

PROCEDURAL GUIDELINES FOR THE SAFE AND SECURE HANDLING OF MEDICINES IN TRUST UNITS REGISTERED AS NURSING HOMES

PROCEDURE REFERENCE NUMBER:	CLPG13-NH
VERSION NUMBER:	2
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CONSULTATION:	Medicines Management Group (Mental Health & Learning Disabilities)
IMPLEMENTATION DATE:	October 2017
AMENDMENT DATE(S):	December 2019
LAST REVIEW DATE:	February 2020
NEXT REVIEW DATE:	February 2023
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	January 2020
RATIFIED BY QUALITY COMMITTEE:	February 2020
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POLICY SUMMARY	
<p>The purpose of this procedural guideline is to ensure Essex Partnership University NHS Foundation Trust has operational procedures in place to minimise the risks associated with the management and use of medicines. It defines the systems that are in place for the safe and secure handling of medicines, including ordering, supply, storage, transportation, prescribing, dispensing, administration and disposal.</p>	
<p>The Trust monitors the implementation of and compliance with this policy in the following ways:</p>	
<p>This policy and procedural guidelines will be monitored by the Medicines Management Team according to a three yearly rolling, medicines management audit programme.</p>	

Services	Applicable	Comments
Trustwide		
Mental Health & Learning Disability	✓	Only those facilities registered as nursing homes
Community Health Services		

The Director responsible for monitoring and reviewing this policy is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**PROCEDURAL GUIDELINE ON THE SAFE AND SECURE HANDLING OF MEDICINES
IN TRUST NURSING HOMES**

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**PROCEDURAL GUIDELINE ON THE SAFE AND SECURE HANDLING OF MEDICINES
IN TRUST NURSING HOMES**

1. INTRODUCTION

- 1.1. Essex Partnership University NHS Foundation Trust (EPUT) is required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner within its nursing homes. This document defines the operational procedures for the ordering, storage, administration and disposal of medicines needed to achieve this.
- 1.2. This document is based upon statutory requirements and guidance issued by various official bodies. These include:
- The Medicines Act (1968) as consolidated by the Human Medicines Regulations 2012, as amended
 - The Misuse of Drugs Act (1971) as amended
 - The Misuse of Drugs Regulations (2001) as amended
 - Royal Pharmaceutical Society / Royal College of Nursing *Professional Guidance on the Safe and Secure Handling of Medicines* (update to the The 'Duthie Report') (2018)
 - Nursing and Midwifery Council / Royal Pharmaceutical Society *Professional Guidance on the Administration of Medicines in Healthcare* (2019)
 - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC Fundamental Standards)
 - NICE *Managing Medicines in Care Homes* (2014)
- 1.3. All staff involved in the resident's care are responsible for ensuring that medicines are managed appropriately. The primary responsibility for the prescribing and monitoring of medication and the resident's condition rests with their general practitioner (GP), in consultation with other health care professionals involved in the care of that individual.
- 1.4. This document should be used in conjunction with the Trust's procedural guidelines for the Safe and Secure Handling of Medicines in Mental Health Services (CLPG13-MH), and contains cross references to information contained in that where appropriate.

2. SCOPE

- 2.1. All staff who are involved in the handling or administration of medicines are required to read and comply with this procedural guideline.

3. RESPONSIBILITIES

- 3.1. Responsibility for reviewing this document in relation to medicines management rests with the Chief Pharmacist working through the Medicines Management Group.
- 3.2. Responsibility for establishing and maintaining a system for the secure and safe handling of medicines rests with the Chief Pharmacist in consultation with appropriate medical, nursing and administrative staff.
- 3.3. Responsibilities of the Registered Manager**
 - 3.3.1. The Registered Manager is responsible for implementing this procedural guideline within each Trust nursing home; monitoring and auditing the administration of medicines, and ensuring that staff who administer medicines have been trained and are competent to do so.
 - 3.3.2. The Registered Manager carries responsibility for the security of, and access to, medicines held at the site, for ensuring that stocks of Controlled Drugs correspond with the CD record book, for the appropriate disposal of medicinal waste, and for ensuring that the medicines policy and procedural guideline is followed by all members of staff.
- 3.4. Responsibilities of Nurses**
 - 3.4.1. Registered Nurses are responsible for ensuring that medicines are administered in line with this procedural guideline and professional requirements, and must bring any breaches to the attention of the home manager.
 - 3.4.2. In administering any medication, or assisting or overseeing the administration of medication, nurses must exercise their professional judgement and apply their knowledge and skills to the situation.
- 3.5. All staff who administer medicines have a duty to do so safely, professionally and in accordance with this procedural guideline.
- 3.6. Staff must work within their sphere of skill and competence and have a duty to bring to the attention of the Registered Manager any concern they may have around their own breadth of knowledge and practice to ensure that the right training / guidance / monitoring can be provided.
- 3.7. The resident's GP should ensure that arrangements are in place for medication review to be carried out for each resident at least annually.

