Sample policy and procedure: The safe handling of medicines in domiciliary care
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The Safe Handling of Medicines in Domiciliary Care

Introduction

The aims of this procedure are

- to promote independence through encouraging people to manage their own medicines as far as they are able
- to help people remain in their own homes and prevent avoidable admissions to care homes or hospital by supporting people with their medication appropriately.
- to ensure that staff use the safest possible practices when supporting people with their medication.

This procedure must be read and complied with by all members of staff who are involved in the assessment of a person’s care needs and all members of staff who are involved in supporting the person with their medication at any level.

The procedure is intended to ensure that medicines are handled appropriately and in accordance with the current legislation and guidance.

This procedure should be read in conjunction with:


- Good Practice Guidance
  - The administration of medicines in domiciliary care
  - Medication Administration Records (MAR) in care homes and domiciliary care
- Pharmacy tips
  - Medication prescribed to be taken when required
  - Administration and recording of creams and nutritional supplements
  - Non-prescribed medication
  - Disguising medicines in food and drink
  - Secondary dispensing

Underlying Principles

The service aims to promote the independence of the person receiving support by consulting with them, or their nominated representatives, about their support requirements and agreeing the support to be provided through a robust assessment process.

Wherever possible the service will endeavour to support the person to maintain control over their own medication by seeking solutions to identified issues. With the consent of the individual, the service will seek support from other relevant agencies (for example, the community pharmacist) to explore all opportunities for maintaining independence. To support this principle the service undertakes to only intervene at the minimum level required to manage any risk as identified through the assessment process.
The service will review with the person, or their nominated representative, the level of support provided on at least an annual basis to ensure it still meets the person’s needs. Earlier reviews will be arranged if necessary or on the request of the person.

People receiving support have the right to expect that assistance is carried out in a professional manner by properly trained staff. To meet this, only care staff who have received the appropriate level of training for the tasks involved and have had their competency assessed will be involved in the administration of medicines.

**Confidentiality and sharing information**

Information regarding a person’s medication and health **must** be treated confidentially and respectfully.

Records kept at the office must be stored securely where they cannot be accessed by unauthorised persons. The person should be asked where they would like to keep their records in their own home. They must be informed that care staff will need to access and complete the records at each visit. It is also recommended, with the person’s permission, that the records are accessible to healthcare professionals visiting the home as they may wish to check or add to the information in the record.

Information about a person should only be disclosed with that person’s consent unless the service is legally obliged to share the information.

Any information shared must be relevant, necessary and proportionate.

If the person agrees, relevant information about them can be shared with their relatives or nominated representatives. The agreement for sharing information should be documented in the care plan.

Information should be shared with health and social care professionals involved in the direct care of the person where it is needed for the safe and effective care of the individual, unless the person has refused to share the information. The person’s refusal should be documented in their care plan and care staff should ensure that the person is aware that such a refusal may compromise their safety if relevant information is not shared.

If it is unclear whether information can be shared or not in a specific circumstance the advice of the registered manager (or nominated deputy) must be sought. The registered manager (or deputy) will need to make the decision in conjunction with the person concerned.

If the person lacks capacity to give consent for sharing of information the opinion of the person with legal authority to act on their behalf (for example, a person with lasting power of attorney for health and welfare) should be sought, or a decision should be made in accordance with the principles and processes of the Mental Capacity Act.

**Assessment and Review**

Before the service commences, the support that the individual requires with their medication must be assessed and a support plan agreed with the individual. **See Appendix 3** for assessment tool.

The person undertaking the assessment must consider the whole range of services and support available including those provided by community pharmacists (for example, advice regarding medication, suitability of containers, MAR charts, reminders, compliance aids, prescription collection and medicine delivery schemes, medicine use review).
People receiving support should be encouraged to participate in current medicine safety schemes, for example, the ‘message in a bottle’ scheme.

The assessment must consider the person’s ability to

- obtain prescriptions, maintain a supply and re-order medication as needed
- act in accordance with the GP’s prescription
- physically take the medicines
- remember to take the medicines

Where an area of difficulty is identified that cannot be resolved by the assessor, advice should be sought from an appropriate healthcare professional. For example:

- There may be situations where a person who is self-medicating would benefit from using a blister pack or monitored dosage system (level 4). Advice should be sought from the community pharmacist who will determine the most appropriate way of meeting the person’s needs, for example, reminder chart, monitored dosage system.

- For people receiving a reablement package of care, where the planned outcome is that the person will be independent at the end of a period of support, it may be appropriate to use compliance devices/monitored dosage systems to develop independence with medication. The advice of the community pharmacist should be sought.

Where necessary, a medication review should be requested.

The person undertaking the assessment must provide sufficient information in the resulting support plan to allow staff to carry out their duties safely. This information must include:

- relevant information about the person including cultural or religious beliefs
- details of all medication that the person is taking (prescribed and bought medication and any supplements)
- level of support required (see page 5 and appendix 1) and specific tasks which are to be undertaken.
- whether medication needs to stored in a secure way
- relevant health and medication details as advised by an appropriate healthcare professional (for example, is the medication for Parkinson’s and is timing critical?)
- medication risk assessment by a healthcare professional (if appropriate)
- name and contact details of the person’s doctor
- name and contact details of any other relevant healthcare teams involved (for example, speech and language team)
- name and contact details of the person’s preferred pharmacy
- a copy of the person’s current support/intervention plan

When assessing the level of support required the assessor must be clear about the difference between assisting a person to take their medication and administering the medication. The following guidance should be taken into consideration:

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\text{When care staff assist someone with their medicine, the person must indicate to the care staff what actions they are to take on each occasion. If the person is not able to do this or care staff give any medicines without being requested (by the person) to do so, this activity must be interpreted as administering medicine. ‘Prompting’ is a very occasional verbal reminder for a person to take their medicines themselves.}
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If the GP has prescribed medicines “to be taken as required” they should be made aware that social care staff are unable to administer these unless a clear ‘as required’ protocol is in place for the person.

The cultural and religious beliefs of the person may significantly impact on their prescribed medicines and the assessors should ensure specialist advice is sought where this may occur (for example, Muslims may be unable to take their prescribed medicines in the daytime hours during the month of Ramadan).

The written consent of the person to the support plan should be obtained following the assessment.

