>Generic name (Approved or pharmaceutical name)</th>
<th>The generic name of a medicine is based on its main ingredient. Each medicine has an approved name or a pharmaceutical name. This is the generic name. A group of medicines that have similar actions often have similar sounding generic names. For example, Penicillin, Ampicillin, Amoxycillin and Flucloxacillin are in one group of antibiotics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proprietary or Brand name (The name given by the company that manufactures the drug)</td>
<td>The company that makes the medication chooses their brand name. Several companies may make the same medicine, each with their own brand name. The name is often chosen to be memorable for advertising, or to be easier to say or spell than some long generic name! For example, Paracetamol is a generic name. There are several companies that make this with brand names such as Panadol, Calpol etc. The brand name of a medicine can be identified by the trademark which is indicated by the symbol ® after the drug’s name.</td>
</tr>
<tr>
<td>Medication group</td>
<td>Examples of medications within the medication group</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
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</tr>
<tr>
<td>Analgesics (Pain killers)</td>
<td>Paracetamol (also used to reduce a high temperature), Aspirin, Ibuprofen, Co-codamol, Morphine</td>
</tr>
<tr>
<td>Antibiotics (To treat or prevent common bacterial infection, such as: chest, urine, ear, nose and throat infections)</td>
<td>Penicillin (first antibiotic to be discovered), Erythromycin, Amoxicillin, Flucloxacillin</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>Fluoxetine, Haloperidol, Amitriptyline</td>
</tr>
<tr>
<td>Hormones</td>
<td>Insulin, Levothyroxine Sodium, Estradiol,</td>
</tr>
<tr>
<td>Steroids</td>
<td>Prednisolone, Hydrocortisone,</td>
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<tr>
<td>Laxatives</td>
<td>Lactulose, Senna</td>
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<tr>
<td>Anticoagulant medication</td>
<td>Warfarin, Heparin</td>
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<tr>
<td>Cytotoxic medication</td>
<td>Methotrexate, Procarbazine</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Furosemide, Bumetanide, Amyloride Hydrochloride</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Chlorphenamine, Cetrizine, Loratadine</td>
</tr>
<tr>
<td>Antacids contain aluminium hydroxide, calcium carbonate, magnesium salts or sodium bicarbonate. These work to neutralise the acid.</td>
<td>Ranitidine, Omeprazol, Gaviscon, Maalox, Rennies</td>
</tr>
</tbody>
</table>
2.2 List conditions for which each type of medication may be prescribed

- **Antihistamines**
  - Relieve allergy symptoms
- **Antacids**
  - Used to treat indigestion and gastritis
- **Analgesics**
  - Painkillers used to treat pain
- **Diuretics**
  - Reduce the amount of fluid in the body
- **Antibiotics**
  - Used to treat infection
- **Psychotropic medication**
  - Used to treat depression
- **Cytotoxic medication**
  - Used to treat some forms of cancer
- **Anticoagulants**
  - Used to thin the blood
- **Psychoactive**
  - Used to treat mental conditions
- **Laxatives**
  - Used to relieve constipation
- **Steroids**
  - Used to reduce severe inflammation
- **Hormones**
  - Used to replace certain hormones, e.g. insulin and HRT
- **Diuretics**
  - Reduce the amount of fluid in the body
- **Psychoactive**
  - Used to treat mental conditions

2.3 Describe changes to an individual’s physical or mental wellbeing that may indicate an adverse reaction to a medication

The administration of medication is a complex procedure which is open to many complications. Every medicine carries the risk of side effects. It is important that you are aware of the side effects of medications that are commonly used within your workplace, in order that you can recognise and act upon them. If an individual displays any side effects from medication that has been administered, you should immediately inform your manager and the prescribing officer, ensuring that you clearly and fully document the reaction in the individual’s notes.
Older people with multiple diseases often end up taking lots of different medication at the same time. With polypharmacy, there is an increased risk of side effects or interactions between them, as well as problems with taking each correctly.

However, elderly people can be at increased risk of side effects from any medication.

**Liver and kidney function**

As we age, our livers become less efficient at breaking down medicines and our kidneys less efficient at excreting them. This means that normal adult doses of certain medicines may be more likely to cause side effects. In order to avoid this, the individual’s doctor may prescribe a lower dose of a medicine.

**Brain and nervous system**

The brain and nervous system becomes more sensitive to certain medicines as we get older. For example, the elderly are particularly susceptible to the side effects of opioid painkillers such as morphine, and sleeping tablets such as diazepam. Over-sedation, drowsiness, acute confusion or delirium can result.

**Diuretics (water tablets)**

Diuretics are designed to draw water out of the body resulting in the person needing to go to the toilet more frequently. For this reason, it is important that individuals can get to the toilet quickly. It is usually best to take diuretics in the morning, in order to avoid disturbing sleep with trips to the toilet at night.

Another possible side effect of diuretic medication is it can cause a drop in blood pressure when the individual gets up from lying or sitting down. This may make them feel dizzy or light-headed. It is important to sit or lie down until the symptoms pass.

Some forms of diuretic medicine also remove salts (potassium and sodium) from the body. For this reason, the individual’s doctor may want to monitor the levels of these salts using a blood test.
Analgesics

Strong painkillers such as codeine and morphine can cause nausea and vomiting, drowsiness, confusion, constipation and, occasionally, dependence.

Anti-inflammatory medicines

Aspirin and non-steroidal anti-inflammatory drugs such as ibuprofen can cause bleeding from the stomach or bowel.

Anti-depressants

Some anti-depressants can cause the individual to become sleepy and confused; they may lower blood pressure causing falls. These medicines may also cause dry mouth, constipation and problems passing urine.

Neuroleptics

These types of medicines are commonly used in the older adult individual. They can cause drowsiness, low blood pressure (hypotension), constipation, impaired temperature control, Parkinson’s disease symptoms, abnormal face and body movements (which may occur after only a few doses), restlessness or involuntary movements (Tardive Dyskinesia) which may occur after the individual has been taking the medicine for a while.

Sleeping tablets

Common side effects of sleeping tablets include unsteadiness and feeling drowsy the next day. Such side effects are more common in the elderly and increase the risk of falls. This group of medicines could become addictive if they have been used over a long period of time. Suddenly stopping this medication could cause serious withdrawal symptoms.

Over-sedation

Occasionally, sedation may be used when individuals are particularly difficult to manage due to the effects of mental illnesses or dementia, such as:

- Sleeplessness
- Agitation
- Aggression.

Great care must be taken to avoid over-sedation. This can have a detrimental effect on the person’s quality of life, making them less able to cope, more susceptible to falls and more at risk from malnutrition and dehydration (too sleepy to prepare or consume food and drink). Remember, over-sedation is a form of abuse and must not occur.
**Antiarrhythmic medication**

These are drugs that regulate the heartbeat. Digoxin may lead to ‘digoxin toxicity’. Symptoms of this toxicity include nausea, vomiting, dizziness, visual disturbance and unusual heart beats (cardiac arrhythmias). Monitoring of pulse rate and rhythm should take place. You should seek advice if pulse rate is below 60, before administering medications. Amiodarone is very effective in controlling disturbances of the heart rhythm. At low doses it is well tolerated, but has important side effects. It may produce headache, flushing, dizziness and stomach upsets. More seriously, and more rarely, it may cause disorders of the thyroid gland, lungs and liver. To avoid these complications, periodic blood tests are carried out. Individuals may also have chest x-rays and lung function tests.

**Antihypertensives**

Medicines to lower blood pressure, such as atenolol and nifedipine, can cause the heart rate to slow below normal. This is called bradycardia. They can also cause nausea and vomiting. There is also a risk of lowering the blood pressure too much causing fainted and falls. It is essential that individuals taking this group of medication have their blood pressure checked regularly.

**Anticoagulants**

These are medications taken to thin the blood such as warfarin. The major side effect is unstoppable bleeding. Because of the nature of this medication, it is important that regular blood tests are performed to keep a close track on blood clotting times. It is essential that you are aware that the dose of anticoagulant is critical, and should be documented and communicated in service user records and at handover.