4. STORAGE AND SECURITY OF MEDICINES

- 4.1. The Registered Manager is responsible for the safe and secure storage of all medicines.
- 4.2. The design and location of all medicines cabinets and trolleys must be approved by the Chief Pharmacist or a designated senior pharmacist.
- 4.3. The following general principles for medicines storage shall apply:
- All medicines shall be stored in a locked clinical room that is not accessible to residents or the public.
 - All medicines cabinets, fridges and trolleys must be kept locked whenever they are not in use. Medicines cabinets must be securely attached to a wall and comply with the requirements of BS2881-1989.
 - All medicines (including dressings) shall be stored in conditions that minimise the risk of deterioration due to humidity, light, extremes of temperature or exposure to other substances.
 - Medicines packaging shall be checked for any special storage requirements, such as the need for refrigeration. Medicines suitable for storage at room temperature must be stored at or below 25°C.
 - Items such as food, residents' valuables or personal property must not be stored in medicines cabinets or fridges under any circumstances.
- 4.4. All cupboards, trolleys and areas used to store or prepare medicines must be kept clean and tidy and should be in good condition. Spills should be cleared up immediately. Any equipment used in the administration of medicines must be clean and in good condition.
- 4.5. Medicines must be stored tidily so that it is easy to locate each individual's medicines and reduce the risk of it being mixed up with another person's medicines.
- 4.6. All medicines shall be stored in one of the following locked cupboards, which comply with BS2881-1989, as appropriate: -
- 4.6.1. **Internal medicines cupboard:** To be used for the storage of internal medicines such as tablets, capsules, internal liquids, inhalers and injections, with the exception of Controlled Drugs and items that require refrigeration. Externally-applied medicines that are intended to have a systemic effect, e.g. hormone replacement patches, glyceryl trinitrate patches, should be treated as internal medicines.
- 4.6.2. **External medicines cupboard:** To be used for the storage of medicines intended for external application, e.g. creams, ointments, lotions etc.
- 4.6.3. **Reagent / disinfectants cupboard:** To be used for the storage of urine-testing products and antiseptic/disinfectant products

- 4.6.4. **Controlled drugs cupboard:** To be used solely for the storage of medicines subject to the Misuse of Drugs Act, 1971. The CD cupboard must meet the requirements of the Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007, and be securely attached to a wall with at least two rag-bolts. It must be separate from other medicines cabinets or located inside an internal medicines cabinet. All CD cupboards must have their own unique 7 lever, key-retaining mortice lock.
- 4.6.5. **Medicines refrigerator:** To be used only for the storage of medicines requiring refrigeration. Enteral feeding products requiring refrigeration may be stored in the medicines refrigerator if there is insufficient storage space in a general-purpose refrigerator. Medicines refrigerators must be regularly defrosted (if not self-defrosting) and be kept clean and locked.
- 4.7. Where separate cupboards are not available, internal and external medicines shall be stored on separate shelves in a locked cupboard.
- 4.8. Medicines in current use may be stored in a portable, lockable medicine trolley. When not being used for a medicines administration round, the medicines trolley shall be kept locked and either securely chained to a wall or locked in the clinical room. The medicines trolley must never be left unattended at any time when unlocked.
- 4.9. Medicines must never be transferred from one container to another. Once a dose of any medicine has been removed from its container it shall never be returned. If not required it must be discarded, by placing in a pharmaceutical waste bin. Where half a tablet from a blister pack is needed for a dose, the remaining half shall be discarded. (See special requirements for controlled drugs, [Appendix 3 of CLPG13-MH](#)).
- 4.10. New supplies of medicines should be placed behind current supplies when medication is received, so that the oldest medicines are used first.
- 4.11. **Custody of keys**
- 4.11.1. The Registered Manager is responsible for the keys to medicines cabinets, trolleys, etc. This responsibility may be delegated to another registered nurse (e.g. the nurse in charge for a shift), but no other person shall have access to the medicines cabinets and keys unless authorised by the nurse in charge.
- 4.11.2. All medicine cupboards and refrigerators shall be kept locked. The keys shall be held on the person of the nurse in charge or her designated deputy. The keys to medicines cabinets, trolleys, etc. must be kept together on a single key ring reserved solely for these keys, and each key should be clearly labelled.
- 4.11.3. The keys to the controlled drugs cupboard shall be kept on a keyring entirely separate to the keys for other medicines storage facilities, and

also be held on the person of the nurse in charge or her designated deputy.

- 4.11.4. The relevant Matron should securely store a spare set of keys for each of the clinical areas under their management. Spare keys are not held by pharmacy or estates departments.

4.12. Temperature monitoring

- 4.12.1. The temperature of the room and refrigerator in which medicines are being stored must be monitored on a daily basis. Daily records of temperature shall be maintained, using a maximum/minimum thermometer. If the temperature cannot be maintained within the appropriate range, the Registered Manager must contact the Estates Department to arrange for a temporary or permanent solution to be installed. Please refer to [Appendix 12 of CLPG13-MH](#) for further guidance on temperature monitoring.
- 4.12.2. Advice should be sought from a pharmacist about the suitability for future use of any medicines that have been stored in a faulty fridge. Medicines shall be quarantined in another working fridge until advice has been obtained and must not be administered until released by a pharmacist as suitable for future use. Arrangements for a prescription for a new supply should be made with the prescriber as a matter of urgency if required.

