The Administration of Medicines in Care Homes Contracted by Torbay and South Devon NHS Foundation Trust for Adults

NOTE: This includes those attending for Day Care services that for the purposes of this policy will be defined as 'Residents'

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Torbay and South Devon NHS
NHS Foundation Trust

Partners in Care

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Document Information

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1925 - Medicines Administration Records (MAR) in Care Homes and Domiciliary Care			
1869 – Delegation of Level 3 Tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon NHS Foundation Trust			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
2		8 April 2013	Organisation Name Change	
3		17 February 2016	Update following review and Organisation change	
4	Ratified	19 October 2018	Revised	Care and Clinical Policies Group Clinical Director of Pharmacy

Contents

1 Introduction

The aim of this policy is to provide guidance to enable the safe administration of medicines in care homes contracted by TSDFT.

2 Statement/ Objective

2.1 This guidance supports Regulation 12 Safe care and treatment which service providers must meet under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This includes the requirement that providers must ensure 'the proper and safe management of medicines'. All standards must be applied to all aspects of care including administration of medication.

2.2 This document is intended to give care homes a guide to good practice with respect to medicines administration.

2.3 N.B. This guidance relates to registered care homes only. It does not apply to care purchased from an unregistered source by individuals using direct payments or any other form of individual budget.

2.4 This guidance should be considered alongside national guidance and local policies from social service departments and health teams when available to care providers.

3 Roles & Responsibilities

It remains the responsibility of all care homes to have, and to adhere to their own Medicines Policy. This policy provides best practice guidance to assist care homes in writing/ updating their Medicines Policy.

4 Administration of Medicines in Care Homes

4.1 Regulations

4.1.1 Where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

4.1.2 The care home's Medicines Policy should provide guidance to staff on the safe management of medicines

4.1.3 As far as the Trust is concerned, our expectation is that care homes will meet the standards set out in NICE guidance: Managing Medicines in Care Homes 2014. "Caring for Care Homes" provides a range of guidance to support homes to meet these standards. Links to these resources are included in the References section. Care homes should ensure that they are able to respond to any reasonable request by officers and staff of the Trust to provide records that will demonstrate evidence of safe systems to support the administration of medicines

4.2 Self Administration of Medicines

4.2.1 It is important to stress that the first priority is the person's wishes. People are free to choose whether or not to keep and take medicines

themselves. This important element of choice promotes independence and dignity. If care homes chiefly promote administration of medicines by care workers, residents may not be aware of other forms of support with medicines that can be offered to them. All care homes should include the self-administration of medicines in their medicines policy.

4.2.2 Care homes should assess any risks to the person who looks after their own medicines. Any potential risks to other people in the care home must also be evaluated. This assessment must be reviewed regularly. It should be carried out by a suitably trained and competent member of staff.

4.2.3 The care home should identify whether people have capacity to safely store and take their own medicines. The Mental Capacity Act 2005 and linked Code of Practice are key documents to consider.

4.2.4 The risk management strategy should include the provision of a secure location to enable residents to keep the medicines in their own rooms. For example, in a locked medicine cabinet near their bedside.

4.2.5 Prescribed medicines belong to the person for whom they were prescribed, identified by the name on the dispensing label. The care home does not own the medicine, even though care workers may request and take receipt of medicines. This applies whether or not the care home provides nursing care.

4.2.6 Residents who have a physical or mental disability should not, automatically, have their medicines given by care workers. Community pharmacists undertake assessments under the Equality Duty imposed on them as part of the Equality Act 2010 and may be able to adjust the way that medicines are packed or labelled for an individual in order to promote self-administration. Examples include large print labels for poor eyesight or containers with ordinary caps instead of child- resistant closures that are difficult to open

4.2.7 Residents in care homes either with or without nursing care have the same rights to choose how they receive their medicines. When a registered nurse provides care this does not automatically mean that residents may not look after their own medicines. However care staff should be aware that the needs of a person may change over time or fluctuate with illness. If problems are suspected with the arrangements for medication administration these should be reviewed with the person to ensure they are still safe and appropriate.

4.2.8 However, there are reasons why some people do not choose to keep their own medicines preferring instead to allow the care staff to take the responsibility for their medication. This is often the case for older people and when this happens the care provider should document that this is the resident's choice. Care providers should agree the arrangements with the person and keep formal signed consent to the arrangements in the person's care plan.

4.2.9 There may also be situations when residents are keen to look after some of their own medicines but not others. This will be recorded in the resident's care plan. An example is when a resident keeps an inhaler for use when they need it to relieve symptoms but prefers the care workers to look after tablets and liquid medicines.

