Medication Conditions Policy

Contents

Purpose

The purpose of this policy is to ensure the safe and effective administration and management of medicines to support learners in St John's residential care home settings and learners who attend St John's college.

This policy aims to promote the health, safety, independence, and wellbeing of all learners at St John's.

This medication policy encompasses regulatory and best practice requirements governing the management of medicines in adult social care and educational settings, including National Institute for Health and Care (NICE) guidelines for the management of medicines in care homes and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This policy also references statutory guidance, Supporting pupils with medical conditions at school, (Department for Education).

This policy describes the arrangements to provide support for learners who take medicines whilst under the care of St. John's. This document sets out the principles and guidelines that all staff at St. John's must follow with regards to the management of medicines

Learners at St John's may be prescribed medicines to treat medical conditions. This policy recognises that any learner at St John's being denied medicines, being given the wrong medicine, or receiving the incorrect dose of a medicine, has the potential to cause temporary or permanent harm.

This policy applies to the residential and college settings. Where there are variations between residential and college, this policy will outline these in the relevant sections or appendices.

Scope

This policy extends to staff working at St John's who support learners with the management of their medicines. The scope of the policy covers the entire medication management process, including training, managing prescriptions, safe storage of medicines, dispensing and administering medicines, and medication errors. The policy recognises the importance of promoting person-centered care, supporting and encouraging learners' independence and preferences, while upholding safety standards and regulatory requirements.

Responsibility

The Registered Care Manager holds responsibility for the implementation and compliance of this policy in their residential care setting, in accordance with regulatory requirements outlined in NICE guidelines for the management of medicines in care homes and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Executive Headteacher, College Principal, and the Lead Nurse hold this responsibility in the college, in line with the guidance and regulations stated above and with reference to statutory guidance, Supporting pupils with medical conditions at school.

Trained and authorised staff are responsible for the administration and management of medicines in line with guidelines detailed in this policy.

The designated healthcare professional, e.g. GP, Pharmacist, Specialist, will provide guidance on the management of medicines and review medication orders, in line with NICE guidance.

The St John's Learning and Development (L&D) team are responsible for ensuring that staff complete mandatory training on the management of medicines and maintain training records for individual staff members.

Section ONE

Training & skills (competency)

Section ONE

Training and skills

Administration of emergency, as required (PRN), medicines

All learner facing staff joining St John's will receive mandatory training on the management of specific health conditions, such as asthma, epilepsy, anaphylaxis as part of their induction program. This training will include theoretical and practical training on why, when, and how, to administer emergency medication, including buccal midazolam (prolonged seizures), adrenaline auto injectors (anaphylaxis), and reliever inhalers (asthma attack).

Staff are required to pass theory and practical assessments during training before successfully completing their induction program. Regular refresher training will be delivered to refresh knowledge and skills.

Administration of regular medicines

Registered Nurses, Health Care Assistants (HCAs), and residential care workers who are involved in medicines administration will receive initial and ongoing training on medicines management.

Staff must successfully complete the *Foundation Course in Medicine Administration (FCMA)* training prior to administering medicines. This should be followed by at least two supervised medication rounds, and a final competency assessment led by the Care Manager, Deputy Care Manager, or Lead Nurse.

Medicines must only be administered by trained staff who have completed the FCMA course and have successfully passed the competency assessment.

Annual assessment of knowledge, skills, and competence

Staff administering medicines must have their knowledge, skills, and competence assessed annually, in line with NICE guidelines and the St John's medication policy, *Guidelines for the safe and secure management of medicines*.

The following annual competency assessment must be undertaken, (as a minimum):

- St John's mandatory *Administration of medicines* e-learning module
- A supervised medication round by a Care Manager, Deputy Care Manager, or the Lead Nurse

The Lead Nurse will deliver termly *Medical Skills and Knowledge* refresher training sessions to individual care teams. Themes for training are to be agreed by the Lead Nurse and the Care Manager.

Training records should be maintained by the Learning and Development team to ensure that there is a record of staff competency in relation to medicines administration practices, in accordance with CQC and NICE regulations.

Delegating a nursing task

Registered Nurses are authorised as part of their practise to delegate care tasks to others involved in a person's care. The nursing regulator the NMC (Nursing & Midwifery Council) defines delegation as:

'*Delegation is defined as the transfer to a competent individual, of the authority to perform a specific task in a specified situation*.'

Delegation of tasks from one individual to another occurs commonly in in health and social care settings. This may be a clinical or non-clinical skill.

At St John's, the Lead Nurse (Registered Nurse), or other registered nurses, (if employed by St John's), may delegate a nursing task to colleagues in residential care and education teams, including healthcare assistants. Typical tasks include administration of buccal midazolam or an adrenaline auto injector.

The nurse delegating the task must make sure the person carrying out the task on their behalf is competent to do so and adequately supported. They must also assure themselves that the outcome of the task meets the required standard.

The NMC and Royal College of Nursing (RCN) set out strict guidance around the delegation of tasks:

- delegation-and-accountability-supplementary-information-to-the-nmc-code.pdf
- Accountability and delegation | Royal College of Nursing (rcn.org.uk)

The registered nurse must ensure that regular training and practice is undertaken to ensure that their knowledge, skills, and competency of the task to be delegated is current and up to date. Evidence of training undertaken should be recorded.

Where the registered nurse does not have the appropriate knowledge, skills, and competency to carry out or delegate a nursing task, then steps must be taken to arrange appropriate training from a community nurse or specialist nurse from NHS primary or secondary care services. An example of this may management of a PEG (percutaneous endoscopic gastrostomy) tube.

Section TWO

Medication ordering process

Section TWO

Ordering medicines

Each St John's residential care home will make their own arrangements for ordering prescribed medicines.

Care staff should ensure that medicines prescribed for a learner are not administered to other residents.

The Care Manager must ensure medication trained staff have protected time to order prescribed medicines and check medicines that are delivered to the home by the pharmacy.

Learners should be involved in the process of ordering their medicines where they have the mental capacity, knowledge, and skills to do so.

The Care Manager should ensure that at least two members of staff have training and skills to order medicines, although ordering medicines, and checking medicines delivered to the home, can be undertaken by one person.

Residential care homes retain the responsibility for ordering medicines from the GP practice and should not delegate this task to the supplying pharmacy.

Care homes must ensure that records are kept of all medicines ordered.

Medicines delivered to the care home must be checked against the record of what has been ordered. This is to ensure that all medicines ordered have been prescribed and supplied correctly. This should be done at the earliest opportunity.

On receipt of medicines, prescription labels should be cross referenced against the learners' MAR chart. Any errors or discrepancies with medicines supplied should be followed up with the pharmacy and/or prescriber, at the earliest opportunity.

Medicines received should be counted and recorded on the MAR chart, where necessary adding to current stock totals for medicines already held.

The member of staff checking the medicines received from the pharmacy must sign the MAR chart to evidence that medicines supplied have been checked.

Over the counter treatments (OTC)

Over the Counter (OTC) treatments can be bought by the public to treat minor, self-limiting conditions, such as mild to moderate pain, constipation, diarrohea, or indigestion.

The Sussex NHS Foundation, *Self-Care Toolkit: Homely Remedies and Supporting Access to Self-Care*, guidance document separates OTC treatments into three categories:

- Homely remedies
- Self-Care treatment
- Personal Care treatment

OTC treatments that have been purchased must be written on Homely Remedy MAR chart or a Self-Care / Personal Care MAR chart, including totals of stock purchased. Administration of treatments should be recorded on the MAR chart when given.

See Section 5 for more information on how to use and implement the *Self-Care Toolkit: Homely Remedies and Supporting Access to Self-Care* guidance.

Section THREE

Safe storage of medicines

Section THREE

Safe storage of medicines

Care homes must store all medicines securely, including controlled drugs.

St. John's provides secure medication cabinets to store medicines. Cabinets must always be kept locked when not in use. All medication cabinets must conform to British standards, BS2881:1989, (the British Standards Institution). Controlled drugs cabinets must also conform to the standards specified in the Misuse of Drugs Act, 1971 (safe custody) regulations. All medication cabinets should be securely attached to solid brick walls. Where possible this should be an external wall.

Care homes must consider how medicines are stored for each learner. This should include providing easy access for individuals who are responsible for taking their own medicines (self-administration).

It is the responsibility of the Lead Nurse (for nursing areas) and Care managers (residential houses) to ensure that:

- All medicines are stored securely in a medication cabinet (except for emergency PRN medicines, e.g. buccal midazolam, where a secure cupboard or drawer may be used for immediate access)
- Medication cabinets are for medicines only. They must be kept clean, organized, and have clear labelling
- Medicines should be stored at room temperature (25°C or below), unless instructions indicate that they should be refrigerated.
- A 'Min/Max' thermometer should always be kept in the medicine cabinet. A daily log (24 hourly) of current, minimum, and maximum temperatures should be recorded. Action will need to be taken if the temperature is consistently at 25°C.
- Medicines that are required to be refrigerated must always be stored between 2-8°C. A daily fridge temperature log should be kept
- Medication cabinets are kept locked when not in use
- Only authorised staff (medication trained staff) should have access to medication cabinet keys
- Medication cabinet keys should be stored securely in a coded key safe
- Duplicate keys are kept separately and securely in the residential house.