**Antibiotics**

Such as erythromycin and amoxycillin can cause nausea and vomiting, diarrhoea and skin rashes. If you suspect a medicine is causing a side-effect, you will need to discuss it with the prescribing officer as soon as possible. All actions taken should be clearly and fully documented.

Your pharmacist will be a good resource and be able to give you a lot of information on side effects. It is good practice for you to learn about each new medicine you encounter.
Anaphylaxis

Anaphylaxis is a word used to describe a serious allergic reaction which develops very rapidly, normally involving more than one part of the body. If severe enough, it can kill and must be treated urgently.

There is always the chance, when a new medicine is introduced, that an individual may have a severe allergic reaction known as an anaphylactic reaction. Signs and symptoms include:

- Rapid onset
- Itchy nettle type rash and reddening of the skin
- Sweating and feeling clammy
- Swelling of hands, face and body
- Low blood pressure (hypotension)
- Rapid heartbeat (tachycardia)
- Faintness/unconsciousness
- Difficulty in breathing
- Stomach pains
- Diarrhoea
- Vomiting
- Death, due to obstructed breathing and low blood pressure.

Allergies

Anyone with an allergy to medication should ideally wear an appropriate alert bracelet and have the details clearly marked on all documentation.
What to do if you suspect a service user is having a severe adverse drug reaction

If you suspect a service user is having an anaphylactic reaction **you must dial 999** immediately. **This is an emergency** and treatment, delivered by the administration of adrenaline, steroids and antihistamines, must be administered as quickly as possible in order to prevent cardio respiratory arrest:

- You will need to alert the manager of your care service - unless the manager is immediately available and on the premises to assist you, you must dial 999 first
- While you are waiting for the ambulance, you must observe the individual closely
- You will need to treat the current symptoms and may need to start resuscitation
- The individual's next of kin will need to be notified, if appropriate
- The GP will need to be informed.

Following such an incident, all actions taken should be fully documented and a note made on whichever medication caused the reaction, so that this will never be administered to the individual again.

### 3.1 Describe the roles and responsibilities of those involved in prescribing, dispensing and supporting use of medication

**Legal responsibilities**

There are many people, with differing responsibilities, involved in the handling of medication including prescribing, dispensing, receiving, storing, administering and disposing of medication. Every health care professional who either prescribes, handles, supplies or administers any form of medication is responsible for working within current legislation and within the code of conduct of their professional body. This also includes health care workers. It is important that you familiarise yourself with your code of practice, in order to assist in protecting both yourself and the service users for whom you provide care.
Role of the General Practitioner (GP)

In relation to medicines, the GP would be responsible for the clinical assessment of the service user, establishing a diagnosis and clinically managing the service user’s condition which may, or may not require prescribing medications, as well as the review of pre-existing medications. The GP will prescribe medication to prevent, treat or relieve medical symptoms.

The General Practitioner would legally be responsible for working within current legislation and within the code of conduct of their professional body.

Medication review

The purpose of a medication review is to ensure that the prescribing, administering and monitoring of all medicines are effective in improving the health outcomes and the wellbeing of service users. It is recommended that individuals over the age of 75 years should have their medicines reviewed every 12 months, with those taking four or more medicines reviewed every six months.

The objectives of a medication review are:

- To identify under-used medicines
- To ensure that medicines are being taken correctly
- To ensure that any changes have been actioned
- To ensure that there is adequate information on the labels of medicines
- To withdraw any treatment that is no longer required
- To reduce the incidence of side effects and adverse drug reactions
- To reduce the likelihood of drug interactions
- To ensure that appropriate drug monitoring is carried out.

Role of the registered nurse

You are likely to come into contact with registered nurses within your role as a health care worker. Community nurses are very experienced registered nurses who have undertaken specialised community training to enable them to meet the nursing needs of the population. They perform a wide range of nursing and medical procedures including:

- Pressure sore management
- Wound care
• Invasive procedures, such as injections or catheterisation
• Enteral feeding (through a tube).

The nursing personnel will monitor the health status of an individual and report any changes to the GP.

All nurses who are registered with the Nursing and Midwifery Council legally owe their patients a duty of care. The nurses’ legal duty of care to the service user lies in their professional accountability for ensuring that patients are protected, have been given sufficient information before treatment and that they receive a safe standard of quality care. After undertaking further training, some qualified nurses can prescribe certain types of medication and appliances.

Specialist nurses may come to visit to provide an individual service to the person. Examples of specialist nurses are palliative care nurses, Macmillan nurses, stoma nurses or continence advisors.

Role of the care manager

The manager of the care service must:
• Ensure that policies and procedures are in place
• Ensure that staff understand the policies and procedures
• Ensure that incidents and near misses are reported and used as a development tool
• Arrange suitable training for care staff
• Keep records of staff development
• Ensure that the appropriate level of assistance is provided to service users
• Ensure that the service they provide is totally professional.

Community pharmacist

The community pharmacist has a professional duty to supply any medicines prescribed by the GP, or other people qualified to prescribe. The pharmacist has to ensure that the medications provided are safe, of a good quality and comply with any legal or ethical obligations, such as packaging, labelling and disposing.
Pharmacists are also available to give advice and information. They can offer support and give advice on compliance issues.

The pharmacist is responsible for checking prescriptions to ensure they are correct, dispensing the correct medication, labelling the container in accordance with the law and offering advice on taking the medication.

By law, the medication label must contain the following information:

- Name of person for whom the medicine is prescribed
- Date of supply
- Directions for use or frequency to be taken
- Name and address of supplier
- Name of the drug
- Dosage of the drug
- Route of administration
- Special instructions
- Warnings or cautions
- Expiry date
- The wording ‘Keep out of reach of children’

Your own role - Accountability

In recognising that health care workers must be accountable for the quality of their work, the Health Care Professionals Council sets out guidelines in meeting the standards of conduct and practice in which they should work.

Accountability can be defined as having a responsibility to someone, or for some activity. Being accountable is taking personal responsibility for the outcome of your actions. As a health care worker you are responsible for any actions that you take within your role. No other person can be accountable for your actions.

Responsibility

There is a difference between the terms responsibility and accountability. Responsibility is concerned with answering for what you do, whilst the term accountability means that you are answerable for the consequences of what you do. As a health care worker you are therefore answerable for everything that you do in relation to any care given to a service user, including administering medication.
It is important to assess your own role in relation to your responsibilities. As an employee within your workplace and under the Health and Safety at Work Act (1974) you have certain responsibilities. After a risk assessment has taken place and consent has been gained from the service user, the level of assistance needed will be identified in the care plan. It is the role of the care worker to familiarise themselves with this, follow it and report any concerns to the care manager.

**Service user**

The risk assessment will identify what assistance is needed to enable the service user to live independently. Some of this support might be needed in order to take medications safely. This would mean the service user has the responsibility to provide staff with access to their medications, MAR charts, prescriptions etc. in order for them to carry out their duties.

**Unpaid carers/family members**

Unpaid carers could provide assistance with medications. Some people you care for will live with their spouse or child, or will have other family members who come to visit. It would be expected that one of these people could provide the help required with medication. If this is not possible, then care workers can provide the assistance, in line with local policies.

**3.2 Explain where responsibilities lie in relation to ‘over the counter’ remedies and supplements**

Over the counter or non-prescription medication includes:

- **Pharmacy only Medicines (P)** - these are medicines that can be bought from a registered pharmacy provided that sale is supervised by the pharmacist

- **General Sales List Medicines (GSL’s)** - these are medicines that can be bought from any shop. These do not require a prescription or the supervision of a pharmacist.
Over the counter remedies

Over the counter or non-prescription medication is another name for homely remedies. The general practitioner, pharmacist and the care home manager should compile an agreed list of over the counter remedies. This list should be reviewed annually, or more frequently, if needed. If you are responsible for administering medication and a service user tells you that they have a headache, but are not prescribed any pain relief, it is important that you are familiar with the policy regarding administering this group of medicines.

The most important factors to take into account are the same as for any medication that you are administering. If you have an agreed list, and it is documented within the care plan that there is an agreement for this particular service user to have Paracetamol, then you will need to read and follow the instructions carefully regarding dosage, frequency and any interactions with other medication that is being taken. You must always document fully the reason for giving the medication and what the outcome is. Over the counter medication should be recorded in the appropriate section of the MAR chart and also within the individual’s notes.

