

Sample policy and procedure: The safe handling of medicines in care homes—with nursing



Have you got the right sample policy?

This sample policy is for the safe handling of medicines in adult care homes with nursing. It should not be used in other settings.

Information on using the sample policy

The sample policy is intended to be used a guide for care homes to develop their own policy and procedures which are robust and specific to the home.

Throughout the policy there is reference to making records. The policy includes details of what should be included in many of these records, where this can be defined. The way that records are kept is at the discretion of the home and the specific method to be used should be incorporated by the home into the policy at the relevant place.

The sample policy assumes that the home keeps paper records. It is possible to keep records, including the CD register, electronically. Such records must contain all the information that would be in the paper records and safeguards must be in place to ensure that:

- The member of staff making each entry can be identified
- Entries cannot be altered at a later date
- Access controls prevent unauthorised access to the records
- Adequate backups are in place to prevent data loss

If the CD register is kept electronically, the information given above applies and in addition the register should be capable of being audited and compliant with best practice. It must be accessible from the premises and capable of being printed. If printed, the details of the medication and the name of the person to which the record relates should appear at the top of each printed page.

Where we have specified a method but another method could work just as well this is indicated *by the use of italics* in the policy document.

In many instances we have developed forms and tools and separate policies which can be adopted by the home to support the safe handling of medicines. These are indicated in the document by the use of an asterisk (*). They can be found on the YHCSU Social Care website. <http://yhcs.org.uk/medicines-management-3/the-safe-handling-of-medicines-in-social-care-settings/>

The term “care plan” is used throughout the document to refer to the record kept by the home of the person’s healthcare.

The policy and procedures need to be reviewed regularly and at least every year.

Comments and feedback

We welcome any comments and feedback on the sample policy and procedures. Please send feedback to karenlepper@nhs.net

Contents

Information on using the sample policy	1
Underlying principles	4
Statutory base and standards	5
Relevant dates.....	5
Procedure	6
1 Introduction.....	6
2 Responsibility for the administration of medication	6
3 Confidentiality and sharing of information	7
4 Self-administration	8
5 Storage of medicines in the home	9
5a. Controlled drugs	10
5b. Medication requiring cold storage	10
5c. Keys.....	11
5d. Storage of oxygen.....	11
6 Record keeping.....	12
6a. Admitting a person into the home and medicines reconciliation	12
6b. Medication administration record (MAR chart)	14
6c. When required and variable dose medication	16
6d. Changes in medication	17
6e. Creams/ointments and nutritional supplements.....	17
6f. Controlled drugs (CD).....	18
6g. Administration of medication by healthcare professionals	19
6h. Document retention and disposal.....	20
7 Obtaining medicines.....	20
7a. Ordering procedure.....	20
7b Mid cycle medication	21
7c. Acute prescriptions.....	22
7d. Emergency supplies of medication	22
8 Receipt of medicines	22
9 Labelling of medicines.....	23
10 The administration of medication.....	24
10a Left for later medication	26
10b When required medication and variable dose medication.	26

10c Anticipatory medication	27
11 Use of homely remedies	27
12 Bought medication.....	28
13 Administration of medication using specialised techniques	28
14 Administration of emergency medication	29
15 Concerns about a person’s health.	29
16 Medication review	30
17 Refusal of medicines and covert administration	30
18 Management of medication errors and incidents	31
19 Disposal of medicines.....	33
19a Disposal of controlled drugs.....	34
20 Arrangements for people in short term care	35
21 Arrangements for short periods away from the home.....	35
22 Transfers of medication to new provider or hospital	37
23 Drug alerts and safety warnings.....	38
24 Complaints and concerns	39
25 Training.....	39
26 Audit	40
Signature Sheet.....	41

Sample Policy and Procedure:

The Safe Handling of Medicines in Care Homes (Adults) – with nursing.

The aims of this procedure are

- To promote independence by encouraging people to manage their own medicines as far as they are able.
- To ensure that the safest possible practices are used when supporting people with their medication.
- To prevent avoidable admissions to hospital by supporting people with their medication appropriately.

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 or who are involved in supporting the person with their medication.