Storage of medicines in hot weather

Spells of hot weather will cause room temperatures to rise and can result in medicines being stored above the recommended maximum temperature.

Most medicines kept in a medication cabinet should be consistently at a temperature of 25°C or below, although manufacturers of some medicines advise storage 'not above 30°C'.

A problem arises when medicines are stored consistently above 25°C, although it's open to interpretation of what is meant by 'consistently'.

The integrity of a medicine may be adversely affected by storing it in unfavourable conditions, e.g. if medicines are stored in hot, humid (excess moisture) conditions over a prolonged period, or medicines are being stored in the cool, moist conditions of a fridge, when they are not manufactured to be stored in this way.

John Greene, Lead Pharmacist and Director of the Medication Training Company, advises that it is best to avoid medication being stored above 25°C **for more than 5 days in a month**.

https://medicationtraining.co.uk/medicines-storage-do-care-homes-really-need-to- monitor-room-temperature

If there are issues with high room temperatures when storing medicines, consider the following measure to reduce room temperatures:

- Ventilate the room by opening the windows during the cooler times of day, in the morning and evening. Ensure that the room remains secure, if not being occupied).
- Close windows when the temperature outside is hotter than inside
- Use (install) blinds to block sunlight from the room
- Use fans or portable air conditioning units to lower room temperature
- Consider installing a permanent air conditioning unit, if necessary.

Refrigerated medicines

Medicines that are required to be refrigerated should be always stored between 2- 8°C.

Action must be taken if the temperature recorded is outside of this range. Report via CAFM immediately to see if the problem can be fixed. Inform the Nursing team of any fridge temperature issues.

Any medication stored within the fridge must be transferred to another working medication fridge as soon as possible.

Medicines should only be stored in a fridge if directed to do so by the prescription label, or by direction from a pharmacist or other health practitioner, (this direction must be recorded).

The following guidance should be followed to ensure the safe storage of refrigerated medicines:

- All medication requiring refrigeration is put away, as soon as it is received, in a locked medication fridge. Each residential area and nurse's area is provided with a medication fridge.
- All medication refrigerators must have a sign on the plug notifying people not to turn it off
- Refrigerators must not be overstocked, in order to allow space for air circulation
- The door must only be opened when necessary and closed as soon as possible, to keep the temperature constant
- Daily checks of the refrigerator temperature are taken and recorded on a daily basis, recording the minimum, maximum and actual temperature. Once this has been

recorded, the reset button must be pressed

- Refrigerators should be cleaned and defrosted at regular intervals, and this should be recorded as being done.

Storage of controlled drugs

The *Misuse of Drugs Act 1971* defines controlled drugs as drugs which are 'dangerous or otherwise harmful' and have the potential for abuse or misuse. These controls are to prevent medicines being misused, being obtained illegally, or causing harm.

The *Misuse of Drugs Regulations 2001* split controlled drugs into five schedules. These schedules correspond to therapeutic usefulness and misuse potential

Schedule 2 drugs must be stored in a controlled drugs cupboard and a stock record of these medicines must be kept in a controlled drugs register. These drugs include ADHD treatments such as Methylphenidate and Dexamphetamine.

Schedule 3 drugs do not need to be kept in a controlled drugs register. However, you must store certain Schedule 3 drugs in the controlled drugs cupboard. Buccal midazolam, an emergency medicine used to treat prolonged seizures, does not need to be stored in a controlled drugs cupboard but should be stored securely.

Controlled drugs cupboards must meet British Standard BS2881:1989 security level 1 and the requirements of The Misuse of Drugs (Safe Custody) Regulations 1973 (legislation.gov.uk).

Schedule 2 (and certain schedule 3) drugs must be stored as follows:

- The cabinet must be secured to a solid wall or a wall with a steel plate behind it
- You do not need to store the controlled drugs cupboard within another cupboard
- Access to the cabinet should be restricted to medication trained colleagues
- The controlled drugs book must be kept in the locked medication cabinet when not being used
- The controlled drugs cabinet must be closed and always locked when not in use
- The keys for the controlled drugs cabinet must be securely stored in the medication key safe when not in use
- Store spare keys securely
- Controlled drugs cupboard should not be used to store items other than medicines
- If a learner is self-administering controlled drugs, they can keep them in their possession provided the controlled drugs are kept safely. A risk assessment should consider where the controlled drugs will be stored.

Storage of prescribed PRN medicines and over the counter (OTC) treatments

Prescribed PRN medication should be stored in a separate medication cabinet, so that it does not becomes confused with regular prescribed medicines.

Over the counter (OTC) treatments should also be stored in a medication cabinet separate to regular prescribed medication or stored securely in a learner's bedroom/bathroom, depending on the nature of the treatment, e.g. moisturising cream, shampoo, toothpaste etc.

Prescribed emergency PRN medicines, such as asthma reliver inhalers, buccal midazolam, adrenaline auto injectors, must be immediately accessible to the person they are prescribed to, if required, but still stored securely, away from other learners.

Buccal midazolam is a Schedule 3 controlled drug. As a schedule 3 controlled drug, there is no requirement for Midazolam to be kept in controlled drug cabinet and a controlled drugs log does not need to be kept.

All emergency medication must be checked prior to learner going offsite. The member of staff supporting the young person must ensure that the medication is:

- Intact (no damage)
- In date
- Correct medication for the learner
- Individual Healthcare plan and PRN protocol is with the medicine.

Section FOUR

Dispensing and administering medicines

Section FOUR

Person centered approach to supporting learners with their medicines

A person-centered approach should be followed when supporting learners with their medicines. Learners at St John's should be involved in decisions about their treatment.

Self-administration of medicines or active participation in medicines management has several benefits for the learner:

- Promotes independence
- Empowers the individual to take responsibility for their medicine(s)
- Promotes feelings of wellbeing and self-esteem
- Maintains the learners' routines
- Can help the learner gain a good understanding of their medication
- Improves trust and relationships between the learner and staff.

Learners should be encouraged and enabled to be as independent as possible in the management of their medicines. Parents, care home staff, the Nursing team, GPs, pharmacists, and social workers can be involved in supporting the learner with the management of their medicines, where necessary.

Authorisation for administration of medicines

Nurses who are registered with the Nursing and Midwifery Council may administer medicine on the instruction of a medical practitioner. Nursing staff may delegate the task of medication administration to other trained and competent staff.

All other staff at St John's must complete medication training and be signed off as competent before administering medication independently.

Training and competence assessment involves completing the *Foundation Course in Medicines Administration (FCMA)* training provided by the Medication Training Company.
This accredited course teaches staff how to dispense and administer medicines in a safe and systematic way.

On successful completion *FCMA* training staff must undertake at least three supervised medication rounds, which will be assessed by a Care Manager, Deputy Care Manager, or Lead nurse, before being signed of as competent.

The member of staff being supervised **must not** in any circumstances administer medication independently until they have been signed off as competent by a senior member of staff.

All staff administering medication must have read and understood this medication policy.

Record keeping

Good record keeping protects learners who receive medicines support and staff who support their care. Secure, accurate, and up to date records about medicines support for each learner must be maintained. This is required under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines support is any support that enables a person to manage their medicines.
In practical terms, this covers:

- Reminding people to take their medicines
- Helping people remove medicines from packaging
- Administering some or all of a person's medicines.

The 7-point check must be followed when dispensing medicines using a Medicines Administration Record (MAR) chart. MAR charts should:

- Be legible
- Be signed by the care home staff or care workers
- Be clear and accurate
- Have the correct date and time (either the exact time or the time of day the medicine is taken)
- Be signed as soon as possible after the person has taken the medicine
- Avoid jargon and abbreviations.

Medicines administration records must be kept up to date. If a learners medicines change, their records must be updated immediately.

St John's MAR charts and the learners Medicines administration profile will include the following information:

- Learner's name and date of birth
- A photo of the learner for identification purposes
- GP details
- Name, form, and strength of the medicine(s)
- Known allergies and reactions to any medicines reaction experienced.
- Route of administration (how the medicine is taken)
- Details of when a medicine should be reviewed or monitored, if necessary
- Support the learner may need to carry on taking the medicine
- Special instructions about how the medicine should be taken (such as before, with or after food).

Retaining records

Medicines administration records must be kept for at least 8 years after the learner has left the care of St John's. After 8 years records should be reviewed. If they are no longer needed, records can be destroyed in line with St John's policies.

Dispensing medicines in a safe and controlled environment.

One of the main reasons for errors being made when dispensing medication is complacency and a poor working environment.

The medication administrator should be free from distractions so that they are fully focused on the task in hand.

The medication administrator should implement the following guidelines:

1. Prevent intrusions and distractions from other staff by placing a '**Medication being administered, Please do not enter'** sign on the door of the room being used to dispense medication.

2. Ask any colleagues sharing the room with you to leave whilst you dispense medication, so that they do not interact with you and distract you

3. Give the house phone to a colleague prior to dispensing medication to avoid the need to answer calls

4. Lock the office door prior to dispensing medication to avoid distractions from others entering the room

5. Ensure that the dispensing area has adequate lighting to ensure that MAR charts and medicine labels can be easily read.

