Medicines Management in Community Settings for Rapid Response Support Workers (RRSW)

Standard Operating Procedure (SOP)

Ref No: **1996**
Version: **4**

Prepared by:
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Medicines Governance Facilitator

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	Review date: 30 October 2020
Relating to policies:	· **Medicines Policy for Skilled Not Registered Staff – Ref 1928** · **Ref 2117 - Covert Administration of Medicines Policy** · **Ref 2148 Controlled Drugs SOP** · **Ref 1716 - Supervision, Accountability and Delegation of Activities to Skilled Not Registered Staff** · **Ref 2146 - Incident Policy** · **Accountability and Delegation Policy** · **Ref 1446** Omitted and Delayed Medicines

Contents

1. Purpose of this SOP

To ensure that medicines are handled safely by skilled not registered staff Employed by Torbay and South Devon NHS Foundation Trust, and staff assigned to Torbay and South Devon NHS Foundation Trust, in the Rapid Response Service

2. Scope of this SOP

All Rapid Response Support Workers (RRSW) staff who work under the RRSW Medicines policy and employed by Torbay and South Devon NHS Foundation Trust, and Devon County Council.

All RRSW who are trained, competent and confident to carry out tasks assigned or delegated to them.

Registered staff who delegate tasks to non-registered staff must ensure that their staff adhere to this SOP. The registered staff must ensure that the RRSW is competent and confident to undertake the task and in the case of Level 3 tasks that the appropriate delegation and Patient/Service User specific training has taken place.

Should the RRSW on duty have any concerns regarding any aspect of medicines management which cannot be resolved on site, then they have a duty of care to escalate the concern as promptly as possible to the appropriate person or professional e.g. Service manager, prescriber, out of hours medical services, community nurse colleague or pharmacist.

3. Competencies Required

RRSW in community care setting with responsibility for medicines support and/or administration who have received medicines management training and been assessed as competent to operate services covered by this SOP.

Staff should have completed relevant competencies and receive regular medicines management updates at least every two years

Where level 3 medicines are administered by skilled not registered staff (see definition in the Skilled Not Registered Medicines Policy 5.3), the skilled not registered staff will have undertaken the Qualifications Credit Framework (QCF) unit in Supporting the Administration of Medicines accessed from the Vocational Education Centre - 01803 656659.

4. Patient/Service Users Covered

All Patient/Service Users receiving support or administration of medicines by RRSW staff in the community**.**

5. Administration of Medication

All administration is to be carried out in conjunction with the Torbay and South Devon NHS Foundation Trust (TSDFT) Medicines Policy (Ref 1928) recognising differing levels of medication administration / levels of competency and delegation requirements.

Before administration, RRSW is required to:

5.1 Ensure that they are competent and confident to undertake the task and in the case of Level 3 tasks (Administering medication by Specialist techniques) that the appropriate delegation and Patient/Service User specific training has taken place.

5.2 Check the identity of the Patient/Service User to whom the medication is to be administered.

5.3 Check that the medication has not already been administered. If in doubt, refer to line manager and the doctor.

5.4 Check that the name, form, strength and dose of the drug on the medicine label corresponds with the Medication Administration Record (MAR). If there is any discrepancy, refer to line manager and do not give the medication until clarification is given.

5.5 RRSW working under the supervision of a community nurse must ensure that the MAR has been signed by a prescriber and check that the MAR is in date.

5.6 Ask the service user if they are willing to take their medicines before removing them from the pack. People can refuse medicines for different reasons.

5.7 Check the MAR for any special dosing requirements for the medication e.g. take with food.

5.8 The RRSW will ensure that there is a glass of water available if oral medicines are administered. Hot drinks are not recommended for this purpose Tablets and capsules should be swallowed one at a time whilst the patient/service user is sitting or standing to minimise the risk of choking.

5.9 Where medication is in a Monitored Dosage System / blister pack the RRSW will open the appropriate section and empty the medication into a medicine pot and hand it to the patient/service user.

5.10 Where medication is in a bottle or strip pack, the appropriate number of tablets/capsules will be transferred into a medicine pot and handed to the patient/service user.