If, following an appropriate assessment, it is agreed that the person receiving support does not have sufficient mental capacity to give valid consent, the principles and processes of the Mental Capacity Act must be followed. Any relevant advanced decisions regarding medication made by the person must be taken into account. Where there is a person with legal authority to act on the individual’s behalf (for example, a person with Lasting Power of Attorney for Health and Welfare or Court Deputyship covering medication) the arrangements should be discussed with them and they must sign the written consent to indicate their agreement with the planned service. The views of an individual who acts as the main carer/representative of the person and that of relevant health and social care professionals should sought when a best interest decision is made.

A review of the support a person needs with their medication must be undertaken as a minimum at their annual review, or more frequently if necessary.

Line managers must ensure staff have all the relevant information available to them prior to commencement of the service. A copy of the support/intervention plan must be available at the person’s home for the care staff to refer to. Line managers must also ensure that their staff are aware of the level of support required, individual arrangements for collecting prescriptions, obtaining medication, storing medicines appropriately, reporting concerns or difficulties experienced by the person and disposing of unwanted medicines.

**Carers must not offer any assistance with medication unless an assessment has been carried out, the level of support required is clearly documented and a care plan is in place and accessible within the person’s home.**

**Outline of levels of support that can be provided**

**Level 1**

The person looks after their own medicine but care staff keep a general eye on things.

**Level 2**

The person may need the care staff to help with some or all of the following:

- Requesting repeat prescriptions from the GP
- Collecting medicines from the community pharmacy/dispensing GP surgery
- Disposing of unwanted medicines safely by return to the supplying pharmacy/GP practice (when requested by the person)
Level 3
The person can still take responsibility for their medicines but they may request assistance with tasks such as opening of bottles or popping tablets out of blisters. An occasional verbal reminder from care staff to the individual to take their medicines may be made. A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medicines and should trigger a review of the person’s support plans.

Level 4
The person can still take responsibility for their medicines but can no longer cope with conventional bottles/containers and a healthcare professional e.g. a pharmacist decides that a compliance aid may be helpful.

Level 5
The assessment may identify that the person is unable to take responsibility for their medicines this may be due to impaired cognitive awareness but can also result from a physical disability. The need for medication to be administered by care staff should be identified as part of an assessment process and recorded in the support plan. See Appendix 2a for examples of these tasks.

Level 6
Administering medication by specialised techniques. In exceptional circumstances and following training and a competency assessment by a healthcare professional, care staff may be asked to administer medication by a specialist technique including:

- Rectal administration, e.g. suppositories and diazepam (for epileptic seizure)
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)

See Appendix 2b for further examples of these tasks.

Consent/Additional Requirements For level 5 or 6 tasks
Any person who is assessed as requiring support at level 5 or 6 must give informed written consent to receive support with the management and use of their medication. They must also consent to the relevant records being made and kept in their home. See Appendix 4 for consent form.

The person seeking this consent (the assessor or provider manager) must ensure that the person’s consent is valid by ensuring the person is

- fully aware of the medication tasks that will be undertaken
- aware that staff must have access to their prescribed medicines and any information, which will enable them to carry out their duties safely
- aware of the implications of refusing the service

If there is reason to believe that the person lacks capacity to give informed consent then the principles and processes of the Mental Capacity Act must be followed including a formal assessment of capacity and a best interests decision recorded.
For level 6 tasks

Managers must ensure that any tasks undertaken are covered by the organisation’s insurance.

- There must be a ‘Health Care Plan’ in place, completed by a healthcare professional.
- Appropriate training from healthcare professionals must be arranged and completed before level 6 tasks can be undertaken for an individual person. The training must include a competency assessment.
- There must be an up-to-date support plan written by the person undertaking the assessment.

Care staff can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so. Care staff must inform their line manager if this is the case. Further training and development opportunities should be provided where appropriate.

Storage of Medication

The choice of where to store medicines is that of the person themselves. However, staff should encourage people to store their medication in a safe and appropriate way that does not put others at risk.

- Medicines must be stored where they are readily accessible to the person and the care staff unless the assessment process has identified that this would put the person at risk.
- As far as possible medicines should be stored in a cool dry place, for example, not in a steamy kitchen or bathroom.
- Medicines should be stored in the container supplied by the pharmacist. This will be correctly labelled and suitable to keep the medicine in good condition.
- Medicines should be stored out of the reach and sight of children. (Older people may have children visiting at times).
- Some medicines may need to be stored in a refrigerator; this will be stated on the dispensing label. They should be ideally be stored in a box with a lid – they must not be frozen. If the person does not have a fridge, the medicines should be stored in the coolest possible place. Some medicines only need to be stored in the fridge until they are opened.
- The patient information leaflet and the packaging of a medicine can provide useful information about the storage of the medicine. The pharmacist can also be contacted for advice if required.

The hiding of medicines from a person, or storing them in a locked box or medicine safe will only occur where the risk assessment has indicated that this is needed to protect the health and safety of the person. Written consent must be gained from the person to store their medication in this way. If the person lacks capacity to give consent, a best interests decision should be reached in accordance with the principles and processes of the Mental Capacity Act 2005.
It is important to note that certain ‘as required’ medicines must never be locked away and should remain available to the person at all times. If, on assessment, the person is deemed to be at risk from these ‘as required’ medicines this should be discussed with the prescriber. Such medicines include reliever inhalers (such as salbutamol) and glyceryl trinitrate spray (GTN spray).

Information about how to access medicines which is stored securely must be available to relevant staff.

**The monitoring of stock levels**

Care staff are accountable for

- Ensuring adequate stocks are available when
  - Supporting people at Level 2 with ordering and collection of repeat prescriptions
  - When administering medicines at Level 5 & 6
- Correct completion of the MAR chart
- Referring any concerns regarding any fluctuations in medicine stock levels to their line manager

*Due to the nature of the setting domiciliary care staff cannot be accountable for detailed stock levels unless the service has control over secure storage.*

**Obtaining New Supplies**

If it is identified at the assessment stage that care staff will be responsible for ordering prescriptions and/or collecting medicines from the community pharmacy/dispensing GP practice (Level 2) the arrangements must be fully documented in the support plan.