6. Ensure that the dispensing area is uncluttered so that there is plenty of space to work

7. Ensure that the dispensing area is clean and free from dirt and dust.

8. Ensure that you have all necessary equipment ready before you start dispensing medication, e.g. clean, dry medicine pots and/or syringes, pill crusher, water, cups, black pen etc.

9. Have the MAR charts next to you ready before dispensing medication.

10. Take time to make all necessary checks when dispensing medication. Systematically use the '7 point check' and avoid skim reading by touching the information you are reading with your finger

11. If giving medication away from the room where you are dispensing the medicine(s), take the MAR chart with you and sign the chart as soon as you have observed the learner taking their medication.

Administering medicines

The following process should be used to support the learner take their medication:

- Understand what medical condition the medicines prescribed to a learner is treating
- Read the learners *medicines administration profile* to understand how their preferences for or how they take their medication
- Identify and be certain that you are giving the medicines to the right person
- Greet the learner positively and ask them if they are ready for their medication
- Be mindful that learners can refuse their medicines for different reasons. Where a medicine is refused, consider waiting 15 - 20 minutes and ask the learner again, or use other strategies that may support the young person to take their treatment

- Ensure that the learner has a tumbler of water to support the swallowing of tablets

- Encourage the learner to sit upright or stand up to support the safe swallowing of tablets. Tablets should not be administered when the learner is lying down, as this makes swallowing difficult and tablets could get stuck in the throat, and may cause the individual to choke

- Observe the learner taking their medication, do not assume that they have done so

- Sign the MAR chart immediately after the medicine has been administered

- Record if a learner refuses to take their medicine, (see *Refusal of medicines*, Section FIVE).

- Refused or accidently dropped medicines must secured in the medication cabinet, before being disposed of at the pharmacy or taken to the Nursing team

- If a learner is unable to swallow medicines in tablet or capsule form, then this should be discussed with the prescriber or a community pharmacist who can advise if a liquid product is available. Do not crush tablets or empty medicines from capsules without consulting with the prescriber or a community pharmacist.

The Pot, Dot, Give, Sign procedure should be used when dispensing and administering medicines, as demonstrated in PCMA/FCMA medication training:

- Pot (the medicine)
- Dot (the MAR chart to indicate it has been dispensed)
- Give (the medication the learner to take)
- Sign (initial the MAR chart immediately after administration of the medicine).

The MAR chart must be signed immediately to indicate a record of medicines that have been administered, omitted, intentionally withheld, or refused. There should be no gaps on MAR charts.

The Care manager and Nursing team will keep a list of up-to-date signatures of all staff trained to administer medicines, (signature verification sheet).

Care Managers will ensure MAR charts are checked regularly to ensure that they are in order.

Dispensing medicines (the 7-point check)

The 7-point check procedure **must** be followed to ensure the safe dispensing of medicines.

Carry out a 5-point label check. Cross reference the prescription label of the medicine against the MAR chart. Check that the learner's name, the name of the medicine, the strength of the medicine, the form of the medicine and the direction for administering the medicine match and there are no discrepancies.

Also, check the medicine inside the box is the correct medicine, do not assume it is.

And, check the expiry date / discard date of the medicine to ensure it is in date.

7-point check standard operating procedure (SOP), see appendix 1.

Skim reading

Skim reading is a technique that uses rapid eye movement to focus on keywords when moving quickly through text to get a general overview of information. Skim reading helps to process and understand information quickly. However, skim reading can cause information to be mis-read or misinterpreted and we sometimes read what we expect to see, rather than is written. Skim reading can be the cause of medication errors.

To prevent skim reading, staff should touch the information they are reading with their finger, when carrying out the 7-point check. Touching each word will changes the way the brain processes the text being read. Following this approach consistently will reduce the risk of medication error occurring, especially errors that reach the learner and have potential to cause harm.

Care managers should monitor to ensure staff are employing this technique when dispensing medicines.

Expiry dates and 'Once opened' discard dates

Care staff must check that medicines and treatments being administered have not reached or passed their expiry date or 'once opened' discard date.

Medicines and treatments that have expired or reached their 'once opened' discard date must not be administered.

Manufacturers of products such as topical treatments, oral liquids, and eye drops, may indicate that a product must be discarded after a specified number of days or months after first opening.

If the manufacturer states when a product should be discarded after opening, this guidance must be adhered to.

Green '*stock*' stickers should be used to indicate expiry dates or the 'once opened' discard dates.

Note:

NHS CCG (Clinical Commissioning Groups) have previously applied default dates for disposing of certain products, where the manufacturer has not specified when to dispose of a product, once it had been opened.

For example, some NHS, CCG guidance has stated that tubs of topical preparations, such as Vaseline or Sudocrem, should be disposed of one month after opening, tubes to be disposed of three months after opening, and liquids/lotion preparations disposed of after six months.

Care homes may still have NHS guidance sheets advising of when to dispose of emollient creams, ointments, liquids etc.

NICE guidelines have been updated and now state that these default 'once opened' discard dates no longer apply. Many NHS CCGs have taken up this guidance to prevent unnecessary waste of these types of products. See NICE guidelines: Managing medicines in care homes (full guidance). full-guideline-pdf-2301173677 (nice.org.uk)

Care staff should be aware that all products, once opened, can be used up to the manufacturer's expiry date unless the manufacturer advises otherwise. Exceptions will be printed on the product packaging and/or the pharmacy prescription label.

John Greene, Lead Pharmacist, and Director of the Medication Training Company, recommends that eye drops continue to be discarded 28 days after opening, unless otherwise stated by the manufacturer.

For further guidance, please follow the link to the Medication Training Company website. Review of Expiry Date Advice - Medication Training .

Controlled drugs

The procedure for the administration of a controlled drug is the same as any other drug but with these additional requirements:

- The controlled drug book is a separate bound book with numbered pages
- A stock check is required prior to administration and a closing balance entered before returning it to the medication cabinet
- The administration must be witnessed by a second member of staff
- When a second checker is involved (controlled drugs) the person must witness the entire procedure from identification of the medicine prescribed through to witnessing administration to the learner. The person must also sign the MAR chart and the controlled drug book (the witness is not required to be medication trained. However, they must understand the responsibility that they are undertaking)
- Details of the administration must be recorded on the MAR chart as well as the controlled drugs register
- No entries in the controlled drugs register may be altered or crossed out. Errors in recording must be highlighted and an explanation of the error written on the next line If a controlled drug is wasted or partly used this must be recorded and witnessed
- Returns of controlled drugs to the nursing team must be recorded in full for collection by the pharmacy
- If there is a difference in the controlled drug book and the controlled drug cupboard, the discrepancy must be reported immediately to the care manager, on call manger or the nursing team, for investigation.

Single checking is acceptable for drugs other than controlled drugs.

NO PERSON MAY ADMINISTER CONTROLLED DRUGS WITHOUT A SECOND PERSON WITNESSING.

Self-administration of medicines

It should be assumed that a learner can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise.

An individual risk assessment should be carried out to determine how much support a learner requires to take and look after their medicines themselves.

The risk assessment should consider:

- The learners' choice around managing their medicines
- Whether self-administration is a risk to other learners

- Does the learner have the mental capacity and manual dexterity to self-administer their medication?
- Is the learner able to take the correct dose of their medicines at the right time and in the right way
- How will medicines be stored?
- The responsibilities of care staff to support self-administration (this should be documented).

The risk assessment should be reviewed regularly.

If the risk assessment determines that it is appropriate for the learner to self-administer, then an individualised development program should be devised, including the opportunity to develop an understanding of their treatment, making reasonable adjustments to support self-administration, e.g. using large print on labels and MAR charts.

There may be varying levels support with of self-administration of medication. These may range from learners' who have been assessed as able to administer medication independently, or those who need more support but are able to participate actively in the management of their medication.

Care homes should ensure that medicines for self-administration are stored safely, as identified in the individual's risk assessment, e.g. in a lockable cupboard, drawer, wall mounted cabinet etc. in the learner's room.

Covert administration of medicines (medicines administered to learners without their knowledge)

St. John's does not promote or encourage the covert administration of medicines. Care staff and the Nursing team should not administer medicines to a learner without their knowledge.

However, on occasions, following a best interest meeting, it may be agreed that the covert administration of medicines is the most appropriate course of action for the individual concerned to support their health and wellbeing.

The Care manager and Lead nurse will ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the learner who is receiving the medicine(s) and the staff involved in administering the medicines covertly.
St John's must ensure that the process for covert administration of medicines to learners in an adult social care setting includes:

- Assessing the individual's mental capacity assessment
- Holding a best interest meeting involving care staff, the health professional prescribing the medicine(s), pharmacist, social worker, and family member or advocate, to agree whether administering medicines without the learner knowing (covertly) is in the individual's best interests
- Recording the reasons for presuming mental incapacity and the proposed management plan
- Planning how medicines will be administered without the learner knowing
- Regularly reviewing whether covert administration of medication is still needed.