4.1 Describe the routes by which medication can be administered

<table>
<thead>
<tr>
<th>Route</th>
<th>Method of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Oral medication is taken by mouth</td>
</tr>
<tr>
<td>Buccal</td>
<td>Tablet is placed between the top gum and the cheek and is left to dissolve</td>
</tr>
<tr>
<td>Sublingual</td>
<td>Tablet is placed under the tongue and is left to dissolve</td>
</tr>
<tr>
<td>Intra-ocular</td>
<td>Into the eyes</td>
</tr>
<tr>
<td>Intra-aural</td>
<td>Into the ears</td>
</tr>
<tr>
<td>Intra-nasal</td>
<td>Into the nose</td>
</tr>
<tr>
<td>Inhalation</td>
<td>Breathed in via the nose/mouth into the lungs</td>
</tr>
<tr>
<td>Topical</td>
<td>Applied to the outer surface of the skin</td>
</tr>
<tr>
<td>Transdermal</td>
<td>Applied via a patch to the outer surface of the skin</td>
</tr>
<tr>
<td>Vaginal</td>
<td>Into the vagina</td>
</tr>
<tr>
<td>Method</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rectal</td>
<td>Into the rectum</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td>Medication that is injected just below the surface of the skin into the subcutaneous layer of tissue</td>
</tr>
<tr>
<td>Intra-muscular</td>
<td>Injected into a large muscle of the buttocks, the arms or the legs. Intra-muscular injections would only ever be given by a trained nurse or doctor or other trained health care professional. Care workers would never be expected to give medication by this route</td>
</tr>
<tr>
<td>Intravenous</td>
<td>Medication is given via the large veins and make for a faster route of administration. Intravenous injections would only ever be given by a trained nurse or doctor or other trained health care professional. Care workers would never be expected to give medication by this route</td>
</tr>
<tr>
<td>Intra-dermal</td>
<td>Very small amounts of injection given just under the skin e.g. TB vaccine</td>
</tr>
<tr>
<td>Percutaneous Endoscopic Gastrostomy (PEG)</td>
<td>Medicines given directly into a PEG tube which has been inserted directly into the person’s stomach.</td>
</tr>
</tbody>
</table>

Trained nurses and doctors would be responsible for the administration of intra-muscular, intravenous or intra-dermal injections. Administration of subcutaneous injections should only be carried out by staff who have undergone specific training and have been assessed as competent to do so. Then a strict protocol must be followed.
4.2 Describe different forms in which medication may be presented

You will know from your own experience that medication is manufactured and can be administered in many different forms. The form is simply the way that the medication is presented; for example, tablet, liquid, cream, suppository etc. The prescribing officer (the person who prescribes the medication, such as a GP or dentist) will decide which form of medication to prescribe. This choice will largely depend on the part of the body that is being treated and what will be the best way for the body to absorb the medication. The purpose of these various forms of medication is to carry the active constituent (the drug) to the area where it is most needed and, in so doing, avoid or keep to the minimum, any unwanted effects on other areas of the body.

The route of administration that you will be most familiar with will be the oral route. The most common forms of medication given by this route will be tablets, capsules and liquid preparations.

Preparations for oral administration

Tablets

Tablets come in various colours, shapes and sizes and have different coatings; there is actually a reason for this. The formulation may be very simple and result, for instance, in a plain white uncoated tablet, or it could be complex and designed with specific therapeutic aims. Some tablets are known to be an irritant to the lining of the stomach so these tablets will be formulated with an enteric coating. You may recognise this from the letters E.C. after the medicine name e.g. Aspirin E.C. This coating is designed to allow the tablet to remain intact in the stomach and to pass unchanged to the small bowel where the coating dissolves allowing the drug to be released and absorbed.

Some tablets are formulated specifically to achieve control of the rate of release of drug from the tablet as it passes through the digestive system. Manufacturers describe these preparations by use of terms such as sustained release, modified release and controlled release. The medicine will be released over 12-24 hours. These medicines must not be cut in half, chewed or crushed, as this will affect the rate at which the body absorbs the drug and could cause an accidental overdose.
Some tablets are known as **dispersible, effervescent or soluble**. These preparations are designed to be dissolved in a suitable liquid before administration.

Some tablets are made to be placed between the gum and the inside of the mouth; these are known as **buccal** medicines. Other tablets are designed to be placed under the tongue. **Sublingual** medicine is given under the tongue, usually in tablet or spray form; the tablet should be allowed to dissolve under the tongue.

**Capsules**

There are two forms of capsules: hard and soft. Hard capsules contain powder or semi-solid preparations, whilst soft capsules contain liquids. The shell of hard capsules are usually made from gelatine that consists of two parts and are cylindrical in shape. Soft capsules are also made from gelatine, but have no join and contain liquid. Capsules are intended to be taken whole and must not be opened or broken before being administered.

**Lozenges and pastilles**

Lozenges and pastilles are solid, single dose preparations which are designed to be sucked, giving a local or systemic effect within the mouth and throat.

**Liquids**

Liquid preparations are extremely useful for administering medications to individuals who find it difficult to swallow tablets or capsules, or when the drug is not available in tablet form. It is particularly important that liquid medicines be adequately mixed before each dose is measured, in order to ensure that the measured volume contains the correct amount of the drug.

**Drops, sprays and ointments**

Drops and sprays are used to administer medication into the eyes, nose and ears. Ointments are also used to treat some conditions of the eye.

**Eye drops and ointments** are generally used to treat conditions of the eye, such as glaucoma and conjunctivitis.
Nasal sprays, drops and vapour are mainly used for conditions such as sinusitis and hay fever.

Ointment may be used for the treatment of MRSA.

Eardrops are used to soften earwax or to treat infections. These are likely to be dispensed in a bottle containing an applicator.

Inhaled preparations

Service users with chronic chest conditions such as asthma and chronic obstructive pulmonary disease (COPD) are likely to have medicines that are to be taken by inhalation.

Inhaled preparations usually come in the form of inhalers and nebulisers. Both allow the inhalation of a wide range of drugs that have a localised therapeutic effect.

An inhaler works by passing a metered volume of medication through a valve under pressure and allows the delivery of a measured dose of drug in a very fine spray. Bronchodilators and steroids are commonly administered in this way.

Service users who have severe chest conditions may also require a nebuliser. Nebulisation involves passing oxygen or air through a solution of a drug which is put into a small chamber. The result is a very fine mist which is then inhaled via a facemask. Bronchodilators are generally administered in this way.

Rectal and vaginal preparations

Enemas

Enemas are generally solutions that are given into the rectum as a laxative, but some enemas can be used for diagnostic purposes; for example, barium enemas.

Suppositories

Suppositories are solid pellets used for rectal administration. They may be used as a laxative or for systemic therapy. Many drugs such as Paracetamol for example, are absorbed when administered in this way.

Pessaries

These are solid pellets that are administered into the vagina and are usually designed to have a local therapeutic effect; for example, Canestan pessaries are often used for the treatment of vaginal thrush.
Topical preparations

Topical medicines are those that are applied externally on the skin. These should be treated in exactly the same way as other types of medicine, and applied in the dosage and frequency prescribed. You should wear gloves and an apron when administering topical preparations. The cream, ointment or spray should be gently spread over the affected area; they should not be rubbed in, unless specifically instructed, as this may cause damage to the skin.

Transdermal preparations

Patches

Transdermal medicines are administered in the form of a patch which is placed on the service user’s skin; it releases effective amounts of the drug over a period of time. One of the main advantages of administering medication in this way is that it bypasses the gastro intestinal tract, therefore reducing the chance of side effects which may be caused if taking the medicine orally. Transdermal patches can be used for pain relief, for hormone replacement therapy and to help people stop smoking.

Care must be taken not to underestimate the effects of analgesic given in patch form because they look like plasters. They must be checked regularly to ensure that they are still in place. Service users must be discouraged from using hot water bottles or taking hot baths, as increases in temperature can cause the medicine to be delivered more rapidly. The main problem with transdermal preparations is that the service user may be allergic to the adhesive on the patch.