The information should include

- How the medication is to be ordered and where this should be recorded.
- How the prescriptions are to get from the prescriber to the person responsible for dispensing the medication.
- How the medication will get to the person.
- How the process will be monitored to ensure medication is received in good time.
- How medication collected/received will be recorded.

Where the person themselves or their nominated representative is responsible for the ordering and collection of medication that care staff are giving there must be a robust arrangement, detailed in the support plan, of how staff are to inform the person ordering the medication that new supplies are required. Care staff should document in the person’s notes when they have requested the new supplies and any reminders issued.

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| - Medicines must be ordered from the surgery approximately a week before they are due to run out. The details of how this is done must be recorded in the individual’s support plan.  
- A record should be made that the medication has been ordered along with the date the order was placed.  
- No more than 28 days supply of medicines, including those on repeat prescription, should normally be requested for an individual at any one time. |
• Surgeries usually require two working days to process requests for repeat prescriptions. After this time, the prescription (or medication if a dispensing GP is used by the person) can be collected.

• When the medication is to be dispensed at a community pharmacy, care staff should take the prescription to the person’s preferred pharmacy to be dispensed. If available, the pharmacy’s prescription collection and/or delivery service should be used, if appropriate for the person with their consent. Wherever possible, the person’s chosen pharmacy should be used to provide all the person’s medication. This means that the pharmacy will have a complete record of the person’s dispensed medication which is helpful if advice is needed.

• For those that are assessed as requiring support at level 5 or level 6, care staff should request prescribed medications be provided in traditional containers, complete with dispensing label and patient information leaflet, rather than monitored dosage packs.

Collecting/receiving medication

• When medication is collected from the pharmacy/dispensing GP or a new supply is received staff should record this on the MAR chart. This means that staff can identify how much medication should be available and helps to identify any discrepancies.

• If the medicines received from the pharmacy/dispensing GP’s differ unexpectedly from those received for the person in the past, care staff must check with the pharmacist or GP’s surgery before administering the medication. Any actions taken or advice given must be documented in the care notes.

• The medication should be put away in the agreed storage area.

Controlled Drugs

Care staff collecting controlled drugs (CD) prescriptions from the pharmacy or dispensing doctor practice should be prepared to provide personal identification if requested to do so. Once a controlled drug is in the person’s own home it should be treated the same as all other medication. The additional safe storage and recording requirements for controlled drugs in care homes do not apply in these settings.

Record Keeping

A MAR chart must be maintained in the person’s home whenever Level 5 or 6 support is provided. The MAR chart must include all prescribed medicines and should be used to record all medicines administered including non prescribed medication such as ‘bought medicines’.

• The MAR chart must show
  o The name, DOB and address of the person
  o Start date and day of the MAR chart
  o GP Name
  o Any known allergy
  o Name, form and strength of the medication
  o The dose to be given
  o Frequency and time of administration of each dose
  o Date of receipt of each medicine and quantity received
  o Date of discontinuation of medicines where appropriate
  o Any special instructions, for example, ‘swallow whole’
• Where a MAR chart is supplied by the pharmacy/dispensing GP this should be the document used.

• Where a MAR chart is not provided by the pharmacy a MAR chart must be written by a trained and competent member of staff. Line managers must ensure that a supply of blank MAR charts are available to staff. See Appendix 7.

• Where more than one agency is involved in the administration of the person’s medicines one MAR chart should be used and this should be shared and completed by all agencies involved. Other carers, including relatives, who assist the person receiving support (for example, at weekends) should be encouraged by the assessor or manager to complete the MAR chart to ensure that records are complete.

• It is essential that the MAR chart is completed at the visit by the member of staff responsible for the administration of medication. Care staff must not sign the MAR chart for medication administered by others.

• It is acceptable for care staff to add a code to the MAR chart at the next visit to indicate, for example, that the medication was not given on a previous occasion as the person was in hospital or on holiday.

• There must be no gaps on the MAR chart for regular medication. If care staff identify any such gaps they must contact their line manager to report this. The reason for the gap should be investigated to establish if the medication has not been given or whether the MAR chart has not been completed. Advice should be sought from the GP/pharmacist regarding actions to take if it is established that the dose has been missed.

• If care staff forget to sign the MAR chart they should contact the line manager as soon as they realise so that this can be recorded.

• If a medication is discontinued or changed, a trained and competent member of staff must update the MAR chart. The original entry should be cancelled by drawing a diagonal line through it and any remaining signature spaces should be ruled through. A note should be added to the entry saying the medication had been discontinued/changed and the name of the healthcare professional authorising this. The member of staff making the change should sign and date the entry. A corresponding entry should be made in the person’s care plan. Where necessary, care plans should also be reviewed and updated to reflect the changes.

• Where a new medication or new dose of current medication is prescribed, a new entry should be made in the next available space on the MAR (or a new MAR chart created, if necessary) to reflect any change in dose or new medication. All changes to the MAR must be signed and dated by the member of staff making them and checked by a second competent member of staff (wherever possible) who should also sign the record.

• Managers must keep a record of signatures/initials of staff involved with administering medication to people receiving support at Level 5 or 6. See Appendix 6.
• Completed MAR charts must be returned to the offices of the service for archiving. These forms must be kept with the person’s file. If more than one agency is involved the opportunity to obtain a photocopy of the completed MAR Chart should be offered to the second agency.

Following the introduction of the new CQC guidance on 1st April, further advice is being sought on the retention of documents. The policy will be updated as soon as possible.

• Line managers must ensure care staff complete MAR charts to an acceptable standard by carrying out a regular audit of the charts. (See separate audit tool.)

• Any reminders, omissions, missed doses and any advice given to the person to consult their GP or another healthcare professional should be recorded in the contact sheets.

An example of a completed MAR chart for reference is given in Appendix 8 of this document.

Administration of Medication

Where care staff are to be involved with the administration of a person’s medicines, this must be included as part of the person’s support plan, which is agreed in writing by the person. If the person is assessed as lacking capacity to make the decision then the arrangements should be agreed with a person with legal authority to act on their behalf or in accordance with a best interests decision (see under assessment and review for further information).

The support plan must clearly document the support required and be accessible within the person’s home.

Care staff must only give medication which they have been trained and assessed as competent to administer.