Dispensing medicines for administration during off-site trips

Secondary dispensing occurs when medication is removed from the container in which it

was received from the dispensing pharmacy and put into a different container prior to administration.

Secondary dispensing is not best practice and should be avoided unless necessary.

There may be occasions when a young person is due their medication when they are away from the college or their residential care home, e.g. work experience, a medical appointment, a social activity in the community etc.

If a risk assessment has been carried out and it is not deemed safe to take a full stock of medication off site with the learner, then single doses of medicines can be decanted (secondary dispensed) from the original packaging into a secure pot, which is clearly labelled.

If a medicine is going to be secondary dispensed for this purpose *then the Guidelines for dispensing medicines to be administered off site* Standard Operating Procedure (SOP) must be followed. See Care drive - T:\Templates May 2022\Medication File Templates\Medical S.O.P .

Prescribed PRN (pro re nata) medicines

Prescribed PRN (pro re nata) or 'when required' medicines can treat medical conditions, such as prolonged seizures (buccal midazolam), anaphylaxis (adrenaline auto injectors), asthma attacks (reliver inhalers), and anxiety (psychotropic medicines).

Learners prescribed emergency PRN medicines to treat medical conditions will have a PRN protocol, which guides staff on when and how to administer the medicine.

Staff administering PRN medicines must:

- Follow individual protocols for PRN and emergency medication
- Record the use of PRN medicines on the individuals PRN chart

If PRN and emergency medications are being used increasingly regularly, care staff or the Nursing team will arrange a review with the individuals GP or specialist practitioner.

PRN medicines taken off-site

PRN medicines/emergency bags (buccal midazolam, reliver inhalers, adrenaline auto injectors, anxiety/behaviour medication etc.) must be rigorously counted off site and back on site to ensure the whereabouts of the medicine are known and that there is no discrepancy in stock totals. This should be recorded, even when the medicine has not been used.

A signing 'out' and 'in' form can be used to record and track PRN medicines taken offsite, (see Appendix 2).

Section FIVE

Management of medicines

Section FIVE

Medicines reconciliation

Medicines reconciliation is the process of identifying an accurate list of medicines a person is taking on admission to a new setting, and at each transfer of care, and comparing it with the current list or stock of medicines supplied, to identify any potential discrepancies.

All medicines should be reconciled within 48 hours following admission to a residential care home.

The Lead Nurse and/or Care Manager should ensure that the following people are involved in medicines reconciliation:

- The learner and/or their family or carers
- A pharmacist
- Other health and social care practitioner involved in managing medicines for the resident, as agreed locally.

A medicines reconciliation from should be completed for all new learners.

Two sources of information should be used to reconcile medicines. A pharmacy prescription label, issued within the last 6 months, should always be one source.

Other sources include:

- The learner (must have capacity, with the information shared being reliable)
- Family/Carers/next of kin (including St John's medical entrance form)
- Hospital discharge letter
- Repeat prescription slip
- Medical/hospital correspondence
- GP summary (Summary Care Record)
- Previous MAR chart
- Other source (this should be specified).

Medicines reconciliation can also be used to record changes in treatment for a learner whilst at St John's. This may be helpful where the learners care is supported by parents/carers, and medical correspondence, and treatments, are supplied from home. It will allow for any discrepancies to be recorded, with details on how these are being managed.

Medicines review

All learners' receiving prescribed medication should receive an annual medication review from their GP or other appropriate medical practitioner.
Learners with a learning disability should be registered on their GPs learning disability register so that they receive an annual health check, which will include a review of their medicines.

Where a residential learner is registered with a GP at home with their parents/carers, then it is the responsibility of the parents/carers to support annual medicine reviews and health checks.

The parents/carers of day learners are responsible for supporting annual medicine reviews and health checks, with support from the St John's Nursing team, where appropriate and practicable.

Monitoring of medicines

The Care manager, Quality Assurance Manager, and Lead Nurse will carry out regular checks and audits of practices involving the handling of medicines.

Residential teams carry out weekly audits of MAR charts, stock totals, cabinets, and fridges**.**

The Lead Nurse and/or local NHS Medicines Optimisation in Care Homes (MOCH) teams will complete an annual medication review and audit and feedback outcomes to Care managers.

Creation and management of Medication Administration Record (MAR) charts

The Nursing team create and update Medication Administration Record (MAR) charts for St John's residential teams.

All MAR charts must indicate:

- The learner's name, date of birth, and place of residence
- A photograph of the learner for identification purposes
- The name and contact details of the learner's GP
- The allergy status of the learner
- List of any dietary requirements that may affect medication
- List the name, strength, and form of the medicine
- List the treatment directions, e.g. dose, route, (oral, topical etc.), and time of administration
- List any cautionary and advisory advice in relation to the medicine.

The Nursing team transcribe instructions accurately from the prescription label onto the MAR chart. The instruction should be checked by two members of the Nursing team, the Lead Nurse or Lead HCA and a HCA. The Lead Nurse or Lead Health Care Assistant will sign MAR charts to evidence it has been checked before handing over to the residential care team.

On receipt, a medication trained member of the residential care team must cross reference the MAR chart against the medication held in stock. The member of staff should sign the MAR chart if they are happy that the instructions are accurate no errors or discrepancies have been found.

Any discrepancies found must be reported and followed up immediately with the Care manager or senior member of the care team/shift lead.

Residential care staff must not alter information on the MAR chart in relation to the dose and directions of use of the prescribed medication or other treatments.

Medicines prescribed to be administered regularly must be given each day at the time specified on the MAR chart, until the prescription is cancelled, or the period of time to take the medicine has finished, e.g. a five or seven day course of antibiotics.

If medicines are not administered at the correct time or within an hour of the specified time, contact the Care manager or the Nursing team for advice. If they are unavailable guidance should be sought from a local pharmacy or NHS 111.

Discontinued medication must be crossed through on the MAR chart so that the medicine is not administered in error. A record must be added to the notes section of the MAR (and the Support Plan) detailing who authorised the decision and why. The medicine will then be removed from the MAR chart at the earliest opportunity.

If a prescriber changes the type of medicine or the dose of an existing medicine to be administered, then the MAR chart must be amended accordingly, with changes being signed by the Nursing team.

Changes to prescribed medicines

How to implement a change of prescription (or new prescription)

- See *Changes to prescribed medicines* SOP (Standard Operating Procedure)

Verbal instructions to change prescribed medicines

Colleagues must not change a learner's prescribed treatment solely on a verbal instruction from a health professional, e.g. GP or psychiatrist, or from a parent/carer.

Health professionals prescribing medicines should use telephone, video link, or online prescribing, (remote prescribing), only in exceptional circumstances and when doing so should:

- Follow guidance set out by the General Medical Council or the Nursing and Midwifery Council on assessing capacity and obtaining informed consent from residents
- Be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing
- Ensure that care home staff understand any instructions
- Send written confirmation of the instructions to the care home as soon as possible.

Any changes to a learner's prescription, or a prescription for a new medicine, must be supported in writing, e.g. a letter and/or email, by the prescriber before the next dose (or first dose) is administered.

https://www.nice.org.uk/guidance/sc1 - 1.9 Prescribing medicines.

Transcribing medication details on to temporary MAR charts

Occasionally, a temporary MAR chart may need transcribed by care staff when the Nursing team are unavailable (evenings, weekends & holiday periods) to produce a new MAR chart.

This may be following a change to a learner's prescribed treatment, which needs to be implemented immediately, e.g. prescribed antibiotics, introduction of a new medication, or a change in the dose of a medication.

Transcribing should only be undertaken by members of staff who are medication trained and deemed competent by the Care home manager.

Transcribing medication is the action of copying details of the medication onto the temporary MAR

chart from the pharmacy label on the medicine box/container.

On receipt of the new medication, check that it is fit for purpose:

- Medicine label states the learner's name
- The name of the medicine inside the packaging matches that on the label
- The medication has not exceeded the expiry date
- The label on the packaging is clear and directions for use understood.

Carefully transcribe the medication details and directions for on to the temporary MAR chart:

- Learner full name, date of birth, location (residential house), G.P. details and details of any allergies should be clearly written on the temporary MAR chart.
- All information must be handwritten legibly in black ink.

The name of the medicine and the directions for use must be written in full as printed on the label.

The following details must be stated on the temporary MAR chart:

- Name of medication
- Strength of medication (10mg, 100mcg, 10ml etc.)
- Form of medication (tablet, capsule, topical cream, or ointment etc.)
- Direction of use (e.g. Take one tablet, twice a day.)
- Cautionary and advisory labels (dissolve in water, 'give with food', mat cause drowsiness' etc.).

The person completing the temporary MAR chart must sign and date the chart upon completion.

The MAR chart must also be checked by a second competent medication member of staff. The 'checker' should ensure that the details on the medication label have been transferred onto the temporary MAR chart accurately and sign and date to indicate that they have undertaken theses checks.

Staff administering medication from the temporary MAR chart **MUST NOT** administer the medication if there is any uncertainty regarding the accuracy of the instructions on the medicine label and those stated on the MAR chart. If unsure contact the Care manager, shift lead, and/or a local pharmacy for further guidance.