4.13. Oxygen

- 4.13.1. Oxygen cylinders should be stored safely, under cover and not subject to extremes of temperature. This should be in a clean dry, well ventilated area away from highly flammable liquids, combustibles and sources of heat and ignition. A statutory warning notice should be displayed in any room where oxygen is stored or used.
- 4.13.2. Guidance and advice around the storage and administration of oxygen can be sought from the supplier
- 4.13.3. Cylinders should be handled with care, never knocked violently or allowed to fall over. They must be switched off when not in use. Cylinders should only be moved using a trolley specifically designed for the purpose and the cylinder size, apart from small portable cylinders.
- 4.13.4. In the case of fire, it is the responsibility of staff to inform the fire brigade that oxygen cylinders are present and where they are located. When evacuating the home, oxygen cylinders should be switched off, where it is safe to do so, as part of the evacuation process.
- 4.13.5. Empty oxygen cylinders should be stored separate from cylinders that still contain oxygen, and should be labelled as such

5. OBTAINING MEDICINES

- 5.1. **It is essential that no-one is without medication because it has not been ordered in time.**
- 5.2. All staff involved in the administration of medicines have a responsibility to ensure that the nurse in charge of the shift or the nurse(s) with delegated responsibility for ordering medication is informed if a resident's medication is running low, so that it can be ordered in good time. If necessary, all staff involved in the administration of medicines should be able to order medicines that are immediately needed.
- 5.3. Routine ordering process**
- 5.3.1. Medication must be ordered at least 2 weeks prior to the start of the cycle to allow time for the prescriber, pharmacy and home to complete their required tasks.
- 5.3.2. The regular order for each month should be initiated by the nurse with designated responsibility for medicines. The Registered Manager must ensure alternative arrangements are in place to initiate the order if the designated person(s) is not available.
- 5.3.3. Dedicated time must be set aside for the regular order to be done without distractions.
- 5.3.4. Before requesting any medicines the current MAR chart should be checked for any medication which has been changed or discontinued. Current supplies of medicines already in the home should be checked, especially "when required" items. Only items which will be needed for the next cycle of medicines should be ordered.
- 5.3.5. Expiry dates and shelf life of opened medicines should be considered when deciding if items need to be reordered. There must be sufficient in-date medication to last to the end of the next cycle.
- 5.3.6. Medication should be ordered by requesting it from the GP surgery using either the most up to date repeat medication slip, or online ordering as instructed by the surgery. The GP surgery will require at least 3 working days' notice to produce repeat prescriptions
- 5.3.7. The current MAR chart must be checked for accuracy against the repeat medication form and actual medication, so a three point check of medications required, Items should then be 'ticked off' as required, adding additional items ,if not already on repeat order form.
- 5.3.8. If a repeat medication form is not available for the resident, the repeat prescription order form (Appendix 1) should be used. The original repeat medication form should be sent to the GP surgery; a copy must be retained at the care home.

5.3.9. Newly issued prescriptions from the GP must be checked against the copy of the repeat medication form retained by the home and the current MAR chart to ensure that all details are correct including checking:

- Personal details - name, date of birth
- Each medication - name, strength, form, dosage, frequency of administration, amount of medication

Discrepancies must be queried with the GP surgery

5.3.10. The Registered Manager must complete the reverse of all prescription forms, signing and dating the declaration. A copy of the prescriptions must be taken and retained by the care home.

5.3.11. The original prescription is then sent to the community pharmacy so that the medication can be dispensed. The community pharmacy will require at least 3 working days' notice to dispense the medication.

5.4. Mid cycle medication

5.4.1. Care must be taken to ensure that medicines prescribed mid-cycle do not run out. Where the medication is to be continued long term the prescriber should be asked to prescribe a one-off quantity that will bring it in line with the regular ordering cycle. The nurse should advise on the quantity required.

5.5. Acute prescriptions

5.5.1. Acute prescriptions are items which are prescribed in response to an illness, for example antibiotics for an infection.

5.5.2. It is essential that such medicines are obtained as soon as possible after being prescribed.

5.5.3. If no computer generated MAR chart has been supplied by the community pharmacy, the medication should be recorded by the Registered Manager or nurse in charge on the MAR chart including how long the course should continue, this should be double checked by another staff and signed by both...

5.6. Remote prescription / direction to administer (verbal orders)

5.6.1. In exceptional circumstances, where medication is **currently prescribed** but where changes to the dose are considered necessary by the GP, and the GP is not present on the premises, the use of information technology, such as fax or email is acceptable to obtain confirmation of a change.

A verbal order is not acceptable on its own. The fax or email must be stapled to the resident's MAR chart and a copy filed in the resident's healthcare record.

In an emergency, when no other form of communication is possible (i.e. no fax or email), a verbal order for dose changes may be accepted but must be witnessed by a second nurse. The instruction should be read back to the prescriber checking the resident's full name and date of birth, the name of the medicine, dose and route.

The nurse shall endorse the MAR chart "dose change instruction by telephone" and enter the date, time, name of the prescriber, her own name and signature and the name and signature of the witness.

Ideally, the GP should countersign the alteration to the MAR chart as soon as possible after giving the verbal order.

5.6.2. Verbal orders for a **previously un-prescribed substance or for schedule 2 and 3 controlled drugs** are not acceptable. New medicines must not be initiated without a prescription.

5.6.3. Text messages may not be used to confirm verbal orders, as no record can be retained.

6. RECEIVING MEDICINES FROM PHARMACY

6.1. The community pharmacy will deliver the dispensed medicines and new MAR charts for the coming monthly cycle. All medication and MAR charts must be checked against the retained copy of the prescriptions:

- Personal details - name, date of birth
- Each medication - name, strength, form, dosage, frequency of administration, amount of medication
- Specific directions regarding storage or administration

Discrepancies must be queried with the community pharmacy.