Care staff may only administer prescribed medicines from the original, labelled container supplied by a pharmacist or dispensing doctor and may not administer medicines from compliance devices filled by others. Bought medicines must only be administered from the original container as purchased. (See section on bought medicines)

The following procedure must be adhered to when administering a person’s medication.

• Wash your hands before administering medicine
• Read the instructions on the MAR
• Select the medicine required
• Check the label with the MAR
• Prepare the medicine, re-checking the administration instructions and confirming
  o The name of the person receiving the medication
  o The name, strength and form of the medicine
  o The dose
  o The time the medication is to be administered
  o The way the medication is to be administered
  o That the medication has not already been given
• Check the identity of the person receiving the medication
- Administer the medicine offering a glass of water with oral medication
- Record the administration on the MAR chart by placing your initials in the correct space once you have visually witnessed the person taking their medication OR enter the appropriate code, which is explained on the MAR chart, to record that a regular medication has not been given/taken.
- Before administering a medicine care staff should check that it is still within its expiry date. If a medicine does not have an expiry date on it (for example, medicines in a pharmacy filled compliance aid or in plain bottles with only the dispensing label attached) the dispensing date should be checked. If it is not within the current cycle the pharmacy/dispensing GP should be contacted for advice. The advice given and who gave it should be recorded in the person’s records.
- Some medicines have a short shelf life once opened (the product packaging or patient information leaflet should be checked for information on this). When first opening a medicine with a short shelf life, care staff should write the date of opening on the container or dispensing label and check at each administration that it is still within its usable shelf life.
- Medicines must be administered strictly in accordance with the prescriber’s instructions.
  - If medicines are labelled ‘as directed’ care staff should ask the prescriber for further information. A record of the information provided should be made in the care notes and on the MAR. The prescriber should be asked to amend the directions on the prescription so the information will be added to the dispensing label in the future.
  - If medicines are labelled ‘as required’, care staff should ensure that additional information is available from the prescriber about the dose, how often it can be repeated and what the medicine is for. A record of this information should be made in the support plan/ ‘as required’ protocol.
  - If there is a discrepancy between the instructions on the MAR chart and the label, care staff should satisfy themselves that they are sure which directions are the correct ones before administering the medication. Care staff should check the care notes for any recent visits by a healthcare professional and any subsequently documented changes in the medication dosage. If there is any doubt about the correct dose to give care staff should contact the prescriber for clarification. Any advice received must be documented in the person’s care notes. The line manager should also be contacted.

No alterations should be made to the dispensing label provided by the pharmacist or dispensing GP by care staff under any circumstances.

- Medicines should be administered to a person directly from the dispensed container. Medication should not be handled by care staff and should be directly transferred from the dispensed container into a clean small pot/container as a way of hygienically handing it to the person. Liquid medication must be measured using a 5ml medicine spoon, oral syringe or medicine measuring cup as appropriate to the size of the dose to be given. Teaspoons or similar must not be used to measure liquid medication. Gloves must be worn for administering such items as creams and ointments.
• If transdermal patches are to be administered staff must remove the old patch before applying the new patch. Staff should record the removal of the old patch as well as the application of the new one. The location of the applied patch must be recorded. The instructions must be checked carefully to determine the appropriate place to site the patch and the intervals between patch changes. The new patch should be placed in a different place to where the old patch was located.

• When a variable dose is prescribed, for example, ‘Take ONE or TWO tablets’ record the actual dose given on the MAR chart.

• Medication should be given in the time frames indicated on the label and agreed with the person in conjunction with the GP. Care staff should also check the label to see if the medication needs to be given with food or on an empty stomach or if there are special instructions for the medication. Where a medication has several doses in one day which require a specific time between doses, such as paracetamol containing products, the time the medication is given should be recorded and must be checked before further doses are administered.

• For ‘as required’ medicines a check should be made to see if any doses have already been given that day by asking the person and checking the MAR chart. When a medication prescribed ‘as required’ is administered, the time of administration must be noted on the MAR and checked before further doses are administered. A record should only be made on the MAR chart when ‘as required’ medication is actually given.

• Where medication is required at very specific times (such as Parkinson’s medication) this should be clear on the MAR chart and arrangements should be made to ensure it is given on time.

• If it is stated on the support plan that care staff put out medication for the person to take themselves at a later prescribed time to promote their independence, it should be left in the place agreed in the support plan and the appropriate code recorded on the MAR chart.

• Dispensed medicines are the property of the person for whom they are prescribed. They must not be used for anyone else.

Care staff cannot

• routinely carry out any ‘invasive’ or other clinical procedures, which require the skills, knowledge and competence of a registered nurse or other healthcare professional unless special arrangements are in place and the appropriate training has been successfully undertaken.

• give specific advice about medication or make judgements about their use.

• fill weekly compliance aids.

• administer medicines from compliance aids or other containers which have been filled by anyone other than the supplying pharmacist, dispensing doctor or hospital pharmacy.

• purchase ‘bought medicines’ for people without obtaining advice from a pharmacist. This should usually be the pharmacist at the pharmacy where the supported person obtains their prescriptions.
Pharmacists have a responsibility to ensure that supported people or their carers receive appropriate information and advice to support them in gaining best effect from any medicines supplied.

If a person asks for information about their medicines they should be advised to read the patient information leaflet. Care staff should support the person to access this leaflet if necessary, for example, by reading it out loud for a person who has difficulty seeing the print. If no leaflet is available or it does not answer the person’s questions they should be advised and/or helped to contact the pharmacist or GP as relevant. With the person’s permission, care staff can contact the relevant healthcare professional for advice on the person’s behalf. Any such actions taken must be documented in the care notes.

**Under no circumstances should care staff try to advise people they are supporting about their medicines from their own general knowledge.**

**Supporting people using oxygen**

Care staff may only support people to use their oxygen if they have been trained and assessed as competent to do so.

All staff must read and follow the safety information provided by the oxygen supplier when working in the home of a person using oxygen.

Under no circumstances should care staff smoke near oxygen equipment. They should also request that the person does not smoke around the equipment. If the person insists on smoking near oxygen equipment or while the oxygen is running care staff should contact their line manager for advice as this is a significant health and safety risk.

**Refusal and Covert Administration**

It is an individual’s right to refuse medicines and staff must never force a person to take a medicine. However, generally it is worthwhile waiting for a few minutes and re-offering the medicine.

