Administration of Medication Policy

Responsibilities

Deafblind Scotland is responsible for ensuring staff are trained to prompt, manage and administer medication as required.
The Service Manager's role is to organise staff training, supervision and assessment of staff competencies, they will also ensure that all staff who have responsibility for storage, recording, administering and disposal of medicines for the people we support in services where this is applicable. All staff have an obligation to carry out these duties in accordance with instructions where applicable.

All staff will be trained and supported where applicable to follow the National Care Standards applicable to their Service and in accordance with the guidelines set out in the Royal Pharmaceutical Society of Great Britain - Handling of Medicines in Social Care, and best practice guidelines published by the Care Inspectorate.

SCOPE

All operational staff

DEFINITIONS

- **Medicines -** The term 'Medicine' includes liquids, tablets, ointments, creams, drops, suppositories, injectable products and any other internal or external medicines. Complementary remedies are included in this definition. These may be prescribed by a General Practitioner, Dentist and Hospital General Practitioner/Consultant or may be available to purchase "over the counter."
- **Dispensing -** 'Dispensing' is where a Pharmacist prepares medicines ready for administering i.e. Monitored Dosage System or contemporary packaging.
- **Invasive Procedures –** An "Invasive Procedure" includes injections, the use of suppositories and rectal diazepam: when supported individuals have conditions, which require medication or a procedure to be provided quickly, and in some situations oral medication is not practical. All staff must be trained prior to carrying out an invasive procedure or any such intervention, regardless of previous experience.
- **Homely Medicines -** Medicines not prescribed by General Practitioner or another health professional.
- **MDS** – Monitored Dosage System
- **MAR** – Medication Administration Record

LEGISLATION AND BACKGROUND

The Medicines Act 1968
The Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007
Access to Health Records Act 1990

Data Protection Act 1998
COSHH Regulations 2002
Adults with Incapacity (Scotland) Act 2000, Section 47
The Regulation of Care (Requirements as to Care Services) (Scotland) Act 2001
National Care Standards
Covert Medication – Good Practice Guide (Mental Welfare Commission)
Improving Patient Outcomes - Royal Pharmaceutical Society (July 13)

RELATED POLICIES AND PROCEDURES

Admission / Discharge (Operations)
Document Storage and Destruction (Corporate Services – General)
When Someone Dies (Operations)
Recording of Information of the people we support (Operations)
Risk and Safety (Operations)
Risk Assessment (Corporate Services – Health and Safety)

PROCEDURE

1. Labelling

1.1 The Pharmacist (or Doctor) will normally label each container of medicine and/or monitored dosage system with the name of the medicine it contains, the name of the person for whom it is prescribed and clear instructions for its use. It is unacceptable to label medicines 'as before' or with other vague phrases.

1.2 Labelling must not be altered unless on the written instructions of the Doctor, ideally a new label should be sought from the Pharmacist. Where labels have been detached or become illegible, the contents must be returned to the Pharmacist for disposal.

2. Administration

2.1 There are five levels of administration.

- Level 1 = Independent self-administration. No assistance required (95% of our service users)
- Level 2 = Prompting. (4% of our service users)

Reminding someone of the time and asking if they are going to take their medicines

- Level 3 = Assisting. (1% of our service users)
  Individual retains control of their medication but requires assistance with simple mechanical tasks such as ordering/collecting of prescriptions or opening bottles or packaging *at the request and direction of the person who is going to take the medicines*
- Level 4 = Full Administration.
  Individual cannot take responsibility for managing their medicines and requires support to take the correct medication, at the correct time and in the correct way
- Level 5 = Healthcare input required District nurse etc

2.2 In all cases where individuals are able and wish to manage their own medicines they must be encouraged and supported to do so. Self-administration of medicines is not an 'all or nothing' situation. Individuals may have different 'levels of administration' need, for different medicines and each must be recorded separately. This decision should be made in conjunction with the person and if relevant, other parties (e.g. GP, family/other carers). The decision must be taken at the time the support service commenced or at a time appropriate for the supported individual to develop skills to enhance his/her independence. This will be recorded in the Personal Plan and reviewed regularly.

a) The following will need to be taken into account when such a decision is made: The individual's wishes
b) Past and current mental state
c) Physical ability
d) Understanding of the individual's outcomes and possible adverse reactions to Specific medicines.