Self-Care Toolkit
Homely remedies, Self-Care, and Personal Care treatments

Sussex Commissioners in association with Sussex Community NHS Foundation Trust have created a document called, *Self-Care Toolkit: Homely Remedies and Supporting Access to Self-Care*.

The aim of Self-Care toolkit is to guide care homes to support residents in self-care for selected health conditions by using over the counter treatments, where possible

The toolkit has been approved by the Sussex Optimisation Operational Committee (SMOOC) for use in care homes across Sussex.

It is recommended that St John's care homes follow the guidance in the Self-Care toolkit when supporting learners with minor illnesses or ailments, which can be treated with over-the-counter treatments (OTC).

Brighton & Hove CCG and East Sussex CCG, Medicines Optimisation in Care Homes (MOCH) teams, are available to support St John's implement the Self-Care toolkit.

sc-tr.moch-brightonandhove@nhs.net

sc-trmoch-eastsussex@nhs.net

Over the counter treatments (OTC)

Medicines on sale to the public fall into two categories:

- General Sales List (GSL), which are available widely from a range of shops
- Pharmacy medicines (P), which are available only from a Pharmacy.

These medicines are known as over the counter treatments (OTC). Over the counter treatments are used to treat minor, self-limiting conditions.

The Self-Care toolkit should be used to support learners in self-caring for selected conditions using OTC treatments. The *Self-Care Toolkit: Homely Remedies and Supporting Access to Self-Care*, guidance document separates OTC treatments into three categories:

- **Homely remedies** – a non-prescription medicine that can be kept as stock and used in the care home for the short-term management of minor, self-limiting conditions, such as cold symptoms, headache, occasional pain, or indigestion

  The Self-Care toolkit replaces the need to sign individual agreements for each learner for the homely medicines included in the toolkit. However, staff should take advice on the suitability of homely remedies from a healthcare professional, such as a GP, community pharmacist, a member of the MOCH team or the Lead Nurse. This can be in advance of or at the time of need
- **Self-Care treatment** – products and medicinal preparations used to treat minor, short-term condition, such as earwax, or longer term, such as hay fever. These are purchased specifically for a learner and should not be kept as stock in the care home
- **Personal Care treatment** – conditions and remedies listed a personal care are deemed to be outside the scope of medical care. They include 'off the shelf' remedies from supermarkets in the health aisle or a pharmacy, and do not necessarily require pharmacist advice to support the sale, although a consultation with a pharmacist is recommended, if available. Products include lozenges for a sore throat, non-drowsy cough medicines, anti-dandruff shampoo, menthol vapor rub to ease nasal congestion, emollient creams, and lotions to treat dry skin.

All Homely remedies, Self-Care, and Personal Care treatments must be administered in line with the manufacturers guidelines and any advice given by a health practitioner, (if received).

All Homely remedies, Self-Care, and Personal Care treatments should be stored separately from regular prescribed medicines and treatments.

Staff should refer to the *Sussex Community NHS Foundation Trust, Self-Care toolkit: Homely remedies and Supporting Access to Self-Care* document for guidance on:

- Buying OTC treatments for learners, (or purchasing on their behalf)
- How to use OTC treatments
- Maximum duration of treatment before seeking assessment of symptoms and further guidance from a GP.

Self-Care Toolkit - Homely Remedies and Supporting Access to Self-Care February 2022 FINAL (1) (1).pdf (cdn-website.com)

Psychotropic medicines

Psychotropic medicines are used to treat mental health conditions, such as anxiety, depression, and psychosis. Psychotropic medicines can be prescribed to be given regularly daily or on a PRN 'as required' basis.

When psychotropic medicines have been prescribed to learner at St John's, therapeutic strategies must be employed alongside medicines to support the mental health needs of the young person.

Psychotropic medicines should only be prescribed where a clinical need has been identified. They should be used for as short a time as possible. The effectiveness of psychotropic medicines should be reviewed regularly by the individual's GP and/or psychiatrist. A reduction in dose, or withdrawal of the psychotropic medicine, should be considered if there is an improvement in the young person's mental health condition.

Before the use of PRN psychotropic medicines is considered to treat episodes of anxiety/ agitation, staff must follow guidance detailed in the learner's PRN protocol and implement strategies in their Personal Behaviour Support plan. The use of PRN medication should be recorded, monitored, and reviewed regularly.

Any concerns about the overuse of PRN medication to treat anxiety and/or behaviours that challenge should be reported to the St John's nursing team and raised with the prescriber.

The overuse of psychotropic (or other) medicines may need to be reported as a safeguarding incident via *My Concern*.

STOMP

STOMP is an NHS England project to prevent young people with a learning disability and/or autism being over medicated.

STOMP stands for, **'***Stop The Overuse of Medication young people with a learning disability, autism, or both'*.

Young people with a learning disability, autism, or both, are more likely to be given medication, (including psychotropic medication), than other children and young people. Young people should only stay on medication for as long as is necessary, so a regular review of there is essential.

Psychotropic treatments include anti-depressants, anti-anxiety, anti-psychotic, and stimulant medicines. Psychotropic medication should not be used instead of support and therapeutic treatments and strategies.

St John's recognises and supports the aims of STOMP.

https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/

Reporting adverse drug reactions

Any adverse drug reaction, or suspected reaction, or concern, should be reported immediately to the Nursing team, the prescribing G.P., community pharmacist or NHS 111.

In the event of a **serious drug reaction** resulting in a learner experiencing breathing difficulties, or concerns about their consciousness/alertness, immediate help should be sought by dialing 999 or 112.

Staff should record the details of the adverse reaction in the learner's daily notes and, along with actions taken, including guidance from medical practitioners, or details of any treatment needed (hospitalization), if required.

Detail of adverse drug reactions should be shared with parents and the Nursing team, at the earliest opportunity.

Refusal of medicines

Learners' have the right to refuse their medication. They may refuse for several different reasons.

Learners should not be pressured into taking their medication, however support and an explanation of how their treatment supports their health and wellbeing is acceptable.

Care staff & Nursing staff should explain to the learner why the medicine has been prescribed and the potential harm that could be caused by not taking it.

Care staff & Nursing staff should ensure that the learner understands the possible consequences of refusing their medication so that they are making an informed choice, where they have the capacity to do so.

It may be beneficial for another colleague, a change of face, who has an established relationship with the learner, to support the young person to take their medication, where they have initially refused.

If possible, it is important to understand why the learner has refused their medication. Is there an established pattern of refusal?

Possible reasons for a child or young person to decline their medication, include:

- Finding tablets difficult to swallow
- Not knowing what the medication is for
- Not thinking that they need the medication
- They are affected by side effects from the medication
- Staff may not have followed the correct routine the learner has for taking their medicine.

Any medication that is refused must be recorded on the MAR chart with the code 'R'. A

reason for the refusal must be written on the notes section of the MAR chart and in the learner's daily log sheet.

Any medicines that have been refused must be reported to the Nursing team immediately. Document and follow any outcomes from the Nursing team.

If a medicine is refused in the evening, night or at weekends then a senior member of the care team should be informed. Further advice on a declined medication should be obtained from the pharmacist, or NHS 111.

Continued refusals to take medication

Continued refusal to take medication should be reported to the prescriber (GP) as soon as possible, but within at least 24 hours. Document and follow any outcomes from the GP

after reporting the continued refusal of medicines.

Missed dose of medication

The timing of administering medication must always be taken into consideration so that a sufficient period occurs between doses if a medicine is taken more than once a day.

Occasionally medicines may not be taken at the normal time. This may cause a problem because missing a dose may make the medicine less effective but taking subsequent doses too close together can increase the risk of side effects**.**

There can be various reasons for missed doses, including:

- Staff may mistakenly forget to dispense the medication at the correct time
- The learner is off-site at an event/activity and their medication isn't available for them
- The learner is unexpectantly delayed in returning to the residential house in time for their medication
- The learner refuses their morning medication at weekends or holiday periods because they choose to sleep in
- The learner may initially refuse their medication but choose to take it later.

There are circumstances where a learner may not receive their medication at the prescribed time, but it may still be appropriate to administer it later without this presenting a risk to the individual.

It is important that staff receive guidance from a medical practitioner, including GP, community pharmacist, and NHS 111, to determine whether a missed dose can be given later, or whether it should be omitted. Any guidance received must be recorded.

Action to take following a missed dose:

- Follow the manufacturer's guidance on missed doses by checking the *Patient Information Leaflet* (PIL) supplied with the medicine. PILs usually contain specific advice about missed doses. If there is not a paper copy of PIL available, then majority of PILs can be viewed online in the 'electronic medicines compendium'

(emc): www.medicines.org.uk/emc

- The Medicines Healthcare and Products Regulatory Agency (MHRA) website also lists all PILs for medicines licensed in the UK at www.gov.uk/pil-spc

- If you are unable to find a PIL for a medicine, or the advice in the PIL does not adequately cover the situation you are dealing with, or you are still unsure, then contact a community pharmacist, GP, or NHS 111 and request guidance.

- Be mindful that there may be a delay with a GP or NHS 111 responding to you request for guidance, so contact a community pharmacist first instance if the situation is time critical.