- If a person refuses to take their medicine, this must recorded on the MAR chart, using to correct code, to indicate refusal has occurred. It may be necessary to contact the person’s GP for further advice and their advice followed. The refusal and any advice received from the GP must be documented in the care notes. The GP may also choose to undertake a review of the medication where it is frequently refused.

- If a person refuses “when required” medication which staff have offered because they believe the person requires them (for example, the person appears to be in pain) a record should be made in the care plan that the medication has been offered and refused. Where appropriate, the person’s GP should be contacted for advice.

- The person should be asked if they would tell you the reason for their refusal to take the medication and the reason documented if they are willing to give it. This may help in assessing potential options regarding the medication.

- If a person is having difficulty swallowing their medication, or requests that tablets are crushed or capsules opened, this should be discussed with the person’s GP who may review the medication, be able to prescribe more appropriate formulations or consider referral to a speech and language therapist for further assessment.
• Tablets must not be crushed or capsules opened unless the advice of a pharmacist has been sought to ensure that the pharmaceutical properties of the medication are not altered and that it is safe to administer the medication in this way. The method of administering the medication should be documented and the approval of the GP obtained.

‘Covert’ is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. There may be certain circumstances in which covert administration may need to be considered to prevent a person missing out on essential treatment. This may only be done where the person lacks capacity as defined by the Mental Capacity Act or under the conditions defined by the Mental Health Act (MHA).

• An assessment of capacity should be undertaken, in accordance with the Mental Capacity Act, and the discussions (including who was involved) and conclusions reached recorded in the person’s care plan. If the person has capacity and the MHA does not apply then they cannot be compelled to take their medication even if this is likely to affect their health or wellbeing.

• Any decision made about the covert use of medication for a person who lacks capacity must be the result of a best interests meeting in accordance with the principles laid out in the Mental Capacity Act. Health and social care professionals, relevant to the individual, should be consulted. The person’s GP and any person with legal authority to act on behalf of the individual for medication issues (if one exists) must be involved and agree that covert administration is in the person’s best interest. Information given by informal carers such as relatives or friends should be taken into consideration. The decision reached, the reasons for it and who was involved must be recorded in the person’s care plan.

• A written protocol must be developed which is specific for that person. The advice of a pharmacist must be obtained, as for people with swallowing difficulties, regarding the appropriate method of administration for the medication.

• The use of covert administration should be reviewed on a regular basis which should be at least every 6 months, or sooner if circumstances change. Changes to the existing protocol should be recorded in the person’s care plan.

**Bought Medicines**

‘Bought medicines’ are those which do not require a prescription and can be purchased by the individual, such as paracetamol, herbal or homeopathic medicines and food supplements.

• Care staff should remind people to check with their community pharmacist before taking or using ‘bought medicines’ in order to avoid potential adverse effects or interaction with existing prescribed treatment.

• Care staff must not purchase or administer any ‘bought medicines’ unless suitability has been confirmed with the person’s GP or regular pharmacist. The advice given and the name and professional title of the person giving it should be documented in the person’s care records.

• Care staff must only administer ‘bought medicines’ from the original package as purchased which shows the dose to be taken and the expiry date of the product.
• ‘Bought medicines’ should only be administered in accordance with the directions in the manufacturer’s information. Under no circumstances should a dose greater than that given in the manufacturer’s information be administered by staff.

• When ‘bought medicines’ are administered, this must be recorded on the person’s MAR chart in the same way as prescribed medication.

• Care staff should seek advice from their line manager if they are concerned that a person is using ‘bought medicines’ inappropriately or excessively.

How to Dispose of Medicines

The disposal of unwanted or out of date medication should usually be the responsibility of the person and/or their nominated representative. They should be encouraged to return any such medication to their community pharmacy or dispensing doctor on a regular basis to prevent it being taken inadvertently.

• Where care staff are supporting people at Level 2 to 6 they may return medicines to a community pharmacy on behalf of the person.

• Medicines should be disposed of when they are no longer needed because the prescription has changed or the treatment is completed or the expiry or ‘do not use after’ date is reached.

• When care staff arrange for the disposal of medicines on a person’s behalf, consent for disposal must be given by the person using the appropriate form which details which medicines have been returned to the pharmacy and quantities returned. See Appendix 5.

Medication Errors and Near Misses

It is recognised that, despite high standards of good practice and care, mistakes may occasionally happen for various reasons. The mistake must not be hidden or ignored. If a member of staff is found to have hidden or ignored the mistake this will be considered gross misconduct and disciplinary action will be taken.

In the event that medication has been incorrectly administered

• Make sure the person is somewhere safe and being observed.

• Contact the GP/out of hours service immediately, outline what has happened, confirm any instructions given by the GP and follow them. Establish if ongoing monitoring is required.

• Contact your line manager/duty manager to explain what has happened and the advice given by the GP. The line manager/duty manager should make arrangements for ongoing monitoring if necessary.

• Record all the advice given and actions taken in the person’s care notes, including who you spoke to and the time and date the conversation took place.

• Monitor the condition of the supported person throughout the process.
Medication omitted by mistake

- If you forget to give a medication contact your line manager as soon as you remember to inform them of the situation. A decision will need to be made as to the actions to take, for example, do you need to go back to administer the medication, can it be given at the next scheduled visit, will the dose need to be missed? The advice of the GP or pharmacist should be sought and documented including the name and professional title of the healthcare professional contacted, the advice given and the consequences of missing the dose, if appropriate.

For all errors/incidents

- Explain to the person, in a manner appropriate to them, the medication error and any possible effects (as advised by the healthcare professional contacted), reassure at all times and apologise for the error.

- If the person has capacity, offer to contact family or friends if they would like you to do so. If the person does not wish you discuss the incident with family or friends then this must be respected. Document who you have informed and consent given.

- Where a person has been assessed as lacking capacity, the person with legal authority to act on their behalf (for example, a person with lasting power of attorney for health and welfare) must be informed. This should be done as soon as possible following the incident and an apology should be offered. If there is no person with legal authority to act on behalf of the person then a best interests decision, in line with the Mental Capacity Act and the known wishes of the person, should be made as to whether information should be shared with family or friends. A record should be kept of who was contacted and the information given.

- Complete the incident form including a record of the healthcare professional’s instructions, and the information given to the person or their representatives.