Each supported individual's Personal Plan must state how it is proposed to monitor situations where individuals do take care of their own medication. It is acknowledged that individuals have the right to refuse to take their medication, however based on a risk assessment there may be a need to explain to the individual the importance of taking his/her medicines regularly, ordering repeat prescriptions and storing medicines appropriately. Risk Assessments will require to be reviewed on a regular basis to meet the needs of the individual.

2.3 All individuals have the right to keep their medical information private, providing there is nothing to indicate this would be harmful to their care or support.

2.4 The supported individuals who self-administer medication must be provided with a lockable facility, ensuring that more vulnerable people are not put at risk. This is particularly relevant in 'group' living, but should also be considered in individual tenancies where there is a risk to the individual and/or to safeguard children who may be visiting.

2.5 In some situations staff may collect medication from the pharmacist on behalf of an individual who self-administers medication. On these occasions, staff will need to keep a record of medication passed to the individual. Where possible, these records must be signed by the individual concerned and the member of staff making the record. Deafblind Scotland will provide individuals with Medication Record Sheets for this purpose or details should be recorded in Communication Book.

2.6 The Care Inspectorate has indicated that social care providers should not automatically use multi-compartmental compliance aids (MCA) such as Monitored Dosage Systems (MDS) and daily dose reminders, but should give consideration to the alternatives available.

2.7 They recognise that while an MCA may be of value to assist some individuals to maintain independence in 'self-medicating', they are not always the best intervention for everyone. An assessment of individual need will determine whether the use of an MCA is recommended.

2.8 The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to individuals, where there is no specific requirement for the use of an MCA.

2.9 Where an MCA is requested for the benefit of the care workers, then either the individual or social care provider can be charged for this service.

2.10 Volunteers or any volunteer based in our services should never administer medication. It is acceptable for volunteers, when in a one to one situation (day trip, outing, holiday) to prompt someone we support (level 2 only) to take their medication. This should only happen with Line Manager and guardian approval and must be documented in the supported person's Personal Plan. The Service Manager should be made aware in advance of any planned activity where this is likely to happen.

3. Ordering and receiving of medicines

3.1 Ordering

Where support staff are involved in ordering medication the Service Manager must ensure that guidelines for re-ordering and receiving medication are in place for staff to follow. These must ensure that:

a) There is enough medication available until the next order is delivered, allowing for any delays.
b) A record is kept of what has been ordered. (The Care Inspectorate requires in some services that a photocopy of the prescription is taken)
c) There is a local protocol to deal quickly and efficiently with a prescription of new or 'acute' medicines. An example of an 'acute' medicine is a course of antibiotics to treat an infection and should be started as soon as possible. These medicines are not taken regularly, and are usually for a specified limited time.

3.2 Accepting Delivery

Staff are required to sign that the correct medication has been received. On receipt of medication, staff must check the labelled/typed MDS medication sheet/MAR sheet to ensure that this corresponds to what was ordered.
Staff must ensure the following information is recorded accurately on the medication administration sheet before signing as accurate:

a) Check the individual's name and date of birth
b) Name, strength and form of medication
c) Date received
d) Amount ordered and received is the same (quantity)
e) Time and route of administration

f) Any special instructions such as “take medication with or after food”

If an error is found, it is the receiving person who is responsible for taking action for any amendments required. Staff should consult the Pharmacist in the first instance.

4. Storage of medicines

4.1 Medicines are the property of the individual being supported and any storage of medicines in the home has to be with the agreement of the person or their proxy if appropriate. The Service Manager may advise the supported person on principles of good medicines storage. Any local storage arrangements should be detailed in the care plan.

However, there may be some cases where, following a risk assessment, secure storage is recommended, for example where the individual may seek or inadvertently take more of the medicines at one time than is safe. In general, medicine cabinets must be sited where they are not subject to extremes of temperature or humidity and care must be taken to ensure they are sited away from public view. Nothing else should be stored in the medication cabinet. It should not be used as a safe for valuables. The only reason to open a medicine cupboard should be to get access to medicines.

Facilities must be kept locked at all times except when medicines are being dispensed, received or checked. A cabinet must never be left unattended whilst unlocked. The Service Manager/Team Leader is responsible for ensuring suitable arrangements for the safe keeping of keys and information detailing the location of keys is properly documented.