5.11 Where medication is in a liquid form the RRSW will use a medicine spoon, measure or oral syringe provided by the pharmacy. The patient/service user should not drink medication from the bottle or use any spoon which has not been designed to give medication i.e. tea spoons which may not be an accurate 5ml measure

5.12 For medicines applied to the skin, gloves must be worn by the RRSW to prevent cross-infection and cross contamination.

5.13 Record the administration of medication by initialling the correct date space on the MAR. Each item of medication must be signed for separately.

5.14 Medication that is not administered by the RRSW needs to be recorded on the MAR stating the reason by using the appropriate code on the front of the MAR. Complete the reverse of the MAR with date, time, signature and the reason for non-administration. If the MAR does not provide codes the following should be used:

- R=Refused
- O=Other (with explanation e.g. spillage, medication unavailable)

For all omitted and delayed doses, please refer to the SOP Omitted and delayed medicines (Ref 1446 – Omitted and Delayed Medicines).

5.15 The code **"P" (prepared)** is used if a dose has to be prepared and left for the service user to take later (see section 5). **RRSW must not administer medicines that have been left out for the Patient/Service User to take**. The RRSW should also initial the record to take responsibility for the preparation of the dose. The medication should be left in a suitable place to allow access for the patient/service user but take into account safety issues. A risk assessment should be undertaken as part of the care plan by the RRSW along with GP or line manager's advice before this practice is adopted. This should include advice on how long the medication should be left out for and a means of monitoring the practice.

5.16 Where medication is administered from a Monitored Dosage System, the MAR should be completed "as per Blister pack", and the medication list obtained from the surgery should be attached to the MAR within 72 hours of service commencement. Where a medicine from the pack is not taken/dropped/destroyed, then this should be noted on the MAR with a description of the tablet. Eg. Small white tablet
The code O=Other should be used and details provided on the back of the MAR.

5.17 All records should be written in black ink and be legible. There must be no obliteration with Tippex or similar.

5.18 Any alterations should be crossed through with a single line and initialled by the RRSW.

5.19 If a RRSW believes the patient/service user has already taken a dose of the medication, medication should not be given and advice sought from the line manager/GP/out of Hours Doctor.

5.20 If a RRSW believes the service user is refusing medication on a regular basis, the line manager and GP should be notified.

6. Administration of "As Required" Medication

6.1 It is the responsibility of the service manager in conjunction with the RRSW to ensure that all details of 'as required' (PRN) medicines are recorded in each individuals care plan at all times. The service manager may request the prescriber to highlight how the medicine should be administered and under what circumstances, and this would be recorded using the form PRN (As Required) Medication Instructions' form (Appendix 2)

6.2 It is essential that for each 'as required medication, the following is recorded for each individual patient/service user:

- Patient/Service user name and personal details.
- Medication name, form and how to give (plus any special instructions e.g. after food etc.).
- Reason (precise symptoms) why and when the medication should be given and a description of how the symptoms may be identified and recognised.
- The dosage of the medication to be given and how often the dose can be repeated.
- The maximum amount of medication to be given in 24 hours.
- What actions to take if the symptoms are not relieved within a set timeframe.
- Provide a treatment review date.

6.3 The RRSW must consult the above criteria for each patient/service user before administration of the medication, and where there is any doubt then the GP or Out of Hours Doctor needs to be contacted.

6.4 The medication administered must be documented on the MAR including the dose, time and reason for administration e.g. pain or constipation.

6.5 'As required' medicines should only be administered to the patient/service user when the reasons and symptoms for its administration are met, as defined in the care plan. It is therefore not necessary to record non administration of a dose on the MAR, unless the patient/service user is experiencing symptoms and positively declines treatment.

6.6 Prior to administration of an 'as required medicine', the RRSW must be sure that they do not administer a duplicate dose by mistake, particularly when care is also provided by other care workers or agencies.

7. Handwritten MARs (Completing the form)

7.1 Due to the nature of the Rapid Response Service MAR sheets are completed by hand by the RRSW.

7.2 The RRSW may handwrite a MAR when other measures / requests are not possible. Any handwritten MAR must include all details of the medication taken from a faxed prescription or prescription label.