4.3 Equality and Diversity

People have certain preferences and these may relate to equality and diversity. The Home is responsible for ensuring that they take into account the patient's preferences and cultural/ religious beliefs and that these should be documented in their care plan. For example, the medicine is provided in a gelatine capsule and the person is vegetarian. Some people prefer to have medicines given to them by a member of the same sex.

4.4 Medicines administered by care workers

4.4.1 Care workers may, with the consent of the resident, administer prescribed medication, provided this is in accordance with the prescriber's directions.

4.4.2 Care workers must have clear directions stating which medicine to give and what dose, route of administration and when to give it. Ideally this will be on a pharmacy generated MAR chart. The criteria when to give and what for must be recorded in the care plan if a doctor orders a medicine on an 'as required' basis. For further information refer to the Policy, 'Medicine Administration Records (MAR) in Care Homes and Domiciliary Care'.

4.4.3 In Care homes without nursing care, training is essential before a care worker can give medicines to residents. The care home should provide a training package that will meet the needs of care workers and residents. The essential elements of this training should be:

- How to prepare the correct dose of medication for ingestion or application
- How to administer medication that is not given by invasive techniques, Including; tablets, capsules and liquid medicines given by mouth; ear, eye and nasal drops; inhalers; and external applications and patches
- The responsibility of the care worker to ensure that medicines are only administered to the service user for whom they are prescribed, given in the correct (prescribed) dose, at the correct time by the correct method/ route
- Checking that the medication 'use by' date has not expired
- Checking that the person has not already been given the medication by anyone else, including a relative or care worker from another agency by checking the MAR chart and through other agreed channels
- Recognising and reporting possible side effects
- Reporting refusals and medication errors
- How a care worker should administer and record medicines prescribed 'as required', for example, pain killers, laxatives
- What care workers should do when people request non-prescribed

medicines
- Understanding the service provider's policy for record keeping
- Ensuring good infection control practices are adhered to, to include, for example, washing of hands prior to administering any medicine and having an available supply of Personal Protective Equipment (PPE)

4.4.4 The care home is responsible for ensuring the accreditation and qualifications of the trainer and obtaining evidence that the trainer has appropriate knowledge in the subject of medicines handling in domiciliary care and has relevant, current experience of handling medicines.

4.4.5 The care home must establish a formal mechanism to assess whether a care worker is sufficiently competent in medication administration before being assigned the task.

4.4.6 Regional Office of Skills for Care can assist care providers in identifying suitably accredited training organisations. Support may also be available from the Trust through specific training courses held at the Horizon Centre or through online Trust learning via The Hive.

4.4.7 Many care homes only delegate the task of medicines administration to senior care staff. However, there must be sufficient numbers of suitably trained workers to cover all of the times that residents may need medicines. For example, it is not in the best interests of residents to have restricted access to pain relief during the night because care workers are not of a senior level.

4.4.8 Delegation of medicine administration to a care worker is an important aspect of health and social care provision particularly in care homes for adults when people have medicines prescribed for complex long term conditions. Where a health care professional employed by the Trust feels that it is appropriate to delegate medicines administration to a care worker this must be person specific. For further information please refer to the policy; Delegation of Level 3 tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon NHS Foundation Trust.

4.4.9 When medicines must be administered by specialised techniques, the community nursing service supports people who live in care homes without nursing care. With additional training from a healthcare professional, a care worker can give the following through delegation:
- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Nebulised therapy
- Oxygen therapy

(This is not an exhaustive list.)

4.4.10 If the task is to be delegated to a care worker, the named registered healthcare professional must train the care worker and be satisfied they are competent and confident to carry out the task. It is usual that competence will be reassessed by the registered healthcare professional at regular and agreed intervals. The registered healthcare professional retains the

accountability for delegating the task and any ongoing monitoring that is required.

4.4.11 Delegation is service user specific – a care worker delegated to provide such care for one service user is not authorised to provide similar care to another service user without further delegation.

4.4.12 One care worker is not authorised to delegate medicines administration to another care worker.

4.4.13 The care home's procedures must include support for care workers to refuse to carry out the administration of medication by specialised techniques if they do not feel competent or confident to do so.

4.5 Medicines Policy

4.5.1 There are two important safeguards that care homes must ensure are in place to protect the residents that they care for:

- There is a written policy for the administration of medicines, which is monitored to make sure that care workers follow safe practice. The medicines policy should be regularly reviewed and updated.
- Care workers have the correct level of training, appropriate to the tasks that they will undertake, before giving any medicines. This training should be recorded and regularly updated.