- Consideration should be given as to whether the incident should be reported as a safeguarding incident with the local authority.

- CQC must be informed if the error/incident could or has resulted in significant harm to the individual or the incident has been reported to the police. CQC must be notified using the forms available on their website. If the incident requires reporting to CQC then a safeguarding alert should also be raised.

- If you are unsure whether a notification to CQC and/or a safeguarding alert is needed you must seek advice from your manager.

- Where appropriate in line with the duty of candour, a written record of the incident must be given to the person (or to the person legally acting on their behalf for a person without capacity). The written record should include an apology for the incident, the information already given verbally, what actions have been taken, any enquires made and their results. Support should be offered to the person (or their legal representative) regarding the incident. A copy of any information given must be kept in the person’s records as should any further communications regarding the incident.

Errors should be dealt with in a constructive manner and line managers are responsible for investigating them, with the aim of learning the underlying reasons for the incident and preventing its recurrence.
During an investigation the manager will need to differentiate between those cases where there was a genuine mistake, or where reckless/unsafe practice was undertaken. A thorough and careful investigation should be conducted before any action is taken.

The line manager must consider the need for further action in relation to supporting the member of staff who made the error. This could include retraining, reassessment of their competence, whether there is a need to stop the member of staff from undertaking medication duties and/or suspend them from all duties. This must be done within the bounds of relevant employment law.

A medication incident log should be kept and reviewed on a regular basis to identify any trends if they exist and to learn from the incidents to prevent recurrence wherever possible.

Complaints

The service intends that medication should be handled and administered safely and respectfully. However, if a person or their representative has a concern or complaint this must be taken seriously and investigated.

- Any member of staff who is approached with a complaint about medication handling or administration should inform the registered manager who should establish the details of what has happened.
- The investigation should be documented in the person’s care plan along with any actions taken to prevent reoccurrence. Where necessary, procedures should be updated and all staff should be made aware of this.
- The person and/or their nominated representative should be given information on what action has been taken. Care should be exercised to ensure that the confidentiality of the staff is not breached when providing information to the individual and/or nominated representative.
- If the complaint or concern is about the medication itself this should be referred to the person’s GP.
- The person and/or their nominated representatives should be encouraged to report concerns or complaints regarding the handling or administration of medicines to the registered manager, or another member of staff if they feel more comfortable.
- A copy of the complaints procedure must be given to the person and/or their nominated representative when the person starts using the service and following any updates to the procedure. They should also be informed that they can raise their concern with CQC directly should they wish to do so.
- A record of the complaints must be kept by the service, including the actions taken, and complaints should be reviewed regularly to identify trends if they exist. CQC may request a copy of this record of complaints.

Changes to the needs of a supported person

Care staff must keep their line managers updated about the needs of the supported person relating to medication and must report any significant changes, any concerns they have, or any difficulties being experienced by the person. This includes changes in the condition, behaviour or abilities of the person receiving support.
Any advice given to the supported person to consult their GP or another healthcare professional should be recorded in the care notes.

Line managers must respond to, and where appropriate, investigate any concerns about medication related issues raised by care staff. This may involve liaising with assessment staff, community pharmacists, general practitioners and other prescribing healthcare professionals as appropriate about a wide range of medication related issues and advising care staff on actions to take.

**Staff Training and Competency**

- Managers must ensure their staff have sufficient information, training, supervision and support to enable them to competently carry out their duties.

- Safe handling of medicines training for domiciliary care staff must encompass all the practical tasks staff may be required to undertake up to and including level 5 support. See Appendix 2a for examples of tasks in level 5 support.

- Medication training should be provided on a frequent enough basis to train new staff and to refresh the knowledge of existing staff.

- Following training staff must have their competency assessed and be signed off as competent by the registered manager before administering medicines unsupervised.

- Managers are responsible for keeping a record of care staff’s training.

- Evidence that the trainer is competent and has knowledge and expertise in the handling of medicines must be maintained.

Line managers must ensure that the care staff who are responsible for the administration of medicines have their competency assessed by direct observation and training needs reviewed at least annually, or more frequently if required.

**Training for Level 6 Enhanced Tasks**

- The healthcare professional must train the care staff and be satisfied they are competent to carry out the task. See appendix 2b for examples of tasks which require this level of training. The healthcare professional should be asked to indicate if refresher training is required and what the appropriate intervals are.

- Where indicated by the agency’s insurers this training must always be person and task specific.

Care staff can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so. Care staff **must** inform their line manager if this is the case. Further training and development opportunities should be provided where appropriate.
## Table of levels of support

<table>
<thead>
<tr>
<th>Level</th>
<th>Assistance Required/Task</th>
<th>Possible Actions</th>
<th>Documentation</th>
</tr>
</thead>
</table>
| **Level 1** | • Monitor/check for difficulties and well being  
• Report changes and concerns | • Observation  
• Report onwards | • Contact sheets/care notes |
| **Level 2** | • Help with ordering and collection of medicine | • Complete repeat request and arrange collection delivery: check order is complete | • Contact sheet/care notes |
| | • Disposal of medication | • Obtain consent and return to supplying pharmacist | • Consent for disposal form |
| **Level 3** | Physical assistance required with:  
• Opening medicine bottles and/or popping tablets from blister packs.  
• Pouring of liquids | • As directed by supported person | • Contact sheet/care notes |
| | • Possible help with disposal | • Obtain consent and return to supplying pharmacist | • Consent for disposal form |
| **Level 4** | • Oversight/Monitoring enabling supported person to successfully use compliance aid | • Observation and refer to community pharmacist if appropriate | • Contact sheet/care notes |
| | • Disposal of medication | • Obtain consent and return to supplying pharmacist | • Consent for disposal form |
| **Level 5** | • Administer Medication | • In accordance with prescriber’s directions | • Consent for level 5  
• Complete MAR chart |
| | • Put out medication for supported person to take themselves | • As directed in the service plan | • Consent for level 5  
• Complete MAR chart with appropriate code |
| | • Ensure safe storage | • As above and taking into account supported person safety and manufacturer’s instructions | |
| | • Disposal of medication | • Obtain consent and return to supplying pharmacist | • Consent for disposal form |
| | • Identify and report any difficulties in the above process | • Discussion/observation  
• Report onwards | • Contact sheets |
| **Level 6** | • Individual Plan for all level 6 tasks | • Individual Plan for all level 6 tasks | |