When people live alone, care should be taken to ensure that medication is stored appropriately. If a risk assessment shows that there is a risk to the individual or any children visiting the service, then the medication storage facility should remain locked at all times when medicines are being dispensed.

4.2 There are no special storage requirements for controlled drugs in a person’s own home.

There is no requirement for storage of such medicines in a controlled drug cabinet.

4.3 Medication must be stored tidily. As far as practical, medicines for internal and external use must be stored in separate compartments.

5. Administering of Medicines

5.1 Medicines must be administered strictly in accordance with the instructions from the prescribing Doctor who prescribed them. Confirm what medicines (if any) have “specific” administration times. Doses must not be varied without medical authority. Medicine prescribed for a supported individual becomes their property as soon as it is dispensed and it is not permissible to administer it to another person.

5.2 Medicines must be administered from contemporary packaging (bottle or foil pack) or Monitored Dosage System using a “non touch” technique to avoid direct handling. Staff should only administer medication from a container that the pharmacist or dispensing GP has labelled and dispensed.

5.3 Staff should not administer medication from compartmental compliance aids [dossette box], even when filled by a pharmacist. They are not tamper evident and it would be difficult to know if the device had been re-filled by anyone not authorised to do so.

6. Good Practice Guidelines

6.1 When administering medicines staff must comply with the following:

a) Wash hands before administration where possible
b) Consider if there are any special care needs when administering. For example gloves may need to be worn.
c) Identify the individual
d) Check the medicine has not already been administered
e) Select all correct medicines and confirm the dose of medicine required by referring to the
MAR sheet and medicine label – avoid direct handling of medication
f) Drink of water to be made available to encourage help wash down the medication. A hot cup of tea instead of water is not a good idea as many medicines are affected by heat.
g) Encourage people we support to sit up or stand when receiving their medication
h) Do not handle medicines. They should be prepared using a ‘no touch’ technique, by pushing the tablet or capsule out of the blister pack, directly into a medicine pot or spoon. Some medicines are harmful to the care worker if they have direct contact with the skin, therefore it is advisable to wear gloves if there is a known health and safety risk.
i) Record on the MAR that the individual has taken the medication as required
j) Ensure that the depletion of medication figure is recorded for each medication every day, where possible.

Staff should only sign the MAR, **after** the medication has been administered to the individual.

7. Covert Medication

‘Covert’ is the term used to describe medication which is administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. This must not, however be confused with making tablets more palatable or easier to swallow by individuals. Nevertheless, covert medication is sometimes necessary and justified, but should never be given to people who are capable of deciding about their own medical treatment. Covert administration of medicines should only take place within existing legal and best practice frameworks to protect people we support and care staff involved.

In the event of covert medication being administered a drug treatment plan needs to be completed by the relevant Medical Professionals and held within the Personal Plan. Regular monitoring and review of drug use is essential.

8. As and When Required Medication

8.1 Medication prescribed 'as and when' requires that a General Practitioner's signature is held within the Personal Support Plan – current medical advice stating number of tablets with a specific time and what intervals they may be given.

9. Support Services

9.1 Within Support Service settings, staff where possible should not administer medication to supported individuals. They may remind them that medication must be taken and they may pass containers to them but wherever possible encourage the individual to take medication from its packaging themselves.

9.2 However in some circumstances medication may need to be administered. In these circumstances, a protocol must be written up by professionals when administrating medication considered **ESSENTIAL** to the individual's health. This should be filed within their of Personal Support Plan.

10. General Principles for the carrying out of Invasive Procedures

10.1 All staff administering drugs have to have received specific training, monitoring & assistance where required. Consent must be sought from the individual people we support and/or their families and that the medicine will be provided by their GP or family Deafblind Scotland staff should only give medicines they have been trained to give. Following training staff can assist people in:

- Taking tablets, capsules, oral mixtures
- Applying a medicated cream/ointment (or patch)
- Inserting drops to ear, nose or eye
- Administering inhaled medication

10.2 This level of training will not cover giving medicine that use "invasive" techniques such as giving suppositories, enemas and injections. The Support worker can administer oral dose medicines, creams ointments, for example while external healthcare professionals will administer medicines by more invasive routes. However, there may be some special cases (for example, rescue medicines for epilepsy or severe allergy) where support staff, after appropriate training, are prepared to administer medicines normally given by external health care professionals.