- If guidance is given to administer the medicine later than prescribed, ensure this is clearly documented on the MAR chart and Databridge, and effectively communicated to colleagues, so that they are aware

- Record the rationale for the late administration of the medicine, e.g. following guidance in the PIL, or advice given by a community pharmacist, GP, or NHS 111

- For medicines given more than once a day (e.g. 2, 3 or 4 times a day), consider that subsequent dosing times may need to be adjusted if a medicine is given later time than the prescribed time, or one dose may need to be omitted. The PIL or a medical practitioner will advise on this

- Always record any advice you are given and by whom

- If a missed dose is omitted, record this on the MAR chart and complete a medical error form

- There is no situation where the next dose should be doubled if one is missed. This could be harmful to the learner.

Other Points to consider:

- Review each individual case and identify the reason for the missed dose
- Is the learner's routine leading to a dose being missed regularly, e.g. wanting a lie in at the weekend, returning late from off-site activities etc.? If so, ask the learner's the GP to review the young person and their medication routine
- Do you believe that there is an issue with the policies or procedures that contributed to missed doses? If so, report to the Care manger and/or Nursing team.

Parents/carers responsibly for medicines sent from home

It is the responsibility of parents/carers to ensure that any medication sent in to St John's is the correct medicine for the learner concerned.

Parents/carers should check that the medicine they are supplying has been correctly labelled by the dispensing chemist before handing over medication to St. John's staff:

1. Name of the learner is correct on medicine label
2. Name, strength, form of medicine is correct on the medicine label
3. Medicines are in date – expiry date
4. Directions for use of medicine are correct
5. Cautionary and advisory instructions on medicines label are correct.

On receipt of medicines, St. John's staff carry out a 7-point check at the earliest opportunity, cross referencing the medication received against the MAR chart to ensure that any discrepancies are picked up.

Any discrepancies must be raised immediately with the Care manager, the Nursing team, the prescribing chemist, and/or parents/carers. If necessary, guidance can also be sought by calling NHS 111 to resolve any issues.

The total amount of medication received from home must be recorded in the 'stock in' section of the MAR chart. The code **IH** should be used to indicate stock has been received from home, (**I**n from **H**ome).

The medication stock total must be amended accordingly to reference the quantity of medication received from home.

Receiving medicines from pharmacy of from home (parents/carers)

Medicines received at the care home should be checked, signed in, and stored securely, as soon as possible.

Medicines that cannot be received by the care home can be stored by the Nursing team, as a last resort. These medicines will be handed over to the care home at the earliest opportunity.

Parents/carers (and escorts) of residential learners are directed to hand over medicines directly to the residential home, where possible.

Where learners arrive at college before returning to the residential home later in the day, medicines will be stored by the Nursing team. In this instance parents/carers (and escorts) are directed to hand over medicines to the Nursing team (via college reception) and not to hand over to education staff.

Education staff must not accept medicines from parents/carers/escorts when learners return to college. They should direct parents/carers/escorts to college reception to hand medication over.

Education staff must not store medicines in classrooms or communal spaces.

Sending medicines home (parents/carers)

All medicines being sent home to parents/carers must be recorded and stock totals adjusted.

The total amount of medication being sent home must be recorded in the 'stock out' section of the MAR chart. The code **OH** should be used to indicate stock has been sent home, (Out to Home).

The MAR chart stock total must be adjusted accordingly to indicate the quantity of

medication remaining in the care home.

A '*Handover of medicines'* form must be completed for medicines being sent home. The name, strength and form of the medicine(s) should be recorded on the form, along with the quantity of the medication being sent home, e.g. Epilim 500mg tablets. 10 tablets.

The handover form should be attached to the bag/container that the medication is being sent home in. When the medication is handed over to the learner's parent/carer or escort, they should check the medication they are receiving and sign and return the 'Handover of medication' form, to evidence that they have received the medication. Retain the handover slip as a record.

Arrangements for sending medicines home from college

If a residential learner is going home from the college, care teams must communicate this via stjreceptionhomeleave@st-johns.co.uk before 11:00.

Residential teams should handover medicines to the Nursing team in college who will secure the medicines until the learner goes home.

Medicines should be sent home in a suitable zipped plastic wallet or bag, with a '*Handover of medicines'* form attached.

The Nursing team will liaise with college reception to create a sign out sheet for learners going home with medicines.

Taxi duty will radio reception and tutor team to advise when parents/carers or taxi escorts have arrived to collect a learner.

A member of the tutor team will support the learner to college reception. College reception will radio or call the Nursing team and request the learner's medication.

The Nursing team will handover medication directly to parents/carers or taxi escort who will check the medicines being supplied and sign the '*Handover of medicines'* form. The learner will then be signed out from college by reception.

Disposal of medicines

Care managers and senior residential support workers are responsible for ensuring that all surplus, unwanted and expired medication is disposed of safely.

Before disposing of a medicine, staff should check whether it is still needed, whether it's within its expiry date and what the shelf life of the medicine/product is once opened.

Care homes must keep a record of all medicines (including controlled drugs) that have been disposed of or are waiting to be disposed of.

All medicines being disposed of must be recorded on the *Disposal of unwanted drugs* form. This form should be signed/stamped by the nursing team or pharmacy as evidence that medicines have been handed over and disposed of safely.

Records must contain information relating to the name, dose, and quantity of medication being disposed of, date of disposal, and the address of the pharmacy receiving the medicines.

Medicines waiting for disposal should be kept securely in a locked medication cabinet until

they are taken to the St John's nursing team or a pharmacy. They should be kept away from current medicines.

When disposing of medication, stock totals on MAR charts should recalculated accordingly.

Care homes should return unwanted to their dispensing pharmacy or where this is not possible it can be handed over to the St John's Nursing team for disposal.

The Nursing team will document any medicines received for disposal. Unwanted medicines for disposal will be collected regularly by our contracted healthcare waste management company.

Section SIX

Medication incidents (errors)

Section SIX

Medication incidents (errors)

A medication incident is any safety incident**,** where there has been an error while handling medicines, as listed below:

- Prescribing
- Preparing
- Dispensing
- Administering
- Monitoring
- Providing advice on medicines.

It can be either:

- an error of commission (wrong medicine or wrong dose)
- an error of omission (omitted dose or failure to monitor)
- an error in recording the medicines chart correctly, or not recording that medication has been administered.

An error in recording on the MAR chart or controlled drugs book must be crossed through with a single line, so that the writing beneath is still legible.

Near misses should also be reported. NHS England defines a near miss as, 'an incident that has not caused harm but has the potential to do so'.

Medicines errors are not the same as adverse drug reactions.

Care Managers and the Lead Nurse must ensure that there is a robust process in place for identifying, reporting, reviewing, and learning from medication incidents (errors) involving learners.

Recording medication incidents (errors)

All medication incidents (errors) must be recorded via Databridge on a *Health and Safety incident report, medication error*.

All incidents relating to medicines, including near misses, should be reported immediately to the Care manager (residential setting) or the Lead Nurse (college setting), who will investigate.

If the incident (error) has reached the learner contact the prescriber, local pharmacist, or NHS 111, immediately to establish the risk of the learner coming to harm.

Record and follow guidance received from the practitioner on how to monitor and support the learner.

If the learner has a serious adverse reaction to a medication incident (error), e.g. concerns with breathing and/or consciousness, then ring 999 or 112 and request an ambulance.

Categorising errors

St. John's recognises that errors may occur during the dispensing and administration of medication to learners.

St John's uses the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) system for categorising errors.

NCC MERPP categorises errors fall into one of four outcomes:

- No error
- Error, no harm
- Error, harm
- Error, death.

https://nccmerp.org/types-medication-errors

See appendix 3 and 4 for NCC MERP medication error categories and error algorithm.

Medication errors must be reported to the person in charge, (Care manager, Senior care staff, Head of learner services, Principal, Lead Nurse, or a member of the Safeguarding team) so that an investigation can be carried out.

Investigating medication incidents (errors)

Medication incidents (errors) will be investigated in residential settings by the Care manager or Deputy Care Manager and the Lead Nurse in the college setting. See, *Medication investigation error timeline* SOP.

Investigations should be started within the time framework listed below.

Medication error category	Start investigation
Category **A – B**	Within **1 week**
Category **C - D**	Within **24 hours**
Category **E – I**	**Immediately**

The investigation process can be supported by the Lead Nurse and/or the (Care) Quality Assurance Manager, where necessary.

A *Medication error investigation form* should be completed when carrying out an investigation. Care drive - T:\Templates May 2022\Medication File Templates\Medication Errors

The medication incident (error) investigation should be a supportive action for the member of staff involved.

The purpose of an investigation is to:

- Establish the details of the incident
- Establish level of harm caused by the incident, (if any)

- Establish what action was taken on discovering the error
- Establish whether the error is reportable, (see reportable errors)
- Support the person who made the error to reflect openly about the incident
- Use the incident as an opportunity to learn – improve processes and/or behaviour, to reduce/eliminate future risk of harm
- Share conclusions of the investigation with the team, without apportioning blame to the member of staff involved in the incident.

Medication incidents (errors) investigations should start in accordance with the timeline stipulated in the *Medication investigation error timeline* SOP (Standard Operating Procedure).