Injectable preparations

Injectable preparations may come in vials that need to be drawn up via a needle and syringe, or they may come in pre-drawn up and measured syringes.
4.3 Describe materials and equipment that can assist in administering medication

Equipment

The techniques for administering medication also relate to the equipment used. These must be prepared and checked, and may include:

- A tap, available to wash hands or obtain clean water for drinking
- Disposable apron
- Clean medicine spoons and measuring pots
- Disposable gloves
- When small doses of liquid medicine are required, an oral syringe should be used in preference to a spoon or graduated medicine pot, in order to ensure accuracy. However, medicine should not be administered via an oral syringe
- Jugs, glasses and water
- Syringes
- Sterile water
- Syringe drivers
- Tablet splitter
- Equipment for measuring pulse and blood pressure
- Spacer device for administering inhalers.

Labelling

If the individual has a condition which affects their eyesight, you could suggest the use of a magnifying glass or request large print instructions on tags securely attached to the containers. Some pharmacists may provide large print or Braille labels on request.

Medicine compliance devices

These devices are designed to promote the safe self-administration of medicines by service users. They help individuals, who may have reduced strength and manual dexterity, to access their medicine and also provide a visual pointer to remind them which medicine to take and when.

There are two types of manufactured medicine compliance devices. The Daily Dose Reminder (DDR) and Monitored Dose Systems (MDS).

Monitored Dose Systems are usually heat-sealed in foil blisters or Nomad cassettes and are assembled in the pharmacy.
Day care medicines

In the case of an individual going to day care or out for the day, either the individual’s original medicines or a separately dispensed supply of medicines should be used. Medicines should not be placed in temporary containers or envelopes. Any medicines leaving or entering the care home should be fully documented.

5.1 Demonstrate how to receive supplies of medication in line with agreed ways of working

Guidelines for receiving, and indeed storing, medications are very well documented. It is important that you are aware of current European and National legislation, and National Guidelines and protocols which affect your practice, in relation to receiving and storing medication.

Medication may come into the home from a variety of different sources, such as:

- Repeat prescriptions
- One-off prescriptions, these are typically short term courses of treatment, such as antibiotics
- Brought in on admission
- Brought in by visitors - visitors should be advised not to bring in medication for service users and under no circumstances should medication be accepted or administered which is not prescribed for the individual
- Self-purchase - whilst individuals are entitled to exercise their rights and purchase their own medication, staff do need to be vigilant in monitoring and recording such use. Medicines may interact and it may be necessary to seek advice from the pharmacist or GP on the individual's behalf. If service users do wish to purchase their own medications, it may be necessary to get them to sign a disclaimer form. Special attention should also be paid to the safe storage of self-purchased medication. Always act on the advice of your manager and adhere to organisational policies and procedures
- From hospital.
All medicines arriving into the care home, either from the person’s home, pharmacy or other health care setting, should be fully documented. Documentation may consist of service user records, stock books, order requisitions and the controlled drugs register.

The records should clearly state the following:

- The date of receipt
- The name, strength and dose of the medication
- The quantity received
- The individual for whom the medication is prescribed
- The signature of the care worker receiving the drug.

**The receiving of controlled drugs**

The Controlled Drugs Register must record:

- The date the controlled drug was received
- The name of the person who took delivery of the controlled drug
- The amount of controlled drug received
- The form in which it was received e.g. tablets, liquids in millilitres and injections in ampoules.

These records must always be available for inspection and stored for 7 years

**5.2 Demonstrate how to store medication safely**

**Storage of medicines**

Guidelines for the storage of medicines are well documented. However, you should use your local or organisation’s policy on The Safe Storage of Medicines, as these should have taken all the legislation and guidelines into account. It is the registered person’s responsibility to ensure that there is a policy covering the storage of medicines, but it is your responsibility to access the policy and comply with it.
General considerations

Storage of medication also includes:

- Stock rotation; this refers to using medication with the shortest expiry date first. These should be placed at the front of the cupboard and used before other bottles or packages are opened. The expiry date on medicine bottles should always be checked before administering.
- Maintaining suitable conditions
- Disposing of out-of-date stock.

Documents may include:

- Service user records
- Stock books
- Order requisition
- Controlled drugs register.

Storage area

The care setting must have designated secure and temperature controlled areas to store medicines. There must also be space to store nutritional supplements, prescribed dressings and ostomy products, complying with the manufacturer’s storage advice. No medicinal item should be stored on the floor.

Medicines for internal use should be stored separately from those for external use. Both should be kept in a locked cupboard and clearly labelled. These cupboards should be in locked rooms, preferably without external access via windows. If this is not practicable, then the window should be secured with bars or other securing devices. The store should never have access via an external door.

If it is not practicable to have a secure room to store medicines, then a secure cupboard can be used. This should be of a size suitable for storing all medicinal items needed. It must be fitted with a quality lock and access restricted to authorised persons only. These are:
• The registered person - the manager or senior person who is registered with the appropriate Care Commission to do so
• The designated person - a member of the care home staff appointed by the owners or registered person to have a specific responsibility; in this case, the safe handling and administration of medicines
• The pharmacist
• Regulating authorities, Care Standards Commission, Health and Safety Executive
• Internal quality audit personnel.

For individuals who are cared for in their own homes, you should seek advice from your manager, and adhere to local and organisational policies. Any concerns with regard to safe storage should be reported immediately, and discussed with the individual and those caring for them at home.
Medication that is not stored safely may be accessed by those it is not prescribed for. The consequences can be very serious, especially if young children mistakenly take the medication.

**Storage of controlled drugs**

Unless individuals are self-medicating, controlled drugs must be stored in cupboards which meet the requirements set out in the Misuse of Drugs (Safe Custody) Regulations 1973 (as amended 2007). These regulations specify the quality, construction method of fixing and the locking system of controlled drug cupboards.

It is usual in care homes that controlled drugs are kept within a secure, lockable metal cupboard which is mounted on an internal wall. Only members of staff who have authorised access are permitted to hold the controlled drug cupboard keys; this means you should never give the keys to a member of staff who is not permitted access to controlled drugs. Only controlled drugs must be stored in the controlled drug cupboard; items of value such as money/jewellery or other non-controlled drugs should never be stored in this cupboard.

Controlled drugs should only ever be taken out of the controlled drug cupboard whilst they are being dispensed or counted for stock control purposes. For individuals who
self-administer their own controlled drugs, these should be stored in their own individual lockable cupboard, to which the individual has their own key.

**Storage of oxygen**

Oxygen is a flammable gas. The following should be adhered to closely, when storing oxygen:

- Store in dry, clean, well-ventilated areas
- Store away from highly flammable liquids, other combustible materials and sources of heat or ignition
- A warning sign is required on the storage door and also anywhere oxygen therapy is used in the care home
- Individuals, staff and visitors must be instructed not to smoke or use naked flames near oxygen cylinders
- Cylinders should be stored on an oxygen trolley and securely chained to the wall of the storage area.

**Storage of drugs for self-administration**

Individuals, where possible and following a comprehensive risk assessment, should be encouraged to store and administer their own medicines. This may help to preserve their independence. Individuals who are self-administering medicines should be provided with a lockable cupboard or drawer in which to store their medicines, and they should be responsible for the key. Care workers may only access this store with permission from the individual. No unauthorised person should have access to the medicine.

It is the responsibility of the care home to ensure that people who are self-administering understand that their medicines must be kept safely locked away. Regular checks should be made to ensure that this is being maintained.

**Mobile storage**

If a trolley is used to store medicines, it should have the capacity to lock away all medicines, including those not currently in use for that medicine round. It must be locked and secured to a wall when not in use. This area should not be accessible or readily
visible. Ideally the trolley should be secured in a locked, suitably designated room. Lockable trolleys or lockable secure containers should be used when conveying medicines to individuals situated in other areas of the care environment. All mobile storage containers must be under the observation of the designated person at all times when administering medicines, and must be locked and secured to a wall by an approved device, and preferably locked out of sight when not in use.

The keys and access to all areas and containers for the storage of medicines must be kept safely with the designated responsible person at all times. Access to these areas should be restricted to authorised personnel only.

Careful consideration should be given to how the medicines have been dispensed e.g. MDS cassettes. Adequate storage must be provided at all times, including storage of replacement cassettes during return and delivery receipt.