10.3 Specialised training to give medicines. There may be occasions when support workers are willing to give medicines that registered nurses normally administer. This only happens when the registered nurse 'delegates' and the NMC have set out their guidance for this. It is helpful in many situations, for example, when a rectal solution is given to a young adult to control an epileptic fit. No one would prefer to wait for a registered nurse, doctor or paramedic to give such important treatment.

The important issues are:

- The person consents to a care worker giving this treatment
- The care worker(s) agree to do so
- Clear roles and responsibilities are agreed by the agencies and the people involved in providing care.

This training is both person-specific and care worker-specific.

10.4 A dose of a medicine can be left with the supported person to take at a time when the support worker is not there IF the supported person has been assessed as being able to manage this and they/their proxy agrees to it. This assistance arrangement should be stated on the agreed "contract" and be noted in the care plan. Any assistance with medicines such as this should be recorded appropriately by the carer

10.5 Written guidelines will be prepared for each person we support in consultation with relevant Health Professionals, Pharmacists and the individual themselves or any other professional who can provide training.

10.6 Once completed, these guidelines must be stored in the individual's Personal Plan. All staff and carers will be made aware of individual guidelines and treatment plan and will receive training as necessary to implement them. There may be a need to consider the existence of a welfare guardian or secure a certificate of incapacity.

10.7 A separate record will be held detailing the use of each procedure which must be completed after every use. Written guidance will be formally reviewed on an annual basis. Training provided will address the following areas:

a) General information on the condition requiring intervention, involving good care practice.
b) The purpose and use of the medication required and its effectiveness in controlling the condition.
c) Methods of administration of the 'Life Saving' medication.

d) Preserving the dignity of individuals requiring the procedure.
e) Frequency of training will be site specific

10.8 Deafblind Scotland recognises that staff may feel anxious or uncomfortable about administering some of these procedures and will be assured that they will receive the organisation's full support provided that these guidelines are adhered to.

11. Administration records

11.1 Where staff are required to assist the individual with medicines, a comprehensive record of medicines prescribed, supplied and administered to the individual is essential.

12. MAR Sheet

12.1 Number of remaining medicines from previous month must be carried forward to the current month and recorded clearly on the new MAR sheet.

12.2 An appropriate entry must be made and initialled by the member of staff concerned, immediately AFTER each medicine is administered or supplied to the supported individual. Where it is part of a local procedure that more than one person must undertake the administration process, each member of staff involved in the process must sign to say they were involved. When the medicine is not taken or is refused, this must be recorded
by writing against the relevant medication and time on the MAR. It is good practice to record this in the individual's daily support records and notify the line manager where necessary.

12.3 Individual records for each person we support must also be kept, showing all prescribed medicines. The Pharmacist or Deafblind Scotland provides MAR sheets for this purpose and they must be filled out fully by the staff involved and placed in the appropriate section of the Personal Plan.

12.4 The MAR sheet must be available to the GP whenever they see the people we support. Changes to the MAR sheet must wherever possible be noted by either the GP or Community Pharmacist. Only in unforeseen circumstances where there is no GP or Community Pharmacist available the member of staff on duty will enter the changes.

12.5 Amendments to medication records must be written in block capitals, legible and permanent. The record needs to be dated, and hold details of the person making the change. It must also be cross referenced to the person who authorised the change – ie (name), GP, date

12.6 Amendments to medication charts should always be made as a new entry: an existing entry should NEVER be amended. If the dosage or frequency is changed, then the original entry should be cancelled and a new entry **PRINTED** in full. This should be signed and dated.

An item is discontinued by drawing a line through the entry to be cancelled, and should include date of cancellation, signature of person making change and cross referenced to the person who authorised the change.

12.7 The Service Manager must make every effort to facilitate the regular review of medication received by the people we support by making the MAR sheets available to GPs at every opportunity. The timescale for this review of medication is to be detailed within the Personal Plan, and should take place at least annually.

13. Verbal Orders

13.1 Problems can occur when doses are changed by means of a verbal order but no written document is sent. Usually this happens when a GP telephones a dose change, but a new prescription is not required. It can also occur when someone is discharged from hospital, without a discharge letter.