6.2. The amount of medication received must be entered into the appropriate box on the MAR chart, signed and dated by the Registered Manager or the person with designated responsibility for managing medicines.

6.3. Any items of medication which have been indicated as 'to follow' or supplied in part must be followed up with the community pharmacy before the partial supply is exhausted.

6.4. All medicines received by the home for an individual from whatever source, whether prescribed or purchased, must be recorded on the MAR chart (see section 6.2. The record must show:

- Date of receipt

- Name, strength and form of medicines
- Quantity received
- Name of the resident for whom the medicines is prescribed/purchased
- Signature of member of staff receiving the medicine

Care should be taken to ensure that medicines brought in from the resident's home, discharge medicines from hospital, and medicines prescribed mid-cycle or for an acute illness are included.

Please note that if medicine is purchased by family, it must be approved by a prescriber, before nurses can administer to resident.

- 6.5. A resident information leaflet (PIL) should be supplied by the pharmacy with each medicine. If a PIL has not been supplied, request this from the pharmacy.
- 6.6. All medicines must immediately be transferred to a locked medicines cabinet or trolley.
- 6.7. Controlled Drugs (CDs) must immediately be entered into the CD Record Book. The name, strength and form must be entered at the top of the page, along with the name of the person for whom the medicine was issued, using a separate page for each preparation and person. Every receipt, administration, transfer and disposal of the CD must be recorded on this page maintaining a running balance.
- 6.8. Medication received for use as homely remedies must also be recorded and pre-approved for each resident by a prescriber if nurses are to administer.

7. ADMINISTRATION OF MEDICINES

- 7.1. A registered nurse will have overall responsibility for the administration of medicines. Nursing staff who administer medicines are professionally accountable for their actions or omissions. The standards that apply to the administration of medicines are contained in:
 - NMC Code of Professional Conduct
 - NMC Standards for Medicines Management
- 7.2. Ideally, two people should be involved in the medicines administration process, but it is accepted that at certain times and in certain circumstances, this may not be feasible. Where two persons are involved, the responsibility for the accuracy of the administration is attached to the senior registered nurse who shall sign the administration record. However, both shall check each step of the administration process.
- 7.3. Medicines must be administered directly from the labelled container in which they were received from pharmacy and never transferred into another container prior to administration.

7.4. Medicines prescribed for one person must never be given to another person, or used for a different purpose. Medicines must be administered strictly in accordance with the prescriber's instructions, and the directions on dispensing label attached to the container, taking into account requirements about the timing of medicines in relation to food, and medicines which must be administered at specific times which do not correspond with normal administration rounds.

7.5. The administration of medication must be recorded on the resident's MAR chart immediately after administration. Non-administration must be recorded on the MAR chart using the appropriate reason code, and explanation written at the back of MAR chart when appropriate

7.6. Preparation of medicines for administration

7.6.1. When medicines have to be mixed or reconstituted prior to administration, this shall be undertaken in the clinical room.

7.7. Administration of liquid oral medicines

7.7.1. A 2.5ml or 5ml medicines spoon or graduated plastic medicines pot should only be used to administer medicines such as simple linctus, antacids and cough medicines which do not need accurate dosing. Where accurate dosing is required (for example liquid lithium, anti-epileptics and controlled drugs) an appropriate oral syringe marked 'For oral use only' should be used.

7.7.2. Under no circumstance must an intravenous syringe or domestic teaspoon be used for this purpose.

7.8. Administration of controlled drugs

7.8.1. The administration of a controlled drug must be witnessed by a second practitioner, one of whom must be a registered nurse or doctor. An entry must be made on both the MAR chart and in the CD Record Book, on the relevant page for the resident and the drug (see section 6.5) including:

- the date and time of administration
- the name of the resident
- the dose administered
- the **full** signatures of both the witness and the person administering the drug
- A running balance of the drug

7.8.2. The quantity of stock remaining shall be checked and recorded in the CD Record Book, maintaining a running balance.

7.8.3. If the controlled drug is only partially used or wasted, it shall be destroyed by placing it in a pharmaceutical waste or sharps container

in the presence of a witness and a record made in the CD Record Book.

- 7.8.4. For more detailed information on the administration, recording and disposal of Controlled Drugs, including what to do in the event of a discrepancy between the running balance and the actual amount of stock, refer to [Appendix 3 of CLPG13-MH](#).

7.9. Delegated administration

- 7.9.1. The administration of medicines may be delegated to a member of care staff who has undergone appropriate training and assessment. This is most common for the application of emollients and barrier preparations and the administration of nutritional supplements but could include other prescribed medicines.
- 7.9.2. The registered nurse delegating the task is responsible for ensuring that the member of staff is competent to carry it out. The training and competency assessment for the member of staff should be recorded and a written record kept of the members of care staff who are trained to carry out delegated tasks and which tasks have been delegated to them. (See Competency Framework for Non-Registered Staff for the Administration of Medicines - refer to the Trust pharmacy team for details).
- 7.9.3. The nurse delegating the task must make periodic checks to ensure that the medication is being administered as prescribed and retains overall responsibility for the principles of administration. Competency should be reassessed on an annual basis or sooner if required.
- 7.9.4. The whole task should be delegated including the selection of the product and recording of the administration.
- 7.9.5. The administration of controlled drugs should not be delegated to care staff, although suitably trained and competent care staff could act as a witness to the administration of controlled drugs if necessary.