The temperature for medicines without special storage instructions should be stored between 16 and 25 degrees centigrade and out of direct sunlight.

**Cold storage**

Some medicines should be stored in a refrigerator; the recommended storage temperature will be marked on the packaging, or a label applied by the dispensing pharmacist.

A separate lockable refrigerator should be used for storing these medicines and should not be used for storing any other items. The temperature should be monitored daily and recorded using a minimum/maximum thermometer. The normal range for the temperature should be minimum 2 degrees centigrade and maximum 8 degrees centigrade.

**Problems with storage**

Problems may sometimes occur with storage; so it is essential that these are acted upon immediately, in order to maintain the safety and effectiveness of medications and to prevent errors from occurring. Local policies should be in place in order to advise staff what actions to take.
If a label from a container becomes detached or is illegible, prompt advice from the person who supplied it must be sought. Until then the container should not be used.

In all circumstances, it is essential that documentation is made and maintained.

**Standard precautions (infection control)**

Standard precautions are a series of interventions which are aimed at minimising or preventing cross infection. This includes hand washing and cleansing before during and after an activity, and the use of personal protective equipment, when appropriate. In minimising and preventing contamination from medicines, it is important to take these issues into account.

**5.3 Demonstrate how to dispose of unused or unwanted medication safely**

Medicines that are stored and administered within a care environment must be appropriate to the current therapy and prescription for each individual. Therefore, all surplus, unwanted, contaminated, discontinued medicines or those past their expiry date must be disposed of in the appropriate manner. Your organisation will have a policy that deals with safe disposal of medicines. You or any other staff must not dispose of medicines, but must return them to the supplier which will be, in the majority of cases, the pharmacist (chemist) who dispensed them.

All medicines prescribed and dispensed for a person are the property of that individual. If a person leaves the care setting, their medicines should be given to them, unless the individual gives consent for their safe disposal.

Following the death of an individual, all medicines must be kept for 7 days before disposal, in case the Coroner’s Office or the Courts require them.

The pharmacist is the only person who is permitted to, and is responsible for, the disposal of medicines in the correct manner. Since 2005 local community pharmacists have required a Waste Management Licence in order to accept medication from care homes for safe disposal.
It is the responsibility of the staff within the care setting to ensure that a complete record of medicines going out of the home is recorded. This record should be kept safe for 8 years.

The record must be able to provide a full audit trail (an audit is a review, inspection or check of what happens by whom, where and when). This record must include:

- Date of disposal/return to pharmacy
- Name and strength of medicine
- Quantity removed
- The name of the individual for whom medicine was prescribed or purchased
- The signature of the member of staff who arranged the safe return of the medicines to the pharmacist
- In the case of controlled drugs, the signature of the pharmacist is also required, on receipt of the drugs.

The safety of the public is paramount when disposing of unused medication. The waste disposal regulations make it an offence to dispose of medicines into the general sewage system e.g. via sinks or toilets. By following the correct procedures for the safe disposal of medicines, there is no possibility of false allegations of misuse of medicines by staff. All drugs must be accounted for.

6.1 Explain the importance of the following principles in the use of medication

- Consent
- Self-medication or active participation
- Dignity and privacy
- Confidentiality.
Consent and understanding

Before administering any medication to an individual, it is essential that you have their consent to do so. You must respect the individual's rights to determine what happens to their own body. As well as being a fundamental part of good practice, it is also a legal requirement.

Whether administering medication or helping an individual to get dressed, it is vital that you have their consent. In seeking consent, you must also be aware that every individual has the right to refuse their medication, and it should never be assumed that individuals cannot make decisions just because they are elderly or frail.

A risk assessment should be undertaken with the service user, who must consent to the support that is identified. If the service user does not consent to the help, or if they later withdraw their consent, the worker cannot then provide the support. It should be recorded on the care plan that the service user has consented; equally, it should be reported if they withdraw their consent. Under no circumstances should a care worker force the person to take medicines. There are many reasons why they might not want to take a medication and the right to refuse must be accepted.

In order to give consent, service users need to know what they are consenting to and may need to be informed about any possible side effects from their medication. This should always be made clear to service users.

Some people will have difficulty communicating their consent. Consent should be given in writing wherever possible, but it may also be verbal or by use of body language. A person who does not open their mouth and clenches their teeth together when offered medication is clearly not giving consent. If the person is unable to communicate consent at all, the prescriber must formally state that the treatment is in the best interests of the service user.

Information about the medication

Individuals have the right to information regarding the medication that they take. If individuals understand what they are taking their medication for, they are more likely to comply and benefit from the desired effects of the medication.
Self-administration of medicines and active participation

Active participation is a way of working that recognises an individual’s right to participate in the activities and relationship of everyday life, as independently as possible. The individual is regarded as an active partner in their own care of support, rather than a passive recipient.

Self-administration is the term used to describe the service user storing and administering medicines for their use. Individuals who are self-administering medications should be assessed and supported to self-administer and store their medicines.

The National Minimum Standards for Older people and Adults placed great emphasis on the rights of individuals and the importance of preserving independence. The more recent CQC Fundamental Standards relating to dignity and respect reaffirm these rights. Individuals, where possible, should be encouraged to take responsibility for their own medication. It is important to emphasise that the prescribed medicines are actually the property of the individual for whom they were prescribed and it should not automatically be assumed that care staff have a right to remove these medicines from them.

Each person is an individual. If an individual has the ability to collect their own prescription and take it to the pharmacy for dispensing, they have the right to choose where the prescription is dispensed. Likewise, if an individual does not have the ability to take control over their prescription, it does not mean that they will not be able to exercise control over their medicines.

Dignity and privacy

Person-centred planning

The key idea behind person-centred planning (PCP) is that ideas and values used to plan activities and life are done with a person, rather than for a person. Person-centred care is one of the Care Quality Commission’s Fundamental standards.

Medication is also an important daily living skill, so the people you work with should be encouraged to be as independent as possible with their medication. This includes ordering, collecting, taking and disposing of medication. This is an example of good practice that supports a person-centred approach. It is about caring with, rather than
caring for someone; encouraging them to care about themselves and be responsible for their own medication and health issues. This also promotes dignity, as it shows you respect the person, their choices and their independence.

Ensure you are in a suitable location in which to administer the planned medicines. Some people get embarrassed doing this in front of others, so there are confidentiality issues to consider too.

This is especially important if creams are to be applied, or pessaries, enemas or injections administered. This should take place in a private area. Always ensure clothing is replaced or rearranged to preserve dignity.

Confidentiality and medication

This information can be very personal and it is important to remember the principles of confidentiality in relation to the administration of medication, and be mindful of where you discuss an individual’s medication regime. For example, following an individual’s medication review it may be necessary to communicate any changes to their medication to other members of staff; this must be done in private. Any changes in an individual’s treatment should be documented in their notes and MAR.

6.2 Explain how risk assessment can be used to promote an individual’s independence in managing medication

Risk assessments

When a person receives care services, a medication risk assessment must be carried out. The risk assessment identifies any potential problems and solutions before they happen. This ensures the health and safety, of both the service user and the worker. The medication risk assessment should be carried out by a suitably qualified person, such as a care service manager or social worker, or a care worker who has had specialist training, in line with agreed ways of working.

Depending on the nature of the person and highlighted concerns, undertaking a risk assessment may involve contacting the service user’s family, pharmacist, general practitioner, hospital consultants, hospital ward staff (if they have recently been discharged), community nurses, health and safety officers or NHS direct.
The risk assessment must be constantly reviewed, as changes could mean the service user requires ‘administration’, rather than ‘assistance’ with medication. This should be reported in the care notes and to the care service manager.