The service must keep a detailed written record of:

- Name of staff who received the call
- Time of call
- Name and designation of the person making the call
- Change(s) made

The person receiving the call, should then:

- Read back the information that has been written down to reduce the chance of a misunderstanding
- Spell out the name(s) of the medicine(s)
- Ask the person making the call to repeat the message to another member of staff, if possible
- Request written confirmation as soon as possible by email, letter or by issue of a new prescription.

14 Collection of Medicines

14.1 Medication is collected or delivered in a manner suitable to the supported individual's needs.

A Patient Information Leaflet should accompany and remain with each medication. Alternatively if an MDS is supplied, each one should be stored along with the Mar sheet for people we support and staff reference.

14.2 In some situations staff may collect medication from the pharmacist on behalf of an individual who self-administers medication. On these occasions, staff will need to keep a record of medication passed to the individual. Where possible, these records must be signed by the individual concerned and the member of staff making the record. Deafblind Scotland will

provide individuals with Medication Record Sheets for this purpose or details should be recorded in Communication Book.

15. Disposal of Medicines

15.1 When a particular course of treatment is ended or discontinued, remaining medicines prescribed for that person must not be used for any other individual or taken into stock, but must be disposed of without delay by returning to the prescribing pharmacist.

15.2 When a person we support dies, medication must be held for at least one week (7 days) before it is disposed of, as in the event of a sudden death the Police may wish to remove any prescribed or over the counter medication that the individual was taking prior to death.

15.3 The normal method of disposing of drugs which are no longer required, is by returning them to the Pharmacist. Under no circumstances must they be put in a waste bin or flushed away into the public sewerage system. Staff must make a record to show that the medicines were handled correctly. The Pharmacist or Deafblind Scotland provides a medicines disposal record for this purpose.

The following information should be recorded:

- Date of disposal
- Name and strength of medicine
- Quantity removed
- Name of supported individual for which the medication was prescribed
- Signature of staff member arranging disposal
- Witness signature (pharmacist where possible)

Particular care must be taken when disposing of aerosols which must never be burned: dispose as per instructions on the container. Empty medicine containers must be returned to the dispensing Pharmacist. Where syringes and needles are used they must be disposed of safely using a 'sharps bin'.

15.4 The disposal of unwanted medicines must take place in the presence of a witness, recorded as appropriate and signed by the staff member on duty and the witness, where possible a pharmacist.

15.5 The disposal or destruction of unwanted medicines are covered by The Control of Pollution (special waste) (Amendment) Regulations, 1988.

16. Controlled Drugs

16.1 Definition - "Medication that comes under the Misuse of Drugs Act. It has to be written, dispensed and handled in a way that is traceable." The Pharmacist will notify an establishment of all occasions when controlled drugs are dispensed.

16.2 There are legal requirements for the storage, administration and recording of controlled drugs. They do not apply to every social care service or when a person looks after and takes their own medicines. Deafblind Scotland recommends that all services have special arrangements for controlled drugs, even though the law does not currently require it.

Controlled drugs are divided into five schedules and each schedule dictates the degree to which the controlled drug is regulated.

Schedule 1
These drugs have no medicinal use and would not be used in any service.

Schedule 2
(Includes diamorphine, morphine, and pethidine)
Schedule 2 controlled drugs are subject to safe custody requirements. They must be stored in a locked compartment within the locked main medicine cupboard. One designated person on shift should take overall responsibility for the key. A separate controlled drugs register [bound, hard backed book] shall be kept showing all receipts, administration and disposal of controlled drugs on behalf of the individuals we support with a separate page being used for each controlled drug.

Schedule 3 (includes barbiturates and midazolam)
The majority of schedule 3 controlled drugs – with the exemption of temazepam, fluitrazepam, buprenorphine and diethylpropion – can be stored in the locked main medicine cupboard. There is no legal requirement to record transactions in a controlled drugs register.

Schedule 4 and 5 (includes benzodiazepines)
There are no specific requirements for schedule 4 and 5 controlled drugs and a register does not need to be kept.

16.3 Administration of schedule 2 controlled drugs to the people we support must be recorded in the controlled drugs register which will include the name of the supported individual, name of the drug and the amount given, together with the date and time given and the signature of the staff member giving the drug.