**NB** Compliance aids should only be used where they maintain or develop independence.
## Outline of tasks that can be undertaken after appropriate medication training

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Detail</th>
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</thead>
<tbody>
<tr>
<td>Oral Medication</td>
<td>Administration of:</td>
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<tr>
<td></td>
<td>• Tablets</td>
</tr>
<tr>
<td></td>
<td>• Capsules</td>
</tr>
<tr>
<td></td>
<td>• Liquid medication</td>
</tr>
<tr>
<td>Topical Medication</td>
<td>Application/administration of:</td>
</tr>
<tr>
<td></td>
<td>• Creams, ointments to skin</td>
</tr>
<tr>
<td></td>
<td>• Eye drops, eye ointment</td>
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<tr>
<td></td>
<td>• Nasal drops</td>
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<tr>
<td></td>
<td>• Ear drops</td>
</tr>
<tr>
<td>Transdermal Patches</td>
<td>• Preparation of skin</td>
</tr>
<tr>
<td></td>
<td>• Application of patch</td>
</tr>
<tr>
<td></td>
<td>• Disposal of old patch</td>
</tr>
<tr>
<td>Inhaler Devices</td>
<td>• Provide assistance to use prescribed inhaler device</td>
</tr>
<tr>
<td>Application of Dressing</td>
<td>• First aid measure whilst medical advice sought</td>
</tr>
<tr>
<td></td>
<td>• One off simple dressing covering a minor wound as an interim measure prior to health input</td>
</tr>
</tbody>
</table>
**Enhanced Tasks**

Below are examples of tasks which care staff may be asked to carry out following appropriate training and competency assessment by a healthcare professional. An explicit health care plan must be in place including agreement on monitoring and providing feedback. For any enhanced task a check must be made to ensure there is appropriate insurance cover.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Samples</td>
<td>- Obtain capillary blood sample and measure blood glucose level using a glucometer</td>
</tr>
</tbody>
</table>
| Percutaneous Endoscopic Gastrostomy (PEG) feeding | - Cleaning PEG site  
- Administration of prescribed medication via PEG tube  
- Administration of bolus feeds via PEG tube  
- Administration of continuous feed via PEG tube using pump |
| Nasogastric Feeding              | - Cleaning of area around tube  
- Administration of bolus feeds using syringe |
| Oxygen Administration            | - Provide assistance to user  
- Connect oxygen tubes and mask to oxygen supply  
- Check correct flow rate |
| Nebuliser Use                    | - Provide assistance to user  
- Connect mask and tubing to nebuliser  
- Empty prescribed dose of medication into reservoir |
| Injections                       | - Administration of subcutaneous insulin injection to person receiving support with stable diabetes using pre-filled pen |
| Emergency Medication             | Administration of :  
- Rectal diazepam  
- Buccal midazolam  
- Subcutaneous injection of adrenaline |
| Enema and Suppositories          | - Administration of prescribed microenema or suppository as part of a regular bowel management care plan for identified person receiving support |
### Medication Assistance Assessment Tool

<table>
<thead>
<tr>
<th>QUESTIONS FOR PERSON RECEIVING SUPPORT / CARER</th>
<th>Y</th>
<th>N</th>
<th>CONSIDERATIONS</th>
<th>Y</th>
<th>N</th>
<th>ACTION (s) TO BE TAKEN</th>
<th>Y</th>
<th>N</th>
<th>COMMENTS / NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you able to obtain supplies of medicines as needed?</td>
<td></td>
<td></td>
<td>Is this appropriate, if not:</td>
<td></td>
<td></td>
<td>Arrange for pharmacy delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please circle if N/A</td>
<td></td>
<td></td>
<td>- Can the pharmacy deliver?</td>
<td></td>
<td></td>
<td>Other (please specify)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Can someone else collect?</td>
<td></td>
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<tr>
<td>2. Can you read the label on the medication?</td>
<td></td>
<td></td>
<td>Consider: - is this a problem?</td>
<td></td>
<td></td>
<td>Refer to Pharmacist for advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please circle if N/A</td>
<td></td>
<td></td>
<td>- Would large print labels help?</td>
<td></td>
<td></td>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Would large print directions help?</td>
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<tr>
<td>3. Can you get the medicine out of the container?</td>
<td></td>
<td></td>
<td>Consider:</td>
<td></td>
<td></td>
<td>Refer to Pharmacist for advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please circle if N/A</td>
<td></td>
<td></td>
<td>- Would different containers help?</td>
<td></td>
<td></td>
<td>Other (please specify)</td>
<td></td>
<td></td>
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<tr>
<td>4. Do you remember to take your medication?</td>
<td></td>
<td></td>
<td>Consider:</td>
<td></td>
<td></td>
<td>Inform Carer / GP (compulsory)</td>
<td></td>
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</tr>
<tr>
<td>Please circle if N/A</td>
<td></td>
<td></td>
<td>- Would a simple reminder help?</td>
<td></td>
<td></td>
<td>Refer to Pharmacist for advice</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Would simplifying the dose help?</td>
<td></td>
<td></td>
<td>Other (please specify who)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- Would a compliance aid help?</td>
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<td></td>
<td></td>
<td></td>
<td>- Can someone else help?</td>
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</tr>
<tr>
<td>QUESTIONS FOR PERSON RECEIVING SUPPORT / CARER</td>
<td>Y</td>
<td>N</td>
<td>CONSIDERATIONS</td>
<td>Y</td>
<td>N</td>
<td>ACTION (s) TO BE TAKEN</td>
<td>Y</td>
<td>N</td>
<td>COMMENTS / NOTES</td>
</tr>
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</tr>
<tr>
<td>5. Do you have any difficulties taking or using your medicines?</td>
<td></td>
<td></td>
<td>Record difficulties:</td>
<td></td>
<td></td>
<td>Inform Carer / GP (compulsory)</td>
<td></td>
<td></td>
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<tr>
<td>Please circle if N/A</td>
<td></td>
<td></td>
<td>Consider if they can:-</td>
<td></td>
<td></td>
<td>Discuss with Pharmacist</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- Take medicine once it is out of the container</td>
<td></td>
<td></td>
<td>Refer to Nurse</td>
<td></td>
<td></td>
<td>Other (please specify)</td>
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<td></td>
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<tr>
<td>- Swallow medicine</td>
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<tr>
<td>- Use medicines properly (such as creams, inhalers, eye drops, etc)</td>
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<tr>
<td>6. Are there any medicines that you do not take as prescribed?</td>
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<td>Why is this? (record)</td>
<td></td>
<td></td>
<td>Inform GP</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Please circle if N/A</td>
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<tr>
<td>7. Where do you keep all your medicines?</td>
<td></td>
<td></td>
<td>Consider: - appropriate storage / containers</td>
<td></td>
<td></td>
<td>Advise on appropriate storage</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Stockpiling?</td>
<td></td>
<td></td>
<td>Arrange for safe disposal</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>- Expiry dates?</td>
<td></td>
<td></td>
<td>Inform GP</td>
<td></td>
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<tr>
<td>- Use of non-prescribed items</td>
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</tbody>
</table>