The risk assessment should identify as many risks as possible, using the following questions as a guideline:

- Can the service user order and collect their own prescriptions? If the answer is no, can family, friends or neighbours assist with this? Does the local pharmacy offer a delivery service?
- Does the service user know which medications they should be taking and where to find these within their own home?
- Are medications stored properly?
- Do the quantities of medicines in the house seem appropriate to what is being prescribed? Are there old medicines lying around the house? Does the service user need to order repeats or can they use existing stock?
- Does the service user understand what they should be taking and when? Would they be able to do this if the pharmacist explained to them? Would they be able to do this if they used a compliance aid such as a pill reminder box?
- Is the service user aware of the day, date and time of day?
- Does the service user want to take their medication? Do they often or sometimes choose not to take it, or miss a dose? If this question highlights an issue, liaising with the GP could be beneficial to explore the reasons why.
- Does the service user usually remember to take their medication correctly and at the correct time? If not, would setting a reminder help? Or compliance aids?
- Can the service user read the label printed on the medicine container? Think about any literacy issues, numeracy issues and problems with vision. This could be overcome by recording sound clips, providing a magnifying glass or asking the pharmacist to give verbal instructions.
- Can the service user open medicine containers by themselves? This is important when considering the level of support that is required as level 1 care would not allow the worker to open the container. If they cannot open the medicine container, maybe a family member or informal carer can help? Maybe the pharmacy can use alternate packaging.
- Can the service user swallow tablets or do alternative options need to be explored?
• Can the service user pick up a bottle of medicine and measure out the dosage correctly? If not, again, informal or family carers might be able to help, or the pharmacy might be able to provide alternate packaging or assistive devices.

• Would the service user have any problems using inhalers, eye drops or other specialist equipment?

• The environment and safe storage of medication. Assessment of the individual’s ability to maintain secure storage and not leave medication unattended.

• Safe re-ordering method. Will the individual prompt re-ordering or will care staff need to keep checking back with the individual?

• Is there a risk of deliberate abuse/misuse?

• Any other relevant factors.

The aim of the risk assessment is to promote dignity by encouraging independence with medications. The correct level of support is the minimum level that the service user requires, in order to take their medications safely and correctly.

Levels of support

Assistance v. administration

The difference between assisting someone to take medications themselves and administering medication on their behalf must be highlighted. The aim should always be for care workers to assist someone, rather than do tasks for them.

The Care Quality Commission (CQC) provides guidance for assisting with medication. The CQC identify three different levels of support that a person can be identified as needing.

These are:

Level 1: Assisted self-medication

Level 2: Physically assisted medication

Level 3: Complete medication management
There are also some specialist tasks that a care worker may be required to perform. The levels dictate what a care worker can and cannot do. It is only when someone is assessed as needing level 3 help, or help with specialist tasks, that the care worker can administer medication for the individual. Administering medication is defined as preparing and giving a dose of a medicine to an individual. When assisting an individual, this is any task that allows them to take the medication themselves, such as verbal reminders or reading the label on the bottle. Staff must also remember that the level of support could change over time, in line with the risk assessment review; so just because someone needs level 3 support now, does not necessarily mean they will always need that level of support.

**Level 1: Assisted self-medication**

If a person is assessed as needing level 1 support, they will be expected to be responsible for their own medication. The role of the care worker at this level is to direct the person to take responsibility for their own self-medication.

The care worker is permitted to:

- Assist with ordering and collecting the prescription
- Give verbal reminders to take medicines
- Help by reading labels or the patient information leaflet
- Give advice on storage of medicines
- Observe the person medicating
- Report any concerns or changes.

At this level the care worker is NOT permitted to:

- Open containers
- Administer medication (handing them a tablet or prepared dose)
- Carry out any invasive, clinical or nursing tasks
- Perform any specialist tasks.

**Level 2: Supervised or physically assisted self-medication**

A service user who needs level 2 assistance self-medicates. They choose the medicine and its dose, but they require physical assistance to prepare or take the medicine. Completion of a Medicines Administration Record Sheet (MARS) is required at level 2.
At this level, the care worker is permitted to:

- Carry out all the support tasks in level1
- Open containers
- Pour liquid doses
- Prepare inhalers or spacer devices
- Prepare a compliance device for eye drops
- Apply creams, ointments and other topical preparations.

The care worker is NOT allowed to:

- Perform invasive, clinical or nursing tasks
- Open containers or prepare doses without direction from the service user
- Assist with opening monitored dose devices (e.g. dosette) that have been filled by family and friends
- Perform specialist tasks, unless specialist training has been provided.

**Level 3: Complete medicines management**

At this level, the service user does not take any responsibility for their medications. The care workers can perform all the tasks in levels 1 and 2 above, but are also required to select and administer the medicine. This would require opening the containers, preparing the dose, handing the dose to the service user and ensuring they take the dose correctly. There is a good practice procedure outlined below for this.

At level 3, all the exclusions of levels 1 and 2 are still relevant. Care workers must still not administer medicines from dosette boxes filled by family members.

**Types of medication suitable for levels 1, 2 and 3 support**

There are currently no compliance aids to assist with ear and nose drops; therefore, assistance with these is considered to be a specialist task.

Eye drops are a specialist task unless a compliance aid is used. Such compliance aid can be prescribed or purchased by the user. The date of opening eye drops must be written on the label and not used after 28 days. This is to prevent infection.
All other types of medication are suitable for support, including oral medication, controlled drugs, topical preparations and inhalers.

6.3 Describe how ethical issues that may arise over the use of medication can be addressed

It is vital that you are aware of your role and responsibilities with regard to ethical issues, and that you adhere to legislation, guidelines, policies and procedures. Any issues arising, such as administration, dietary needs, curative aspects, contents and applications should be reported. Support should be obtained from management.

Consent and administration

A competent adult has the right to refuse treatment, even when the clinical experiences of care workers or other health care professionals differ. Consent is not a one-off event and individuals are entitled to change their minds, even if they have previously given consent.

If this happens you should record the reason for refusal on the MAR sheet and the individual’s notes, using appropriate codes, as stated in local or organisational policy.

If an individual is unable to take their prescribed medicine, they may be ill or just refusing to take it for another reason. This should be reported immediately to your manager and the prescribing officer.

If a person is thought to lack the ability to make an informed decision for themselves, then the Mental Capacity Act would apply. The decision may be taken that the person does have capacity, then the choices they make must be respected. Some people simply do not want treatment for their illnesses. If the person does lack capacity, then all medication support will be at level 3 and all support provided must be in the best interests of the person receiving care. Lack of capacity should never be assumed and the functional capacity test in the Mental Capacity Act must be followed.
Dietary and cultural issues

Cultural issues should also be considered when the service user is consenting. If an individual is practising Ramadan, they might only want to take their medications at a certain time. The gelatine on capsules is not vegetarian and might upset vegetarians. These issues can be explored with the person and, hopefully, a positive solution reached.

7.1 Demonstrate how to access information about an individual’s medication

Information regarding medication can be obtained from a number of sources. It is important that you are aware of how and where to access this information, even if you do not collect the information directly from the source. Sources may include:

- Care plans
- Medication record sheets (MAR Sheets)
- Pharmacy
- Manager
- General Practitioner
- Individual
- Relatives and carers.

7.2 Demonstrate how to support an individual to use medication in ways that promote hygiene, safety, dignity and active participation

The five Rs

The worker should check the care plan to ensure that the service user is assessed as needing level 3 assistance with their medication. The next task is based around what has become known as the ‘five rights’ - the right person, right medicine, right dose, right time and right method.
Right person

The care worker must be confident they have the right person to receive the medication. This is easier once the care worker and service user know each other, but domiciliary care workers should be confident they have the right person, especially if the service user is confused. It is good practice to have a recent photograph of the service user on the front of their file.

Right medicine

Check and double check the medication you are planning to administer. Check it is the correct person’s name on the label and check the name of the drug against the MAR sheet. Sometimes a generic equivalent might be in use and the name of the medication might differ from what is recorded on the MAR. It is very important to be confident you are giving the correct medication.

Consult the BNF, if there is a discrepancy, or contact your care manager or pharmacist, for advice. If you are in any doubt whether or not it is the correct medication, do not give the medication, but remember to record this on the MAR and on the service user’s notes. Some medications look similar and have similar sounding names, so it is worth taking time to make sure you have the correct medicine.

Right dose

Check the dose that is required on the MAR and check the dosage of the medication on its label. Double check that you have the right amount of tablets. Liquids can be measured by using a syringe, as this will be more accurate than using a spoon.

Right route

Check you are giving the medication by the correct route. Never leave medications about and always watch the service user taking their medications. Confused people, or those who experience side effects, could easily take a medication in the wrong way.