Staff must ensure that following administration of a schedule 2 controlled drug, the balance remaining is recorded on the controlled drug register.

This information should also be recorded on the individual's MAR sheet.

Services should have a written protocol for giving schedule 2 and schedule 3 controlled drugs (named above) to people we support. This normally includes a witness to the administration of controlled drugs.

16.4 When controlled drugs are returned to the Pharmacist or dispensing doctor, this should be recorded in an appropriate section of the record for the receipt of controlled drugs and shall include the name of the individual for whom they were received, the name of the medicine, the amount returned, by whom and the date. This procedure must be witnessed and the signature of the witness included in the record.

16.5 Providers should notify the Care Inspectorate of all adverse events and concerns involving a controlled drug (Schedule 2, 3, 4 and 5) when they occur, and while the individual is receiving care in the care service. This includes cases where a person uses a 24-hour service, but was not present in that service at the time that the incident was identified, for example they were in hospital or on an outing. In other services, the notification should be made if the incident occurs or was identified when the service was being provided. Notifications should be made within 24 hours of the event or concern occurring.

17. Non Prescribed Drugs – homely remedies / over the counter and complementary

The people we support may wish to use 'over the counter' or complementary medicines, of the type which would be found in everyday domestic circumstances. A written protocol held within the Personal Plan regarding the people we support's use of the "over the counter" remedies must be agreed in consultation with the GP or Pharmacist.

17.1 Homely Remedies - It is recognised that there is a need to be able to treat minor ailments without necessarily consulting with a GP.

17.2 Treatment must not normally extend beyond 2 days without medical advice being sought and must be recorded on the MAR sheet. Examples of conditions which may be treated by homely medicines are given below:

a) **Mild pain -** Can be treated with paracetamol provided that the person we support is not taking paracetamol in prescription medicines, i.e. co-codamol, co-dydramol, tylex, solpadol. See the written protocol for guidelines.
b) **Mild skin conditions -** Can be treated with an emollient.
c) **Mild constipation -** Can be treated with a bowel stimulant provided the person we support is not on any other laxative and there is no nausea, vomiting or abdominal pain.
d) **Indigestion / Heartburn -** Can be treated with Antacid providing the person we support is not vomiting. If the symptoms are not eased then medical advice must be sought. See the written protocol for guidelines.
e) **Simple Cough -** Can be treated with sugar free simple linctus until medical advice can be obtained.

17.3 'Over the counter' - The administration of 'over the counter' or complementary remedies must always be entered on the MAR sheets of the people we support. Staff may not administer any complementary medicines (e.g aromatherapy, homeopathic, herbal remedies) unless these have been prescribed by a medical practitioner.

17.4 Some people we support will wish to exercise their right to obtain and manage their own 'over the counter' medicines. People we support must be encouraged to advise staff and to consult with their GP or Pharmacist regarding possible interactions with prescribed drugs or to see their GP if symptoms persist. Any concerns regarding the possible misuse of 'over the counter' remedies must be brought to the attention of the individual's GP. The reviews procedure will provide an opportunity to deal with any concern about a supported individual's ability to manage remedies independently and to plan an appropriate level of support in this area.

18. Sun Protection

18.1 Sun Protection may be prescribed in cases of hypersensitivity due to an adverse reaction to medication, however at other times it is staff responsibility to ensure that measures are in place for the regular application of sun protection during warmer weather; if in doubt consult your local pharmacist. As with all topical applications/medicines, the individual has a right to refuse to have sun cream applied.

19. Staff

19.1 Deafblind Scotland does not provide any form of non-prescribed or over the counter products for staff use (this is with the exception of first aid items - see First Aid Procedure section 4, sub-section 6.4). Staff should follow in house procedures for storage of own medicines.

20. Moving In and Moving On

20.1 It is the responsibility of the Service Manager to ensure that all relevant medical details and drugs accompany a supported individual moving in to an establishment.

20.2 On moving out permanently, all medication and a copy of relevant medical details must accompany an individual. The Service Manager has a responsibility to ensure arrangements are made to this effect.