4.5.2 Care workers must also ensure that they only give medicines to residents from the container that the pharmacist or dispensing GP has provided. This container must have the person's name on the dispensing label and provide the full instructions for the care worker to refer to. Under no circumstances should medicines be re-packaged into another container with the intention that a different care worker will give it to the resident at a later time. This is known as 'secondary dispensing'. Both the Royal Pharmaceutical Society and the Nursing and Midwifery Council (NMC) state this is an unsafe practice that can potentially cause medication errors.

4.6 Mixing medicines with food or drink

4.6.1 A care worker should not mix medicine with food or drink if the intention is to deceive someone who does not want to take the medicine. This is called 'covert administration'. The exception to this is when a medical practitioner states that the person lacks 'capacity to consent to treatment' in accordance with the guidelines in the Mental Capacity Act 2005 and a medical practitioner has determined that the medicine is essential to their health and well-being. For more information refer to the Mental Capacity Act 2005 and Code of Practice.

4.6.2 If the decision is taken to give a medicine covertly then the decision must be taken by the person's doctor because it is in their best interests. This should be clearly documented in the care plan notes and the decision should be regularly reviewed. It is not good practice to crush tablets or open capsules unless a pharmacist informs you that it is safe to do so. Many medicines are

not suitable for crushing or dissolving with water. In these cases the GP must be made aware of this practice as it will alter the licenced nature of the drug.

4.6.3 When a resident has difficulty swallowing, it may be necessary to crush tablets if there is no liquid alternative. The prescriber or pharmacist must be contacted before medicines are crushed. Some medicines must not be crushed or dissolved in water before taking. The prescriber may wish to review the patient's medication before giving an instruction to crush a tablet as an alternative licensed medication may be more appropriate.

4.7 Medicines administration responsibilities of registered nurses in care homes

4.7.1 A care home with nursing employs registered nurses. The Nursing and Midwifery Council (NMC) Standards for Medicines Management require that each nurse is to be individually accountable for making sure that all medicines are administered correctly and to be personally accountable for up-to-date practise. This is available at www.nmc-uk.org.

4.7.2 The code sets out how a registered nurse may delegate the administration of some medicines to care workers. An example of this is the application of cream or ointment when the care worker is bathing the resident. The whole task is delegated and the care worker who is responsible should sign the record of administration. However, the registered nurse retains the accountability for delegating the task and any on-going monitoring that is required.

4.7.3 If the registered nurse prepares medicine and gives it to a care worker to take to the resident, the care worker who gives the medicine is responsible and should:

- Make sure that the prepared medicine is correct with the current MAR.
- Sign the MAR.

4.7.4 Under no circumstances should the nurse who prepared the medicine sign the MAR without checking that the resident has taken the medicine.

4.7.5 The administration of medicines by invasive or specialised techniques is the responsibility of the registered nurse in a nursing home. An example of this is the administration of injectable medicines such as insulin. The care provider is responsible for making sure that a registered nurse who gives medicines by a specialised technique has relevant and up-to-date training and competence.

4.8 The use of Monitored Dosage systems

4.8.1 Monitored Dosage Systems (MDS) have in the past been promoted as a safe system of medicine administration in care homes. But MDS are merely a convenient form of packaging for a limited group of medicines. Safe practice is not guaranteed by use of this system alone.

4.8.2 MDS do improve some aspects of medicines handling including:

- Allowing an easier system of organising repeat prescriptions for residents

- Supply to the Care Home of printed Medicine Administration Record charts (MAR)
- Providing a visual check as whether medicines have been removed to give to the resident.

4.8.3 MDS can only be used for tablets and capsules. Some medicines including the following should not be put into MDS:

- Medicines that are susceptible to moisture, e.g. effervescent tablets
- Light-sensitive medicines, e.g. chlorpromazine
- Medicines that should only be dispensed in glass bottles, e.g. glyceryl trinitrate
- Medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate.
- Medicines for use on a 'when required' basis
- Medicines where the dose may change e.g. warfarin

4.8.4 Liquid medicines, creams, eye drops, inhalers, patches, some tablets and capsules etc. must be supplied in their original containers. Care homes that use MDS will need to have systems in place to ensure that medicines not in the MDS are not missed.

4.8.5 Care homes must consider carefully how any changes that the prescriber makes to a resident's medicines are recorded and communicated to ensure that they are not missed. MDS work well when the person's medication is regular and does not change frequently.