Right time

Medications are prescribed to be taken at a specific time for a good reason. Levels of the drug may need to be maintained in the bloodstream; therefore, doses may be spread throughout the day. Other drugs may be required to help the body perform certain functions and therefore the drug needs to be taken at the correct time of day. Some people take a medication at a certain time to avoid side effects, such as insomnia and will, therefore, take the medication in the morning. Other medicines might need to be taken
before, with, or after, food. It is therefore important that the carer makes sure they are giving the medicine at the right time. The suggested procedure for good practice when assisting someone with level 3 medication support is:

1. Check that the service user’s name on the medicine container is correct. Check the strength and dose required against the MAR, check the use by date of the medicine, check the MAR to ensure that no one else has already given the medication. This can happen when family have been or if the person is receiving care from more than one agency.

2. The care worker should thoroughly wash and dry their hands and any equipment that is needed, such as a spoon or glass.

3. Put on protective gloves - this procedure prevents spreading germs, but also means that the drug cannot be absorbed through the care worker’s skin.

4. Check the dispensing label for any special instructions, such as ‘take with food’. Make sure that any special instructions are carried out.

5. Handle the medication as little as possible. Tablets in a blister pack can be pushed through the foil and not touched at all.

6. Make sure the service user is upright. It is not good practice to give medicine to someone who is lying down. If the service user is not or cannot be assisted to sit or stand up, then the home care worker must not give the medication.

7. Offer a full glass of water to take medicines with. Tablets should be swallowed with water.

8. Replace lids and packaging properly and store the medicines in a safe place, so other care workers and the service user know where they are.

9. The care worker should wash their hands again and clean any equipment used.

10. If a service user refuses the medication, spits it out or withdraws consent for assistance, this should be recorded in their notes and on the MAR sheet.

11. If assistance is required applying topical solutions such as creams, the care worker must wear protective equipment, such as gloves. Hands must still be thoroughly washed, even when gloves are worn.
Reading the label

The service user should always be encouraged to read the label before taking the medication. The label gives clear information on how and when the drug should be taken, as well as giving any special instructions. If, after reading the label, the person is still unsure, ask the pharmacist. The dispensing pharmacist’s details will also be on the label. Some people receiving home care will be able to read the label themselves, while others will need it reading to them. It is important to wear corrective eyewear if necessary, or provide a magnifying glass for the service user.

7.3 Demonstrate strategies to ensure that medication is used or administered correctly

Adhering to guidelines on accountability and in the best interests of individuals, it is important that you:

- Know the therapeutic uses of the medicines that you are administering, its normal dosage, side effects, precautions and contra-indications
- Be certain of the individual’s identity
- Be aware of the individual’s plan of care
- Check that the MAR chart and the label on the medication is legible and clear
- Have considered the dosage, form, route and timing of administration, in relation to the individual’s needs and other medication being taken
- Check the expiry date of the medication. The expiry date indicates when a medicine is no longer pharmacologically effective. As medicines deteriorate during storage, using them outside the expiry date is dangerous
- Before administering it, check that the person is not allergic to the medication
- Inform your manager and the prescriber without delay, if contra-indications to the medication are discovered, or if the individual develops a reaction or if it is felt that the medication is no longer suitable.
**Specialist tasks**

In some circumstances, a community nurse might request that domiciliary care workers carry out specialist tasks. If this happens, the nurse still retains responsibility and the assistance required will be written in the care plan. The care worker must receive training and therefore be competent at performing the required tasks. Care workers should still only carry out these tasks if they feel able to do so, and should not be treated any differently if they refuse to provide assistance with these.

Specialist tasks can be:

- Administering eye or eardrops
- Preventing pressure sores
- Assisting with stomas
- Changing dressings
- Giving enemas
- Giving injections
- Giving suppositories
- Assisting with a nebuliser
- Using products for rectal or vaginal use
- Catheter care.

**Controlled drugs**

Standard 9.7 of National Minimum Standards stated:

> ‘In Care Homes with personal care only, all medicines, including controlled drugs (except those for self-administration) are administered by designated and appropriately trained staff. The administration of controlled drugs is witnessed by another designated appropriately trained member of staff’.
Administration of controlled drugs

The administration of controlled drugs will be covered by organisational and local policies. The following must be included in the safe administration of controlled drugs.

- The designated worker takes the controlled drug from the controlled drug cupboard and checks against the MAR sheet. At the same time, the stock amount of the controlled drug must be checked with the Controlled Drug Register. Another designated worker must check this process at the same time.

- The two designated workers then check the controlled drug and its dosage at the same time.

- The remaining stock of controlled drug is then returned to the controlled drug cupboard which is securely locked.

- The two designated workers will administer the controlled drug to the individual using the usual administration process.

- The Controlled Drug Register is then completed, as per policy, and the remaining stock balance documented.

- Stock balances should be checked at each administration and also on a regular basis, as defined by organisational and local policies.

Some drug administrations may require complex calculations in order to arrive at the correct dosage of medication. It is strongly recommended that a second person checks the calculation in order to minimise the chance of an error occurring.
### 7.4 Demonstrate how to address any practical difficulties that may arise when medication is used

Model of good practice: Possible medication problems and solutions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user does not feel well</td>
<td>Report to care manager and GP. Seek advice regarding whether the medicine should be given.</td>
</tr>
<tr>
<td>Label has come off the medicine container</td>
<td>Do not give the medication. Report to care manager who, in turn, will contact the pharmacist.</td>
</tr>
<tr>
<td>Upon getting eye drops from refrigerator, there is no opening date written on</td>
<td>The label on the container should have the date of issue. If this was less than 28 days ago, then it is okay to use the drops. If it was longer, then assume they are not safe to use.</td>
</tr>
<tr>
<td>Service user refuses to take medication</td>
<td>Respect this decision and record it on the MAR chart and in the service user’s notes. Do not hide medicine in food as this is deception and a form of abuse.</td>
</tr>
<tr>
<td>Missed doses</td>
<td>Report in the MAR chart and seek advice from care manager or pharmacy. Do not give a double dose.</td>
</tr>
<tr>
<td>Side effects</td>
<td>If you, or a person you care for, are concerned about side effects, report this in the care notes and seek advice from the care manager who will refer to the GP or pharmacist.</td>
</tr>
<tr>
<td>Service user uses alcohol or illegal substances</td>
<td>Care workers must not administer medication to someone who is intoxicated. Report to the care manager.</td>
</tr>
<tr>
<td></td>
<td>Care workers are not responsible for accidents relating to the service user’s alcohol or drug use, but must report any incidents.</td>
</tr>
<tr>
<td>Problem</td>
<td>Solution</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Infection and contamination</strong></td>
<td>e.g. - lice, scabies, MRSA, TB etc.</td>
</tr>
<tr>
<td></td>
<td>Report to the care manager who will, in turn, report to the appropriate</td>
</tr>
<tr>
<td></td>
<td>infection control team. Care worker should not handle contaminated</td>
</tr>
<tr>
<td></td>
<td>equipment. SHARPS box must be provided, if the person uses injected</td>
</tr>
<tr>
<td></td>
<td>insulin.</td>
</tr>
<tr>
<td><strong>Lost medication</strong></td>
<td>Report to care manager who, in turn, will contact pharmacist.</td>
</tr>
<tr>
<td></td>
<td>Make a record.</td>
</tr>
<tr>
<td><strong>Spilt medication</strong></td>
<td>Report to care manager. Record on designated documentation</td>
</tr>
<tr>
<td></td>
<td>e.g. MAR Sheet.</td>
</tr>
<tr>
<td><strong>Difficulty taking medication in</strong></td>
<td>Report in the MAR Sheet and seek advice from care manager and</td>
</tr>
<tr>
<td>its prescribed form</td>
<td>GP.</td>
</tr>
</tbody>
</table>

**Discrepancies in records of directions for use**

Any discrepancies in records or directions for use, should be addressed immediately. Always record and report to your manager, and check with the prescriber and the person/s who have administered medication.

**Adverse reactions**

If you feel an individual is experiencing an adverse reaction to medication, you must report this immediately and seek medical assistance.

If you suspect that an individual is having an anaphylactic reaction, you must dial 999 immediately. This is an emergency. Treatment is delivered by the administration of adrenaline and certain other drugs known as steroids, but must be administered as quickly as possible to prevent cardio respiratory arrest. While you are waiting for the ambulance, you must observe the individual closely. You will need to treat the current symptoms and may need to start resuscitation.