7.10. Process for administering medication

- 7.10.1. Medicines must be administered strictly in accordance with the prescriber's instructions. Staff involved in the administration of medicines must only give medicines which they are competent to administer. Nurses have a duty to use their professional knowledge to ensure that it is appropriate to administer the medication on each occasion and to contact the prescriber if they have any concerns.
- 7.10.2. Medicines should be administered in a quiet area to allow residents to discuss their medicines if necessary. The nurse administering medicines should ensure that she is not disturbed throughout the process.

- 7.10.3. The therapeutic purpose of the resident's medication and its possible side-effects, interactions and contra-indications should be carefully considered. Reference should be made to the BNF for such information if necessary. If there are any concerns about drug interactions or contra-indications, contact the prescriber or a pharmacist.
- 7.10.4. If contra-indications to a medicine are observed, the dose shall be withheld and the appropriate prescriber informed without delay. A record should be made in the resident's healthcare record.
- 7.10.5. Always wash hands before administering medicines. Read the prescription carefully and ascertain that the dose has not already been given. If the resident has more than one MAR chart, ensure that all are available.
- 7.10.6. Check the entry for allergies on the first page of the prescription chart. If there is reason to suspect that the resident may be allergic to a prescribed medicine, refer to the prescriber or pharmacy.
- 7.10.7. Select the medicine required, check the label with the MAR chart and note the expiry date. If there is any doubt about the identity of the medicine, e.g. ambiguous / illegible wording on the chart or unclear labelling, or any discrepancy between the label and the MAR chart, withhold the medicine and contact the prescriber and/or pharmacy immediately.
- 7.10.8. Prepare the medicines and check the MAR chart with:
- the name of the resident
 - the resident's NHS number where appropriate
 - the medicine including dose and route of administration
 - the calculation, if any (ideally with a second person)
 - the measured dose
 - the expiry date
 - the time of administration
 - the dosage instructions and compare with the label on the container
- 7.10.9. Take the measured dose and MAR chart to the resident, checking his identity before administration. Care shall be taken to ensure that the resident's identity is positively confirmed by visual recognition and/or verbal questioning. If medicines are being administered by a nurse unfamiliar with the resident, a competent second person may need to assist with identification.
- 7.10.10. Ensure that the resident is comfortable and ready to receive their medicine. Administer or supervise the administration of the medicine.

Remain with the resident until the medicine has been taken, or longer if required by the resident's care plan.

- 7.10.11. Immediately sign the MAR chart to confirm that administration has taken place. An entry shall be made on the MAR chart to indicate when doses are either refused or omitted using the codes on the chart. The prescriber shall be informed and a record made in the resident's healthcare record. Where necessary, e.g. students under supervision, the prescription chart should be countersigned.
- 7.10.12. When a variable dose is prescribed, e.g. "one or two tablets", It must be documented and clear to nurses circumstances to give one dose as oppose to the other of the range quoted, and the quantity administered must be documented on the MAR chart.
- 7.10.13. If treatment is refused, professional judgement will be used to determine what next step to take in line with Mental Capacity Act. For information on covert administration of medicines refer to [Appendix 15 of CLPG13-MH](#).
- 7.10.14. More details on the procedure for administering medicines can be found in [Appendices 13 and 14 of CLPG13-MH](#).

7.11. Administration of medicines prescribed 'as required' (PRN)

- 7.11.1. These are medicines prescribed to be used only when necessary, in addition to the resident's regular medication. The minimum interval between doses, the maximum total daily dose and the clinical indication should be stated on the MAR chart, or in a PRN protocol sheet kept with the MAR chart Before administering 'as required' medication the nurse should check when a dose was last administered and whether the minimum interval between doses or the maximum total daily dose has been reached.
- 7.11.2. 'As required' medicines should be administered at the discretion of a registered nurse, e.g. for pain relief or to reduce anxiety. When administered, a note should be made in the healthcare record stating the reason the medicine was given and the outcome.
- 7.11.3. It is essential to check whether an 'as required' drug has also been prescribed on the 'regular medication' section of the chart, to ensure that the maximum daily dose is not exceeded. This is particularly important with products such as paracetamol and compound analgesics, which are frequently prescribed as both regular medication and for PRN pain relief.
- 7.11.4. If an 'as required' medicine is being given on a regular basis, it is the responsibility of the nursing staff to bring this to the attention of the prescriber. If appropriate, the prescriber should consider re-prescribing the medicine on the 'regular medication' section of the

chart. The continuing need for 'as required' medicines should be reviewed on a regular basis.

- 7.11.5. The administration of certain medicines or groups of medicines requires specific care. Further information on these can be found in [Section 21 of the Trust Formulary and Prescribing Guidelines](#).

7.12. Covert administration of medicines

- 7.12.1. If it is felt that to disguise medication in food or drink can be justified in the best interests of the resident, the nurse must ensure before doing so that she:

- has made every effort to obtain the consent of the resident to receive the medicines in the normal way
- has discussed the issue with other members of the health care team, including the pharmacist and, if possible, with the residents carers and relatives in a best interest meeting.
- document these discussions in the resident's healthcare record and provides a detailed account of the disguised administration as recommended by pharmacist.
- Complete a Mental Health Capacity assessment form (available on EPUT intranet)

- 7.12.2. If it is possible to obtain the written consent of carers and relatives this should be done and the consent retained with the records. Further information is provided in [Appendix 15 of CLPG13-MH](#).