7.3 The details must be written on the MAR in black indelible ink, in upper case (Capitals), legible and include:

- Name of the medication
- Form of the medication (e.g. tablets, capsules)
- Strength of the medication ("micrograms" must not be shortened to "mcg", and Insulin "units" must not be shortened to "U")
- Dose and frequency
- Time (hour) the medication should be given, written using 24hr clock
- Any special instructions e.g. after food
- Date of prescription
- Name, date of birth, NHS number or social care reference number, and address of service user
- Care management details

7.4 The RRSW must sign and date the MAR.

7.5 The handwritten MAR must be returned to the office and retained in the care records.

If a RRSW has any doubt about completing any detail in the process of handwriting a MAR then Healthcare Professional Advise must be sought.

8 Leaving Medication Out for a Patient/Service User to Take Later

This activity should be viewed as exceptional.

8.1 If a patient/service user requests medication to be left out for them to take themselves at a later prescribed time, this may only be undertaken if a risk assessment has been documented in the service user's care plan by the RRSW

8.2 The RRSW must undertake a full risk assessment, considering such risks as:

- Ø Will the patient/service user remember to take the medication?
- Ø Will the medication get taken at the correct time?
- Ø Is there a risk of hoarding?
- Ø Are there others in the house e.g. other service users or children who may take the medication by mistake?
- Ø Some medication must not be left out for a service user to take later (see 8.8).

8.3 The risk assessment and decision regarding whether the medication can be left out for the Patient/Service User to take later must be recorded and placed in the Patient/Service User Care Plan.

8.4 A copy of the risk assessment will be given to the Rapid Response Office for approval.

8.5 The RRSW must consult the risk assessment before leaving the medication out for a patient/service user.

8.6 The RRSW must annotate the MAR with a "P" (prepared) and sign. This indicates that the dose was prepared but that administration was not witnessed.

8.7 The RRSW must report back to their line manager any evidence that indicates that the medication is not being taken in the correct manner.

8.8 Medicines not to be left out as Prepared 'P' include (this list is not exhaustive – seek advice):

- Ø Medicines likely to be susceptible to the effects of moisture including: dispersible, effervescent and soluble formulations (e.g. aspirin dispersible), buccal or mucosal products (e.g. buccastem), medicines which are unstable to moisture (e.g. sodium valproate / Epilim)
- Ø Medicines which can cause skin reactions or hypersensitivities on prolonged contact e.g. chlorpromazine
- Ø Cytotoxic medication e.g. methotrexate
- Ø Medicines requiring refrigeration or other special storage conditions

The above list is not exhaustive. If in doubt RRSW's should seek advice from a Registered Healthcare Professional

Under no circumstances should RRSW's administer medicines previously prepared by others i.e. other RRSW's, healthcare professionals, carers or family.

9 Medication Issues Occurring Out of Hours

If medicines concerns are identified out of hours, the RRSW should seek advice of a healthcare professional.

Out of Hours GP may be called for advice. The patient/service user's GP should be advised of the concern or medicines incident with the action taken the next working day.

10 Dealing with Medication Errors

10.1 The RRSW must notify their line manager IMMEDIATELY an error is made or discovered, including if medication has not been administered at the correct time. If an incident occurs out of hours then the RRSW should contact the On Call Manager for TSDFT and Out of Hours GP for advice, and to record the incident. **All incidents must be reported using the Datix system. See incident reporting policy for further details**

10.2 Within office hours, the line manager must contact the GP and family if necessary and may request that the RRSW stays with the patient/service user. Out of hours advice should be followed from the Healthcare Professional and/or On Call Manager.

10.3 Advice given by the healthcare professional must be followed and documented in the patient/service user's record.

11 Disposal of Medication by Relatives and RRSW/PCSA Staff

11.1 Medicines are the property of the patient/service user, but when they are no longer required disposal should be considered.

11.2 A carer, relative or representative of the patient/service user should be routinely asked to take responsibility for the return of any unwanted medication to a community pharmacy.

11.3 These arrangements must be recorded in the care plan by the RRSW.

11.4 These medicines should be stored separately from current medication in use to avoid confusion or administration error.

11.5 The RRSW should contact the nominated carer, relative or representative responsible to advise them of the need to remove unwanted medication from the service user's home. The office will also need to be informed immediately.

11.6 Such medication (excluding sharps) should be returned to any community pharmacy by the service user, carer, relative or representative for safe disposal.