Reportable errors

There is no requirement to notify CQC about all medicines errors in residential settings, but CQC must be notified if a medicines incident has caused:

- a death
- an injury
- abuse, or an allegation of abuse
- an incident reported to or investigated by the police.

A safeguarding referral will also need to be raised.

Controlled drugs incidents (errors), including loss or theft, must be reported to the local NHS Controlled Drugs Accountable Officer (CDAO) at NHS England. Signin (cdreporting.co.uk)

Controlled drugs incidents should also be reported to the police and the prescriber, where necessary.

CQC should be notified if the incident meets the criteria of a statutory notification. Notifications - Care Quality Commission (cqc.org.uk)

Duty of candour

St John's has an overarching duty of candour to be open and transparent with learners and their parents/carers when something goes wrong with their medication, which may cause, or has the potential to cause, harm or distress.

Following a medicines incident (error) staff must:

- Act in an open and transparent way with learner and parents/carers, where appropriate
- Inform the learner in person, as soon as possible, after the error has been discovered
- Use the individual's preferred method of communication to inform them of the error
- Provide an accurate account of what happened, including all the facts that are known at the time
- Where possible, seek the views of the learner after informing them of the error
- Answer, in a timely manner, any question the learner has about the error and the consequences of the error
- Inform the learner of any further enquiries that need to be made
- Offer the learner an apology, and parents/carers, where appropriate
- Complete a written record of all communication with the learner in relation to the error.

Section SEVEN

Equality & Diversity

Equality & Diversity

The Equality Act 2010 provides protection for anyone who has a 'physical or mental impairment that has a substantial, long term and adverse effect on his/her ability to carry out normal day to day activities'.

St. John's recognises that our learners' should be given the opportunity to actively participate in all aspects of their care, including the management and administration of their medication.

St. John's also recognises that learners' who are prescribed medication should be given the same opportunities as others in the college and residential settings.

Enabling and supporting learners' to manage their medicines is an important part of this. However, the level of participation will vary for each individual depending on their specific needs, as well as their level of mental capacity to safely make decisions about their medication.

The Nursing team and prescribing practitioner must provide a good standard of practice, care and treatment whilst considering the learners' views and values, including their cultural, religious, spiritual beliefs.

The Nursing team must not express their personal beliefs (including religious and moral beliefs) to learners in ways that exploit their vulnerability or are likely to cause them distress.

Learners' must be treated fairly and with respect whatever their life choices and beliefs are.

The Nursing team and GP will ensure that any learner who is vegetarian or vegan does not receive medicines containing gelatine.

Where necessary, the Care and Nursing teams will ensure a process for medication administration is altered to take into account religious festivals and fasting, where necessary.

Consent to treatment (mental capacity)

Consent to treatment means an individual must give permission before they receive any type of medical treatment, test, or examination.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

Voluntary, informed and capacity can be defined as:

- Voluntary – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, support workers, friends or family

- Informed – the person must be given all the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead

- Capacity – the person must be capable of giving consent, which means they understand information given to them and can use it to make an informed decision.

The Mental Capacity Act (2005) states that, every young person (aged 16+) and adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot decide for themselves just because they have a particular medical condition or disability.

A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to decide at that time. Examples of how a person's brain or mind may be impaired include:

- mental health conditions – such as schizophrenia or bipolar disorder
- dementia
- severe learning disabilities
- brain damage – for example, from a stroke or other brain injury
- physical or mental conditions that cause confusion, drowsiness or a loss of consciousness
- intoxication caused by drugs or alcohol misuse

Someone with such an impairment is thought to be unable to make a decision if they cannot:

- understand information about the decision
- remember that information
- use that information to make a decision
- communicate their decision by talking, using sign language or any other means

If an adult (18 years +) has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.

Young people (aged 16 or 17) are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances. Like adults, young people are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have mental capacity, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

Gillick competence

In 1982 Victoria Gillick legally challenged Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without parent's knowledge.

In 1983 the judgement from this case laid out criteria for establishing whether a child has the capacity to provide consent to medical treatment; the so-called 'Gillick test'. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its

purpose, nature, likely effects and risks, chances of success and the availability of other options.

The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is an unreliable predictor of their competence to make decisions.

The Gillick competence test is concerned with determining a child's capacity to consent to medical treatment. Gillick competence is used in medical law to decide whether a child under the age of 16 wishes to receive treatment without their parents' or carers' consent, or in some cases, knowledge.

If the young person has informed their parents or carers of the treatment, they wish to receive but their parents or carers do not agree with their decision, treatment can still proceed if the child has been assessed as Gillick competent.

A child will be deemed as Gillick competent if they have sufficient maturity and mental capacity to fully comprehend treatment that is being proposed.

The young person will be assessed for:

- their understanding of the issue and what it involves - including advantages, disadvantages, and potential long-term impact of the proposed treatment
- their understanding of the risks, implications and consequences that may arise from their decision
- how well they understand any advice or information they have been given
- their understanding of any alternative options, if available
- their ability to explain a rationale around their reasoning and decision making.

If, following an assessment, a GP, or other medical practitioner, determines that the child passes the Gillick test, they will be considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else.

Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.

If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment.

Gillick competence will be determined as part of a 'best interest' process on behalf of the individual, involving relevant professionals, such as GPs, other medical practitioners/therapists, Social Workers, teachers, and support workers. The views and opinions of the individual and their parent/carers will also be sought.

Appendix

Appendix 1

The 7-point check

Safe dispensing of medicines: The 7 point check

The **7 point check** procedure **must** always be followed to ensure the safe dispensing of medicines.

5 point prescription label check:

- Check the **Learners Name** on the medicine label and the MAR chart – **do they match?**
- Check the name of the **Medicine** on the label and the MAR chart – **do they match?**
- Check the **Strength** of the medicine on the label and the MAR chart – **do they match?**
- Check the **Form** of the medicine on the label and the MAR chart – **do they match?**
- Check the **Directions** on the label and the MAR chart - **do they match?**

Also:

- Check the medicine **Inside the box** – **is it the correct medicine?**

And:

- Check the **Expiry date / Discard date** of the medicine – **is the item in date?**

Remember:

- **Learner** name
- **Medicine** (Drug)
- **Strength** (10mg, 5mg, 1000mcg, 10mg/2ml etc.)
- **Form** (Tablet, Oral solution, Granules, Dispersible tablets etc.)
- **Directions** (How much of the medicine should be taken and when)
- **Expiry date / Discard date**.

Record all medicines that have been administered on the MAR chart **IMMEDIATELY** after administration. There should be no gaps on the MAR charts.

Note: Monitored dosage systems (Blister packs) do not have expiry dates on them. The Royal Pharmaceutical Society states that medicines packaged in this way have an eight week expiry date from the date the pharmacy dispenses. Each medicine label has a dispensing date on the bottom left hand corner.

Stuart Townsend, Lead Nurse. 03.03.2023

Appendix 2

Emergency medication signing ‘out’ and ‘in’ record.

ALL emergency medication bags/medication should be signed 'out' and signed back 'in' when accessing activities in the community

e.g. Buccal midazolam, asthma reliver Inhalers, adrenaline auto injectors, anxiety/behaviour medication