Following such incidents, all actions taken should be fully documented and a note made about the sensitivity to the particular medication, so that it will never be administered to the individual again.
**7.5 Demonstrate how and when to access further information and support about the use of medication**

**Competence**

Whatever medication is being administered, all staff have a duty of care that requires medication to be handled safely. It is essential that any staff involved in the administration of medication have been appropriately trained and assessed to do so.

The person who is administering medication also has a legal duty to acknowledge their own limitations, and should take personal responsibility for maintaining and updating their knowledge and practice, in relation to handling and administering medication. This should be within the guidelines of the Fundamental Standards and also within the realms of the Code of Conduct for Healthcare support workers and adult social care workers.

You should not undertake any activities which are outside your present level of competence. It is important that you have had sufficient support, supervision and training, and that you feel comfortable within your role. It is also equally important that you understand the consequences of undertaking any aspect of care for which you have not received adequate training, as these consequences could endanger the lives of others.

**Accessing support**

Support, advice and information about medication should always be sought from your manager, GP or pharmacist, if you are at all concerned about any aspects of administering medication. It is essential that you understand your responsibilities and know the process by which you access support and information. If you are unsure of any aspect of this process you should discuss this with your manager.

**8.1 Demonstrate how to record use of medication and any changes in an individual associated with it**

**Recording and documentation**

Accurate documentation of medication administration times, and service user response and refusals, is essential for continuity of care between providers, as well as for the obvious need for legal records.
The MAR chart is the working document which is signed to record the administration of medicines. It contains specific information about the medication each service user has been prescribed.

**The MAR chart must contain the following information:**

- The name and date of birth of the individual
- The name of the medicine
- The dosage of the medication
- The route of the medicine e.g. oral, rectal, vaginal etc.
- The frequency and times for administration for each medicine prescribed
- A code, to explain reasons for leaving out a prescribed dose
- Any known medicine allergies should be recorded in red
- Any special instructions or requirements
- Start date for medication and where a course of medication has been prescribed; for example, for a course of antibiotics, the completion date should also be specified.
- ‘As required’ medicines must include information on maximum dose and frequency
- Page number; for example 1 of 1 or 1 of 2
- Any errors should be crossed through and signed; correction fluid must **never** be used
- All records should be made in black ink.

Individuals who administer medication are accountable for maintaining timely and accurate records of all medications they give. Recording medications should be done as soon as possible after medications have been administered. You document the administration of medication on the service user’s MAR chart and it is extremely important to keep this record precise, free from errors and up-to-date. When you sign for the administration of medicines, you are legally accepting full responsibility for the safe administration of that drug and it is imperative that you have exercised your professional judgement and applied your knowledge and skill, in order to ensure that the safest and highest quality of care is given.
Following the administration of any medication, you are required to sign the MAR chart; or if the service user has refused medication or you have withheld the medication; whatever the reason, you must document this on the MAR chart. This should also be documented in the service user’s notes.

A clear, accurate and immediate record should be made of all medication administered, intentionally withheld or refused by the service user, ensuring that any written entries are clear and legible, and are signed and dated.

**Medication profile**

In addition to a MAR chart, it is a requirement that each individual you care for, in your role as a domiciliary worker, has a medicine profile. This document is extremely important as it provides up to date information about the medications, as well as important medical information about the individual.

The medication profile should contain the following information:

- The service user’s name
- Date of birth
- Any allergies or sensitivities to medication
- Information provided by the pharmacist; for example, any special precautions or contraindications
- Names of medications being taken
- Date medication prescribed
- Date medication received
- Prescriber
- Quantities
- Doses

- Forms
- Strengths
- Routes of administration
- Time to be given
- Any homely remedies being taken
- Medicines refused
- Conditions that may affect the medicine being taken
- Effects of medication
- Any side effects or adverse drug reactions
- Date when medication stopped and by whom.
Administration of medication and recording

Before any administration of medication is recorded, you must ensure that the following principles are followed:

- You must actually observe the service user taking the medication
- You must never leave the medication with the service user to take later
- You must only ever sign the MAR chart when you know the service user has taken the medication
- If the service user refuses the medication, or does not take the medication, this must be documented on the MAR chart and in their notes.

Controlled drug register

Strict records regarding controlled drugs must be kept in the Controlled Drug Register. This is a bound book with numbered pages which specifically deals with records of controlled drugs that are being kept within the Care Home.

The following must be maintained, when making records in the Controlled Drug Register:

- All entries must be clear, neat and legible
- All entries must be in chronological order
- A separate page must be used for each controlled drug for each individual
- Each drug must be recorded as soon as the drug is administered, received into the care home, or sent to the Pharmacist for disposal
- Liquid paper should not be used for alterations
- Mistakes should be crossed through once, so the original entry can still be read. Any alterations or errors should be signed, dated and timed
- Entries must be made in black ink
- The register should not be used for any other purpose
- The register should be kept safe at all times and never removed from the care home
- Controlled Drug Registers must be kept for three years from the date of the last entry.
8.2 Demonstrate how to report on use of medication and problems associated with medication, in line with agreed ways of working

Reporting should be in line with agreed ways of working, following policies and procedures of the organisation. You should be aware of and follow agreed ways of working when:

- Reporting verbally
- Recording and reporting in writing
- When recording, write clearly and legibly in ink in the relevant files, signing and dating all entries.

What is an error, mistake or near miss?

There can be many things that can constitute an error, near miss or mistake relating to medication. Some examples are:

- Giving the wrong dosage
- Giving the wrong medicine
- Missing a dose
- Administering to the wrong person
- Giving the dose at the wrong time
- Medication is missing from the packet.
If medication is missing from the packet, this could be a serious event and should be reported immediately. The manager will have to decide whether to open a safeguarding case. Steps will be taken to find out if the person has had the medicine, or if the medicine is being stolen. No error, however irrelevant or trivial, can be over-looked.

The Social Care Institute for Excellence (SCIE) suggests social care organisations should promote a culture that promotes incident reporting, and learning from mistakes and near misses.

The specific details of what a carer must do if they discover a mistake will be outlined in the home care organisation’s policy. It is important that all workers are familiar with this and follow it.

**Responsibility of care workers**

Care workers must report all mistakes, however irrelevant or trivial they appear. Sometimes small mistakes can have severe consequences. All mistakes should be reported to the care service manager. Ultimately, the health and wellbeing of the service user is the priority, so it is likely that a pharmacist, doctor, NHS direct, or depending on the error, A&E, will be consulted. Making an error is not irresponsible, but failing to report the error is.

In addition to this:

- The error should also be recorded in the person’s MAR chart that is in their home
- The care organisation will have an incident report form which must be completed as soon as possible and passed onto the manager
- Document all action taken and all advice received, who gave the advice and if/when the advice was carried out
- If care workers suspect an individual’s medicines are been misused, or abused, they should report this to their home service manager and also complete an incident report form.

**Responsibility of employers**

The care organisation should encourage staff to report all mistakes and near misses, including medication related ones. Once an error has been reported, the manager has a legal obligation to pass on the incident to any relevant bodies. There is a requirement to
report incidents to the Social Care Inspection (Domiciliary Care regulations, 2002).

The responsibility of the employer is to:

- Make all care workers and managers aware of:
  a) What procedures they must follow in the event of a medication related error
  b) The requirement to complete an incident form
  c) The requirement to complete documentation accurately, thoroughly and as soon as possible after the event

- Send a report to the Commission for social care inspection within 24 hours of the incident, under the care standards regulations that apply to the service

- Review incident forms on a regular basis - identify any recurring problems which could feed into policy review

- Investigate errors thoroughly and fairly

- Do not mask a system failure or individual blame

- Ensure that the person who made the mistake is competent to continue assisting with medications.

Should any errors made by staff result in significant harm to an individual, it is the legal duty of the care provider to inform and apologise to that individual. This forms the Duty of Candour policy.

**Conclusion**

The information you have read within this unit should increase your knowledge and understanding which will benefit you, the individuals you care for, key people and others. Now complete the assessment questions for this unit in the workbook section.