20.3 On temporary leave, the Service Manager must ensure guidelines are in place for any supported individual who goes away from the house e.g. on holiday or for part of the day, to take with them an appropriate supply of any prescribed medication, which may include an appropriate amount in the event of spoilage. Some pharmacists may dispense medication in a separate, smaller amount for this purpose. In cases where the person we support is not able to take responsibility, staff must ensure that the medicines are handed over to the carer and signed on receipt. In all cases a record of the quantity of medicine handed over must be made on a MAR sheet, and appropriate sheet within Personal Plan. Medication being received back into the service, must also be checked and recorded on the appropriate form.

20.4 Secondary dispensing must <u>not</u> occur.

21. Day and Short Stay Care

21.1 Where people come for respite care or attend day care, it is important to ensure that arrangements for safe custody of all medicines (whether prescribed, or complementary) are considered beforehand. A Medication Received record is completed on arrival and a Medication Sent record is completed on their discharge from respite or day care with any surplus medication being returned to either the individual or their Carer.

Whilst individuals are in respite or day care, any medication administered must be recorded on a MAR.

22. Errors/ Mistakes

22.1 All errors and mistakes must be recorded as an incident using Deafblind Scotland Incident reporting procedure, using the recording form and investigated. These incidents must also be reported by a senior member of staff to the Care Inspectorate and the Health and Safety Executive at the earliest opportunity if serious problems arise as a result (normally within one working day).

22.2 Any error in medication, whether or not resulting in injury, may imply a breakdown in the system of drugs administration. In such an event, steps must be taken to review the system. Record what action was taken on the reverse of the MAR. This will assist in identifying if a pattern of error is occurring.

22.3 In the event that a person we support is given medicine other than that prescribed, immediate medical advice must be sought. The circumstances must be recorded and investigated as an accident.

22.4 Follow Incident Reporting Procedure Section 4.4 for RIDDOR reportable cases.

22.5 See 15.5 for guidance on errors or concerns involving controlled drugs

23. Hazard Warnings

23.1 Drug stocks must be checked immediately on receipt of any Department of Health Hazard Notice. In the event that medicines subject of a hazard warning are held in stock or by supported individuals, prompt action must be taken in consultation with the Pharmacist or GP.

24. Security and Stock Control

24.1 Stocks of medication, other than medication in monitored dosage packs, must be checked for depletion on a regular basis. This should be at least monthly, but may be daily depending on local arrangements. Medication must not be kept or used after its expiry date and should be disposed of safely.

24.2 Any significant discrepancy in drug stock accounting must be investigated by the Service Manager/senior member of staff and must be reported to the Care Inspectorate. Some circumstances may warrant early Police involvement, either specifically to investigate or to discuss the concerns and possible action.

24.3 In the event that a physical loss of a quantity of medication has occurred out with the building the loss must be reported to the Police at the earliest opportunity. If the medication is particularly harmful (a Pharmacist will advise if necessary) the police must be advised to arrange suitable warning, for example through the local media.

25. Staff Training

25.1 Staff must be appropriately trained in the handling and use of medication, and have their competence assessed. Administration of Medication training is relevant only to staff who administer medication, and staff require to be re-trained every 3 years. Where possible, new staff should attend classroom training. If no classroom training is available, then the elearning course should be completed and followed up by three Observational Assessments [appendix 1] carried out by the line manager. This should be completed prior to any staff administering medication.

The staff competencies required are those found in the "Administer medication to individuals" (HSC375) unit of the SVQ level 3 qualification. This may involve doing this unit itself or via another training/assessment resource which covers the same competencies.

https://www.skillsplatform.org/health/medication-training

25.2 The staff member's competence will be reviewed annually as a competency as part of the appraisal process and kept on file. Staff skills will be kept up to date with refresher courses at Guide/communicator In Service days and any legislative changes with regard to Management of Medication will be taken account of within these. Following initial training, guide/communicators have shadow shifts and thereafter a competency assessment and spot checks are carried out with the Management of Medication a key quality indicator.

25.3 This training will not cover giving medicines that use 'invasive' techniques such as giving suppositories, enemas and injections. See section 10.

26. Local Arrangements

26.1 It is recognised that some services may have additional rules/ safeguards placed on them by the Local Authority. It may be necessary therefore, for The Manager of these services to develop a local protocol in addition to this procedure. The Manager for the service must ensure that if a protocol is in place, it is reviewed regularly – either two-yearly or sooner if required.