7.13. Administration of medicines by non-care home staff

- 7.13.1. On occasion medicines may be administered to a resident by a healthcare professional who is not a member of the care home staff, for example a district nurse, community psychiatric nurse, palliative care nurse. They are likely to be using their own medicines administration records, but should also be asked to complete the resident's MAR chart so that it represents a complete record of all medicines administered to the resident.

8. RECORD KEEPING

- 8.1. The standard of record keeping should ensure that records are properly completed, legible and provide a complete audit trail of medication. All records relating to medicines should be signed and dated by the member of staff making them.
- 8.2. A list should be maintained of the names, signatures and initials of all staff authorised to administer medicines. This should be kept in the front of the MAR chart folder and updated to reflect any staff changes.

8.3. Records must be maintained of all medicines brought into the home, from whatever source, all medicines administered, all medicines disposed of or transferred from the home, and any medicines carried forward from one medicines cycle to the next. It should be possible to determine the quantity of medicines available for each resident at any time.

8.4. Medicines reconciliation at admission

8.4.1. The admission process for medicines should be undertaken by a nurse.

8.4.2. When a resident is admitted to the home the following procedure must be followed.

- Sufficient current medication must be provided to allow the resident to take their required medicines whilst the home establishes a new supply.
- Prescribed medicines must be supplied in the container as originally dispensed by the community or hospital pharmacy and have the dispensing label attached.
- Any non-prescribed medication must be provided in the original packaging as purchased which includes the manufacturer's full directions for use and the expiry date of the product.
- Before admission it should be determined if the resident requires medication to be administered by any specialised technique, such as via an enteral tube. If this is the case, before the admission can proceed, the home must ensure that sufficient nurses have up to date training on the technique to meet this need, or make arrangements with appropriate health care professionals to meet this need on a temporary basis whilst training is undertaken.
- Residents should be asked to bring all current medication with them wherever possible. These should be checked to establish that:
 - The correct resident's name is on the medication label
 - The expiry date of the product has not passed
 - The medication has been recently dispensed (*if the date on the label is old this may indicate that the medicine is no longer being used*)
- The current medication should be confirmed by comparison with written information from the resident's GP, or hospital discharge information. Discrepancies must be checked with the relevant healthcare professional.
- Where written information is not available, or there are gaps in the information, nursing staff should attempt to obtain the information from the relevant healthcare professional to confirm the medicines that the resident is taking.

- The nurse must document in the resident's care plan any information received when contacting a health care professional including:
 - The medication details (name, strength and form)
 - The directions for administration
 - The name of the person contacted, their job role and the details of the surgery or hospital department
 - The date and time of the phone call

Written confirmation of the information provided should be requested from the healthcare professional contacted.

- Nursing staff should establish when the next dose of medication is due so that arrangements can be made to ensure the person does not miss doses of medicines whilst the admission process is occurring.

8.4.3. The receipt of all medication must be documented. Where staff are to administer the resident's medication a MAR chart will be required.

8.4.4. The nurse should ensure that arrangements are made with the prescriber to ensure continuity of supply of the resident's medicines.

8.5. Medication Administration Record (MAR) charts

8.5.1. There must be a Medication Administration Record (MAR) chart available for each resident where staff are administering medication.

8.5.2. The MAR chart must include all medicines taken by the resident (prescribed, homely remedies, individual's own bought medicines or complementary medicines / supplements).

8.5.3. Nursing staff are responsible for creating a new MAR chart for people entering the home for the first time, and when a new cycle of medicines are supplied. The supplying community pharmacy should produce a printed MAR chart wherever possible.

8.5.4. Where MAR charts are handwritten by nursing staff, the writing must be in indelible ink and be clear and legible. The nurse making the entry must sign and date the entry to provide an audit trail. The entries must be checked and signed by a second nurse, or if necessary, by an appropriately trained and competent member of care staff to ensure that all details have been correctly entered. Mistakes must be corrected with a single line through the mistake followed by the correction and a signature, dates and time. Correction fluid must not be used. More information on transcription is available in [section 15.2 of CLPG13-CHS](#).

8.5.5. Pharmacy produced MAR charts must be checked by nursing staff as part of the receipt of medicines process. Nursing staff must inform the

pharmacy of any discrepancies identified to allow the pharmacy to amend the MAR chart for the next cycle.

- 8.5.6. Information regarding purchased medicines should be taken from the manufacturer's packaging or resident information leaflet. The name, form and strength of prescribed medication and precautions should be taken from the dispensing label. The directions for use should be taken from the dispensing label or from any subsequent directions from a relevant health professional.
- 8.5.7. Each medication must be entered on the MAR chart individually. Where medication is supplied in more than one strength or form, each strength or form must have its own entry.
- 8.5.8. Charts should enable a running total of medicines to be maintained. The balance should be reconciled with actual stock on a regular basis, for example at the end of the cycle, and any discrepancies reported to the Registered Manager and investigated immediately.
- 8.5.9. Each time a medicine is given, the person administering it must record this with their initials in the relevant space on the MAR chart for each medicine. Record must be made at the time of administration, after visually witnessing the resident taking the medicine. The MAR chart must **NOT** be initialled at the end of the medication round or before the medication is administered.
- 8.5.10. If the medication is not administered the reason for omission must be documented on the MAR chart using the codes provided and explaining reason at the back of MAR chart if appropriate