11.7 Sharps (e.g. needles, lancets) will not be accepted for disposal by the pharmacy. Relatives should be advised to contact their local council to make arrangements for the safe disposal of sharps

11.8 Where a carer, relative or friend is unavailable to return unwanted medication, the RRSW may return medication directly to a community pharmacy on an exceptional basis, with consent from the service user.

11.9 All medicines removed for return to a pharmacy must be recorded in the care plan.

It is recommended that form "Disposal of Unwanted Medication" (Appendix 1) is used for this purpose. Any unwanted, discontinued or expired medication should not be stored in the patient/service user's home for longer than necessary.

11.10 When the RRSW agrees to return unwanted medicines to a community pharmacy, the RRSW must request a signature from the community pharmacist on the 'disposal of unwanted medication' form to confirm receipt of the medicines for disposal. If the pharmacist declines to sign, this must be documented by the RRSW and discussed with the service manager.

12 Collection of Prescriptions

12.1 If appropriate, a RRSW will be assigned to collect the dispensed medicine from the pharmacy or the prescription from the surgery.

12.2 The dispensed medication should be taken directly to patient/services user's home without deviation of route.

12.3 For collection of Controlled Drugs, the RRSW will need to provide identification to the pharmacist who will check and record this. The RRSW may be required to sign the back of the prescription to confirm that they have collected the Controlled Drug.

12.4 The patient/ service user's record must detail what medication the RRSW has collected. This must be completed by the RRSW as a record of medication receipt.

12.5 If the medication is not available, then the RRSW will agree an appropriate time to return to the Pharmacy.

References

1928 Medicines Policy for Medicines Management for Skilled Not Registered Staff
2117 Covert Administration of Medicines Policy
Accountability and Delegation Policy

Monitoring Tool

Each team should develop monitoring procedures to show how it will monitor this SOP

Standards:

Item	%	Exceptions
All RRSW staff with responsibility for medicines must read and sign this SOP in association with the medicines policy	100%	nil
How will monitoring be carried out?	Internal audit and signatory sheet	
When will monitoring be carried out?	Annually (or sooner if needed)	
Who will monitor compliance with the guideline?	Service leads managerially responsible for delivering care	

Amendment History

Issue	Status	Date	Reason for Change	Authorised Pharmacist
1	Final	26 March 2013	Amalgamation of Torbay Care Trust SOPs relating to RRSW/ PCSA Staff Medicines Management (not Reason for Change	Pharmacist
2	19 June 2013		Updated	
3	23 December 2016		Updated – removal of Personal Care Service	
4	Ratified	30 October 2017	Revised	Care and Clinical Policies Group Medicines Management Group
5		12 February 2018	Review date extended from 2 years to 3 years	

Appendix 1

Permission to Remove Unwanted Medicines

Service User Name:	
Service User NHS No.	Paris No.
Address:	
GP:	
Surgery;	

The following is a list of drugs (and dressings) which are no longer required because:

* **Key**: **E** = *Expired*, **D** =*Discontinued from treatment* **U** = *Unwanted*

Medication name form and strength	Reason for return*	Quantity Returned

I authorise the removal of the medicines listed above by,
(Name of authorised member of community team) _____
for safe destruction. This is to return the medicines to my local community pharmacy
(Name of pharmacy)_____

Signed: (service user/carer)_____ Date:_____

Printed: (service user/carer)_____

Signed: (member of staff removing medicines)_____

Printed: (member of staff removing medicines)_____

Date:_____

Pharmacist Signed:_____

Pharmacist Printed: _____ Date: _____

To be returned to service user and retained in service user's records.

Appendix 2

AS REQUIRED MEDICATION INSTRUCTIONS	
Name of Service User:	
Service User NHS No.	Paris No.
DOB:	
Address:	
Medication	
Dose	
Reason for Medication	
Dosage Criteria E.g. Give 1 if…… Give 2 if……	
How often dose can be repeated	
Max in 24 hours	
Further info. e.g. after food	
Review Date	
Circumstances for reporting to GP Tick as appropriate	o Persistent need for upper level of dosage o Never requesting dosage o Requesting too often o Side effects experienced
Prescribers Signature: _____ Date: _____	
Printed Name:_____	

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.

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

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 favorably 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