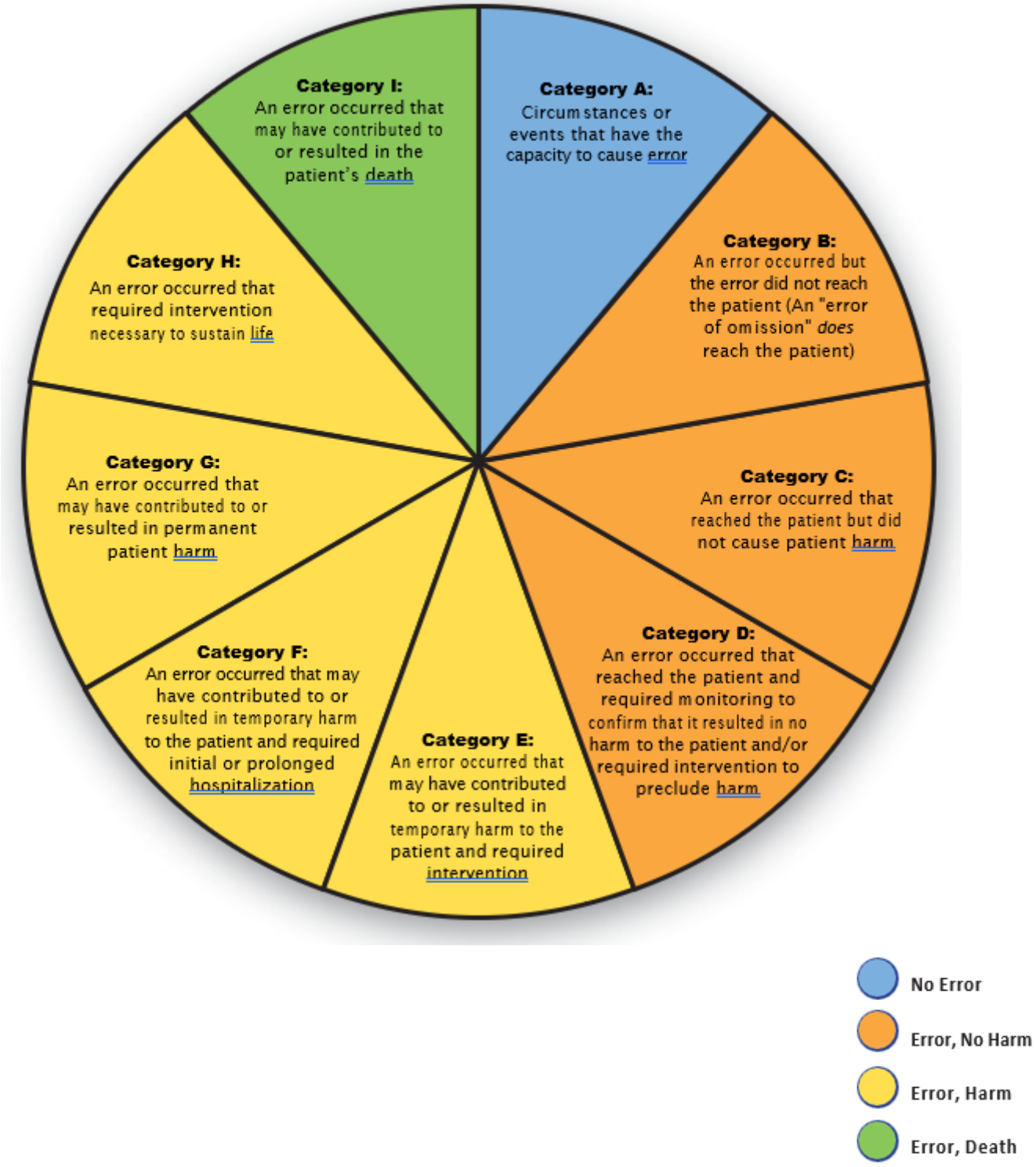
THE PERSON SIGNING OUT MEDICATION IS RESPONSIBLE FOR RETURNING IT AND SECURING SAFLEY

	Medication OUT			Medication IN		
Name of **Learner**	Name of **Medication** signed out	Name of **Staff** signing bag OUT	**Date & Time** Signed out	Name of **Staff** signing bag IN	**Date & Time** Signed IN	**Medication used? Yes/No** Stock total checked and correct?

Care drive - T:\Templates May 2022\Medication File Templates\Medication File Document Templates

Appendix 3

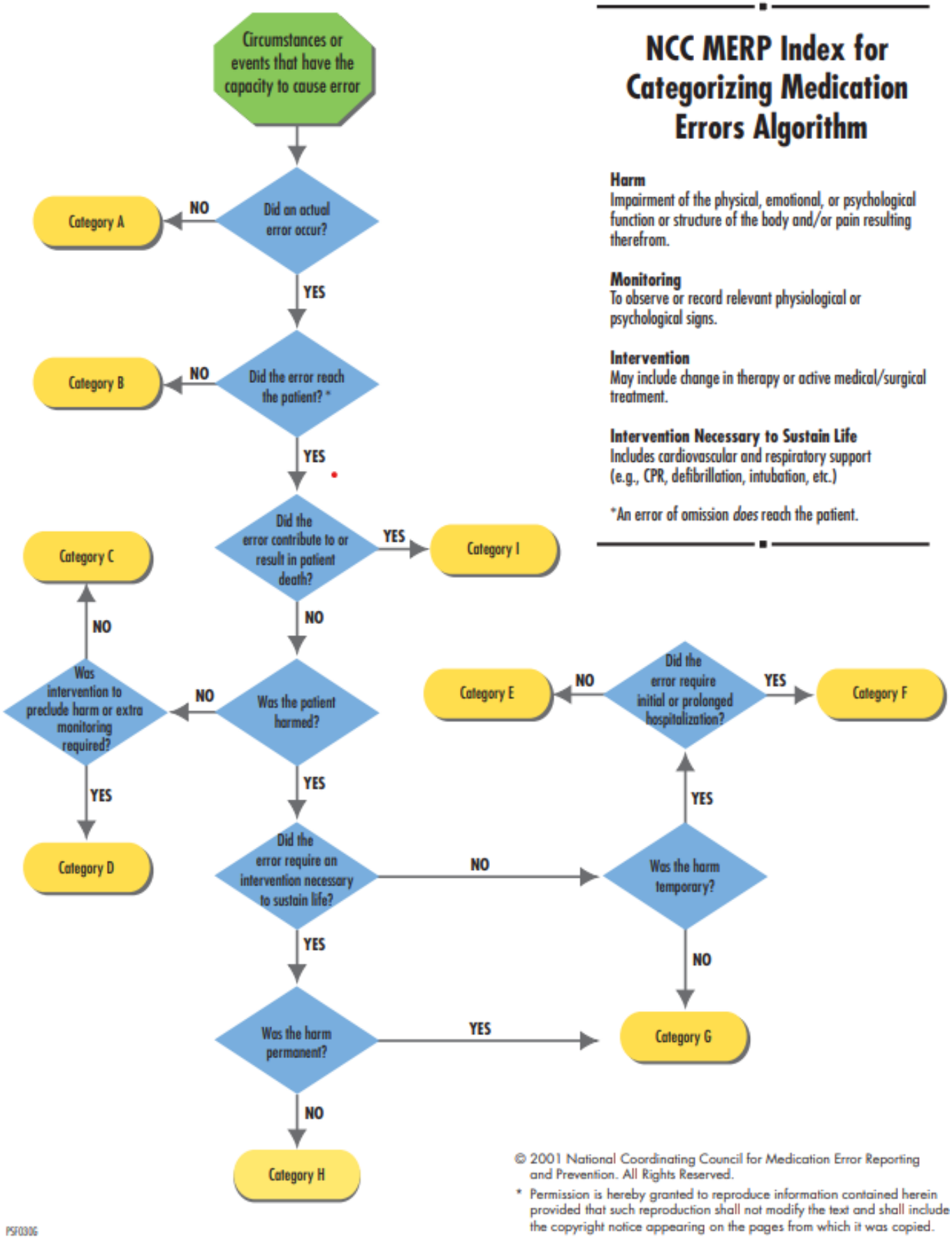
NCC MERP Index for Categorising Medication Errors



Investigation outcomes

- Discussion and reflection.
- Discussion, extra monitoring, and supervision.
- Discussion, supervised medicines rounds, retraining, and potential disciplinary action.
- Disciplinary action and potential dismissal.

Appendix 4



Appendix 5

Standard Operating Procedures (SOPs).

The following SOPs have been created to support the safe and secure handling of medicines at St John's. The SOPs are designed to outline step by step instructions for carrying medicine related tasks to ensure consistent, accurate, and safe practice.

SOPs can be found in the following folders in the Care drive:

Care drive - *T:\Templates May 2022\Medication File Templates\Medical S.O.P*

T:\Templates May 2022\Medication File Templates\Medical S.O.P\Dispensing and administering medicines SOPs

- 7 Point check - Safe dispensing of medicines protocol
- Application of topical medication – Emollients
- Application of topical medication - Steroids
- Dispensing medication in a safe & controlled environment
- Dispensing medicines to be administered off site
- Prevent skim reading poster
- How to use an Metered Dose Inhaler with a spacer

T:\Templates May 2022\Medication File Templates\Medical S.O.P\Controlled drugs SOPs

- Safe administration and storage of controlled drugs
- Signing controlled drugs in and out of the controlled drugs log

T:\Templates May 2022\Medication File Templates\Medical S.O.P\Medicines management SOPs

- Medication error investigation timeline
- Medication stock discrepancies
- Missed doses of medicines
- Medication Ordering and Delivery Process
- Receipt of medicines from parents carers
- Sending medication home to parents carers

Appendix 6

Medicines management templates

The following templates should be used to support the safe dispensing, administration, monitoring, and management of medicines can be found in the Care drive.

Care drive - T:\Templates May 2022\Medication File Templates\Medication File Document Templates

- Record of ordering or receiving prescribed medicines form
- My medicines administration profile
- Emergency Temporary MAR Chart (1)
- Emergency Temp PRN Chart (1)
- Handover of medication form residential (1)
- Medication Reconciliation form
- Medication Stock Record
- Residential houses signing PRN medication in & out
- Stock codes updated
- Verification Signature Sheet

Temperature monitoring templates

Care drive - T:\Templates May 2022\Medication File Templates\Meds cabinet temperature forms

- Medication Cabinet temperature monitoring chart
- Fridge temperature monitoring chart

Medication training and assessment templates

T:\Templates May 2022\Medication File Templates\Medication training and assessments

- Administration of medication sign off form
- Annual medication competency assessment
- Spot check medication competency assessment

Medication errors

Care drive - T:\Templates May 2022\Medication File Templates\Medication Errors

- Medication Error Investigation Form
- NCC MERP Index for Categorising Medication Errors
- NCC MERP Index for Categorising Medication Errors Algorithm

Self administration of medicines in care homes

Care drive T:\Templates May 2022\Medication File Templates\Self administration of medicines

- Self-administration of medicines in care homes Policy
- Risk assessment for self-administration of medicines