8.6. Changes in medication

- 8.6.1. If medication is changed, the MAR chart must be updated by a nurse. The change must be noted in the handover information so that the next shift is informed.
- 8.6.2. The original entry on the MAR chart should be cancelled by drawing a diagonal line through it and any remaining administration record spaces should be ruled through so that it is obvious that doses should not be administered. A note should be added detailing the change and the name of the health care professional who authorised the change.
- 8.6.3. The nurse amending the MAR chart should sign and date the entry and make a corresponding entry in the resident's healthcare record. If required, a new entry should be made in the next available space on the MAR chart (or on a new MAR chart if necessary) reflecting the change in dose or new medication.
- 8.6.4. If the healthcare professional making the change is present in the home and a new prescription has not been issued, ask them to check and sign the amendments to the MAR chart or to detail the changes in

the resident's healthcare record. Otherwise, all such changes must be signed and dated by the nurse making them, and checked by a second member of staff who should also sign the record.

- 8.6.5. Verbal requests for changes should be handled in line with section 5.6.
- 8.6.6. The pharmacy should be informed of any changes to medication and asked to remove discontinued medication from the next MAR chart.

8.7. Controlled drugs (CDs)

- 8.7.1. For medicines that are controlled drugs subject to CD recording requirements, the home must keep a CD register in addition to the record on the MAR chart.
- 8.7.2. The CD register must be a bound book with numbered pages. There must be a separate page for each form and strength of each controlled drug for each resident. A running balance must be kept for each medicine.
- 8.7.3. The name, strength and form of each CD, along with the name of the resident to whom it belongs must be written at the top of the page. Each receipt, administration, transfer or disposal of the CD for that named resident must be recorded on the page.
- 8.7.4. On receipt of a CD from the pharmacy, the date, quantity and where the CD was received from should be entered into the CD register and signed by the receiving nurse. The receipt should be witnessed by a second person. The running balance should be verified as correct each time.
- 8.7.5. When transferring the drug record to a new page in the CD register, the amount remaining should be identified with "Balance transferred from page xx" written clearly on first line of the new page and "Balance transferred to page xx" at the foot of the full page.
- 8.7.6. The administration of each dose must be recorded on the appropriate page of the CD register **as well as** on the MAR chart. The entry must include the date and time of the dose, the actual dose given and the signature of the nurse administering the medicine. A second trained and competent member of staff, preferably a nurse, should witness the process of selecting, and administering the CD and countersign the CD register.
- 8.7.7. The transfer of any CD must be recorded in the CD register. This would include returning medication to the resident, their representative, pharmacy or to another service provider. The record must include the date of the transfer, the quantity transferred, the place or person it was transferred to and the signature of the nurse

arranging the transfer. This should be witnessed and countersigned by a second suitably trained and competent member of staff.

- 8.7.8. The running balance of each CD must be checked against the medication held in the CD cupboard and updated each time that new supplies are received, doses administered, supplied, transferred or disposed of, including zero balances where appropriate. Any discrepancies must be reported to the Registered Manager.
- 8.7.9. If a mistake is made when making an entry in the record book, it **must not be erased, crossed-out or obliterated**; all entries must remain legible. Correction fluid must not be used.
- 8.7.10. The incorrect entry should be bracketed, and '*error*' written next to the brackets. An appropriate footnote should be written at the bottom of the page explaining the error – this should be signed, dated and witnessed by a second suitably trained and competent member of staff.
- 8.7.11. A new entry should then be made on the next blank line, the correct running balance inserted, and the entry witnessed by a second suitably trained and competent member of staff.
- 8.7.12. For more information on the handling of controlled drugs see [Appendix 3 of CLPG13-MH](#).

8.8. Transfer of medicines when a resident moves to / attends another healthcare setting

- 8.8.1. If a resident is transferred to another healthcare setting, for example to an acute hospital or another care home, a copy of the MAR chart or other record of current medication should accompany them. Healthcare professionals should ensure that all necessary information about the resident's medicines is accurately recorded and transferred with the resident, and that responsibility for on-going prescribing is clear.
- 8.8.2. Wherever possible, the resident's medicines, which are labelled with full directions for administration, should also be transferred to ensure continuity of treatment.
- 8.8.3. Where residents need to attend clinical appointments outside the care home, accurate and up to date information about their medication should be available to ensure that safe care can be provided by other healthcare professionals. This may be a copy of the MAR chart, or of their most recent repeat prescription form.