8. What medication are you currently taking?  
List details:

N.B. List is applicable as at date below

How was the information on medication provided?  
- Verbal only from individual/carer.  
- Visual check of meds  
- From repeat prescription  
- Via GP / Health professional/ Pharmacist

Person receiving support / Representative’s statement: I confirm that I have advised as to the importance of providing this information accurately. I understand that this information may be passed on to other health and social care professionals.

Signed: _______________  Date: ______  If not person receiving support, please state relationship to person receiving support: ____________________
Consent to administration form

Please delete the statement which does not apply

I agree that the care staff may support me with my medication in the way that is documented in my support plan.

Or

I do not wish care staff to support me with my medication. I understand the risks from not accepting the assessed level of support.

Signed: ______________________________ Date: ________________

Name: ________________________________
(Please use block capitals)

Address:
____________________________________
____________________________________

If the person is assessed as unable to give informed consent, the section below should be completed by the service following a best interests decision, or by the person holding a valid Lasting Power of Attorney for Health and Welfare for the individual.

Informed consent could not be obtained. Administration of medication, as detailed in the support plan, has been agreed/not agreed (delete as appropriate) following a best interests decision in accordance with the Mental Capacity Act or by the person holding a valid Lasting Power of Attorney for Health and Welfare for the individual.

Signed: ______________________________ Date: ________________

Name: ________________________________
(Please use block capitals)

Do you hold lasting power of attorney for health and welfare?

☐ Yes ☐ No

(for no please fill in sections below)

For agency staff use

Job title: ______________________________

Name of agency: _______________________

Is the best interests decision documented in the support plan?

☐ Yes ☐ No

(The decision must be documented.
Ensure arrangements are in place)
Consent to return unwanted or discontinued medication to the pharmacy/dispensing GP surgery

I (name of person) ............................................. agree that the following medicines can be removed from my home and returned to a local pharmacy/GP dispensing practice for safe disposal by .................................................. (name of care staff).

<table>
<thead>
<tr>
<th>Name, strength and form of medicine</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Signed ................................................................. Date .................

---------------------------------------------------------------------------------------------------------------------

FOR PHARMACY/DISPENSING GP USE ONLY

I ............................................................... confirm that the above medicines have been returned to the pharmacy/dispensing GP practice for safe disposal.

Signed ................................................................. Date .................

Name and address of pharmacy/dispensing GP surgery (or pharmacy/practice stamp)
Initials and signatures of all staff involved in the administration of medicines

Signatures to be updated at least annually or following staff changes.

<table>
<thead>
<tr>
<th>Date</th>
<th>Print name (block capitals)</th>
<th>Initials (as they appear on MAR)</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Medication Administration Record (MAR)</td>
<td>MAR Chart Prepared by:</td>
<td></td>
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<td>---------------------------------------</td>
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<td></td>
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<tr>
<td>Name:</td>
<td>DOB:</td>
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<td>Address:</td>
<td>Start Day:</td>
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<td>Week 1</td>
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<td>Week 2</td>
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<td>Week 3</td>
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<td>Week 4</td>
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<tr>
<td>GP:</td>
<td>Start Date:</td>
<td></td>
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</tr>
<tr>
<td>Allergies:</td>
<td>End Date:</td>
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<table>
<thead>
<tr>
<th>Medication</th>
<th>Carried Forward</th>
<th>Returned</th>
<th>Sig</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Quantity Rec'd</th>
<th>Sig</th>
<th>Date</th>
<th>Carried Forward</th>
<th>Returned</th>
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1 - Refused    2 - Nausea/vomiting  3 - Left for later  4 - Other (please define)
Where a variable dose of a medicine is prescribed e.g. “Take ONE or TWO tablets at night”, the number of tablets administered on each occasion should be recorded on the MAR chart.

The start date of the chart (including the year) should be clearly marked.

Each time a medicine is given the person administering the medicine must sign the chart. If for any reason the medicine is not administered the appropriate code should be entered onto the chart. There should be no gaps on charts.

When a new chart is written for a medicine that is not administered on a daily basis, a cross should be marked in the signature column against each day the medicine WILL NOT be given for the whole of the period of the chart; to avoid it accidentally being administered on a day when it is not due.

MAR charts can be computer generated or handwritten. They cannot be produced by attaching dispensing labels to a blank chart. Staff must sign the charts in ink and correction fluid cannot be used to make any amendments.

The person’s name, address, date of birth and GP should be filled in on each chart in use.

The name, strength and form of the medicine should be copied from the dispensing label onto the appropriate space on the chart along with the full dosage instructions (exactly as they appear on the label) and any additional instructions.

When medicines are prescribed ‘as required’ the MAR chart should be supplemented by additional information recorded in the care plan that clearly describes the circumstances when the medicine should be given. The time and dose administered should be clearly recorded on the MAR chart.

Any known allergies must be recorded on the chart. If the person has no known allergies then this must be recorded.
### Changes to policy

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
<th>Reason</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/15</td>
<td>Change to confidentiality section</td>
<td>In line with NICE NG21 recommendation 1:3:15/1:3:16</td>
<td>KRL</td>
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<tr>
<td>01/10/15</td>
<td>Change to assessment and review – support plan information</td>
<td>In line with NICE NG21 recommendation 1:5:1/1:5:2</td>
<td>KRL</td>
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