4.8.6 The NHS does not fund MDS systems such as Manrex, Nomad, Venalink, Medidose, Dosette and similar systems. The care home may be asked to pay for the equipment. Some community pharmacies may not provide medicines in this way. Individual service users can be assessed by a community pharmacist for support to manage medicines themselves. The pharmacist must provide reasonable adjustments to enable people to be able to take their medicines safely. This does not apply to entire care environments, where the principal benefit is to nurses/ care workers.

4.8.7 Some care homes who have been unable to get medicines in MDS have taken the decision to allow care workers to re-package medicines in similar products called compliance systems. Examples of these are Medidose, and Dosette. This is 'secondary dispensing' already referred to in point 4.5.2 and is not acceptable by the Royal Pharmaceutical Society and the Nursing and Midwifery Council.

4.9 Over the Counter Medicines

4.9.1 Over the counter medicines may be purchased by residents with capacity. Residents may decide to purchase and use these medicines. Care workers should not administer these medicines.

4.9.2 Homely Remedies

The care provider can keep a range of "homely remedies". Homely remedies are used to provide immediate relief for mild to moderate symptoms for a

maximum of 48 hours. They are treatments that people would use themselves without consulting their GP, for example to treat mild headache or indigestion. These medicines are potent and may interact with medicines that the doctor has prescribed for residents. South Devon and Torbay Clinical Commissioning Group has provided a Homely Remedies List for Care Homes with a small list of remedies that may be given for a maximum of 48 hours. This list should be signed by the care home manager and staff must be appropriately trained to administer the medicines on the Homely Remedy List.

4.9.3 The Care Home is under no obligation to provide this treatment. However, if "homely remedies" are purchased for occasional use by residents, the care home must include in the medicines policy:

- How to obtain the resident's consent to treatment that a doctor has not prescribed
- How the administration will be recorded

4.9.4 If a problem such as constipation persists, residents should consult with their GP because the symptoms may be masking other medical problems. This is why homely remedy use should be time-limited.

4.10 Checklist for those monitoring performance in Care Homes

4.10.1 The policy and procedure for medicine administration should explain to care workers what to do and how to do it safely. There should be evidence that:

- Care workers have read and understood the policy
- The principles of the policy are part of everyday practice in the Care Home

4.10.2 Service users should have choice about how their medicines are administered. Evidence should show that:

- The care home has systems in place to support residents to look after their own medicines where safe and appropriate
- How resident consent is obtained and recorded when care workers give medicines.
- The care home has identified individual preferences. This may include the place that the person would prefer to have their medicines or the time that they prefer to be woken in the morning.

4.10.3 The care home should be able to provide evidence that care workers have received appropriate training and are competent to administer medicines. The level of training must be appropriate to the tasks that the worker is required to undertake.

4.10.4 The care home should ensure good infection control practices are adhered to at all times, to include, for example, washing of hands prior to administering of any medicine and having an available supply of appropriate Personal Protective Equipment (PPE)

4.10.5 Useful sources of information that will identify whether medicines are given correctly to people include:

- MAR charts within the Care Home. Please refer to the policy 'Medicine Administration Records (MAR) in Care Homes and Domiciliary Care for Adults'
- Direct observation of a 'medicines administration round'
- What residents say about their medicines
- Whether there are reports to the Trust about incidents or complaints involving medicines

5 Training

Care homes are responsible for organising training to support staff in the safe and competent administration of medicines. There should be regular updates and records of training kept.

6 Monitoring, Auditing, Reviewing & Evaluation

This policy will be reviewed in February 2021 or sooner as any regulatory or contractual changes may dictate.

7 References

7.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7.2 NICE guideline: Managing Medicines in Care Homes (Social Care Guideline) 2014
https://www.nice.org.uk/guidance/sc1

7.3 Link to Caring for Care homes checklist, supporting audits, guidance sheets and newsletters
https://www.newdevonccg.nhs.uk/information-for-patients/medicines-and-treatments/information-for-healthcare-professionals/care-homes-caring-for-care-homes-team/101662

7.4 Information about the Mental Capacity Act 2005
http://www.cqc.org.uk/content/about-mental-capacity-act

7.5 Delegation of Level 3 tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon NHS Foundation Trust Policy
Ref 1869

7.6 'Medicine Administration Records (MAR) in Care Homes and Domiciliary Care for Adults' policy – Ref 1925

7.7 Nursing and Midwifery Council (NMC) Standards for Medicines Management
http://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/

8 Distribution

This policy will be available to staff via The Torbay and South Devon NHS Foundation Trust website.

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Torbay and South Devon NHS
NHS Foundation Trust

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?

PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?		
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?	
Does this document require a service redesign or substantial amendments to an existing process? *PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below*	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:

By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.