9. HOMELY REMEDIES (NON-PRESCRIBED MEDICINES)

- 9.1. A homely (or household) remedy is a term used for non-prescription medicines that are available 'over-the-counter' from a community pharmacy for the treatment of minor ailments which do not need immediate consultation with a GP. Minor ailments include conditions such as cold symptoms, cough, indigestion, mild diarrhoea, constipation, toothache, headache and other occasional pain.
- 9.2. In order that staff are able to respond in a timely way to minor ailments, a number of homely remedies are kept in the nursing home to allow access to products that would commonly be available if residents were still in their own home.
- 9.3. Such remedies can be obtained from the Trust pharmacy, and may be used for a particular resident at the discretion of the resident's GP. On admission staff should discuss the use of homely remedies with the resident's GP and record agreement on the particular medicines and length of time they can be given without reference back to the GP. This should be recorded using the Homely Remedies Agreement (see Appendix 2) and kept with the resident's care plan.
- 9.4. Homely remedies should be stored in the same location as all other medication, but kept separately from resident's own medicines and clearly marked HOMELY REMEDY.
- 9.5. Medication which has been prescribed and supplied for an individual resident must not be used as homely remedy stock.
- 9.6. Homely remedies should only be administered in accordance with the manufacturer's directions and only to those residents for whom the GP has agreed their use.
- 9.7. The decision to administer a homely remedy must be made by an appropriately trained member of staff. Advice can be sought from the GP prior to administering a homely remedy if preferred.
- 9.8. Before administering a homely remedy the staff member must ascertain:
- That the homely remedy has been approved for use for the resident by a GP, Pharmacist, or a non-medical prescriber.
 - that the resident has no potentially serious symptoms
 - whether the resident is taking any medicines which may cause the symptoms
 - whether the resident is taking any medicines that carry a warning to avoid the homely remedy
 - any known allergies
- 9.9. The staff must regularly review and reassess the resident's response to the medicine. If the resident's condition does not respond to the homely remedy or it worsens, refer to the GP even if it is before the maximum period of treatment allowed in the resident's homely remedies agreement.

- 9.10. Further doses can be administered in accordance with the homely remedy's recommended dose regimen.
- 9.11. All doses given must be entered immediately on the resident's MAR chart and details of the resident's conditions in the care plan.
- 9.12. Expiry dates must be checked regularly and before use. Bottles of liquid medicines should have the date of first opening marked on them, and product guidance followed on how long to keep a bottle once opened.
- 9.13. A record of the stock of homely remedies must be maintained, with each homely remedy recorded on a separate page (Appendix 3). This must include full details of the medication, the date it was received / disposed of (including the quantities). Each administration should be recorded, including the date and quantity administered and the resident to whom it was administered. Each entry should be signed by the person making it. This is in addition to a record being made on the resident's MAR chart.

10. MEDICATION ERRORS, INCIDENTS AND NEAR MISSES

- 10.1. A medication error is a preventable incident associated with the use of medicines which may put the resident at risk. Such incidents may be related to any step in the medicines use process, including prescribing, dispensing, preparation and administration. Examples include:
 - administration of a medicine to the wrong resident
 - administration of the wrong medicine
 - administration of the wrong dose
 - the wrong route of administration used
 - failure to administer a medicine without due reason (i.e. no 'missed dose' code recorded on the chart)
 - failure to record administration on the chart
 - a medicine incorrectly prescribed
 - a medicine incorrectly dispensed
- 10.2. In the event of an incident occurring, the well-being of the resident is of prime importance. The designated nurse in charge of the unit must:
 - ensure the resident is safe, and carry out any necessary physical observations
 - inform the registered manager or on-call manager and the doctor responsible for the resident, as appropriate
 - document the incident in the resident's healthcare record
- 10.3. In the event of an error in administration, the nurse in charge shall inform the appropriate doctor, manager and pharmacist. The GP must be informed of the error at the earliest opportunity.

- 10.4. Medication errors will be investigated in line with the CP3, *Adverse Incident Policy* and CPG3, *Adverse Incident Procedural Guidelines*. The primary objective of the reporting system is improvement in care and not the disciplining of staff. It is only via the reporting of errors and near misses that managers can identify shortcomings in systems which need to be rectified.
- 10.5. Disciplinary action will only be taken in respect of a medication error where there is continual or general concern about a person's competence to practice. Punitive measures tend to create a culture of concealment, and operate against a spirit of openness, co-operation and mutual trust. Competency assessment of staff should be in line with the HRP48 *Supervision and Appraisal Policy* and HRP48 *Supervision and Appraisal Procedures* in addition to individual professional standards.
- 10.6. **Near misses:** The Trust encourages the reporting of 'near misses', which are defined as medication incidents that are detected up to and including the point at which the medicine is handed over or administered to the resident, i.e. an error that could have occurred but did not, because of an appropriate intervention.
- 10.7. Near misses should be reported in the same way as medication incidents. The purpose of 'near miss' reports is to use them as a learning tool and for identifying training needs.
- 10.8. Concerns about safeguarding in relation to medicines should be handled in line with the Trust policy and procedure CLP39 *Safeguarding Adults Policy* and CLPG39 *Safeguarding Adults Procedure*.

11. DISPOSAL OF MEDICINES

- 11.1. A dose of a medicine prepared for administration and subsequently not used must be disposed of safely by placing in pharmaceutical waste container or sharps container as relevant. It shall not be returned to its original container.
- 11.2. Spoiled doses and resident's own medicines which are not required should be disposed of on the ward. All medicines should be disposed of in accordance with [Appendix 10 of CLPG13-MH](#). The disposal of controlled drugs will require the involvement of a Trust Authorised Witness (see [Appendix 3 of CLPG13-MH](#)).
- 11.3. **Following the death of a resident the medicines must be retained for at least seven days in case required by the Coroner's Office.** In the case of an active investigation the Coroner may require that medicines are kept for a longer period. Such medicines should be kept securely, separate from in-use medicines and clearly marked 'Retained at Coroner's Request' until permission is given to dispose of the medicines. If it is required that the medicines are given to the Coroner's Court or police as part of an investigation, a record of all medication transferred must be kept.

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