This procedure should be read in conjunction with:

Standards of Medicines Management published by The Nursing and Midwifery Council available at http://www.nmc-uk.org/Documents/NMC-Publications/238747_NMC_Standards_for_medicines_management.pdf

NICE guidelines: Managing Medicines in Care Homes published by the National Institute for Health and Care Excellence (NICE) 2014 available from <http://www.nice.org.uk/guidance/sc/SC1.jsp>

The Handling of Medicines in Social Care published by the Royal Pharmaceutical Society of Great Britain (2007) this can be downloaded from <http://www.rpharms.com/social-care-settings-pdfs/the-handling-of-medicines-in-social-care.pdf>

The '**Good Practice Guidance**' and '**Pharmacy Tips**' which can be downloaded from <http://yhcs.org.uk/medicines-management-3/the-safe-handling-of-medicines-in-social-care-settings/>

Underlying principles

People should be encouraged, where appropriate and following a risk assessment, to retain, self-administer and control their own medication in order to maximise their independence and retain control over their own lives. People who have been assessed as being unable to manage their own medication without assistance need to be protected by the home's policy and procedures for dealing with medicines.

All staff involved in the person's care are responsible for ensuring that medication is managed appropriately. The primary responsibility for the prescribing and monitoring of medication and the person's condition rests with their General Practitioner (GP) in consultation with other healthcare professionals involved in the care of that individual.

Statutory base and standards

The procedure is intended to ensure that medicines are handled appropriately and in accordance with the following legislation and guidance as relevant to the setting:

- Care Quality Commission (Registration) Regulations 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Care Quality Commission (CQC) *Guidance for providers on meeting the regulations* March 2015
- The Medicines Act 1968 and the Human Medicines Regulations 2012
- The Misuse of Drugs Act 1971 and associated regulations
- Guidance from NICE and the Royal Pharmaceutical Society.
- Equality Act 2010
- Mental Capacity Act 2005
- NMC Standards of Medicines Management 2007
- NMC The Code: Professional Standards of practice and behaviour for nurses and midwives March 2015

Relevant dates

This policy comes into effect on _____.

This policy will be reviewed at the latest by _____.

This policy will be reviewed sooner if required due to legislative changes or in response to a critical incident.

Any suggested amendments or improvements should be reported to the registered manager, in order that these can be taken account of when the policy is reviewed.

Procedure

1 Introduction

- The support provided must be tailored to the individual and wherever possible the person should be able to self-administer their medication if they wish to do so and this would be safe.
- All people moving into the home must be assessed for the level of support they need with their medication and agreement reached with the person regarding the support that the home will provide.
- It is the responsibility of relevant healthcare professionals to explain the importance of medication and any potential side effects to the person and their families or carers and the staff who administer their medication.
- The handling of medicines within the home must be in line with this procedure, whether the person is self-administering their medication or requires support.

2 Responsibility for the administration of medication

- Where a person is not administering their own medication, a registered nurse will have overall responsibility for safe administration of the medication.
- The administration of medication could be delegated to appropriately trained and competent members of care staff. This is most commonly done for the application of bland emollients, the use of barrier preparations and the administration of nutritional supplements, but could include other prescribed medication.
- The nurse authorising the task to be delegated is responsible for ensuring that the member of staff is competent to carry out the task. The training and competency assessment for the member of staff should be recorded. The nurse should ensure that the member of staff is adequately supervised and supported and competency should be reassessed on an annual basis or sooner if required. A written record should be kept of the members of care staff who are trained to carry out delegated tasks and which tasks have been delegated to them.
- The whole task should be delegated including the selection of the product and recording of the administration. 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.
- The member of care staff undertaking the delegated task must ensure they follow the home's procedures and must report any problems to the nurse, including when supplies of medication are running low.
- Nurses delegating tasks to members of care staff should ensure that they do so in accordance with the requirements of the NMC Standards of Medicines Management and The Code.
- The administration of controlled drugs should not be delegated to members of care staff, although suitably trained and competent members of care staff could act as witnesses to the administration of controlled drugs when necessary.
- The administration of medication given by invasive or specialised techniques should not usually be delegated to care staff.

- Members of care staff who have not been trained and assessed as competent must not administer any medication.
- **In accordance with the above, medication that is not being self-administered will only be administered by registered nurses or a trained and competent member of care staff to whom the task has been delegated by a registered nurse.**

Although medication administration can be delegated to trained and competent members of care staff, it is important that registered nurses retain overall control of medication administration. This is reflected in the wording of this sample policy and procedure. Where it is used, the phrase “trained and competent member of staff” refers to a registered nurse or a member of care staff who has been appropriately trained and assessed as competent for the specific task by the nurse responsible for the delegation of the task.

3 Confidentiality and sharing of information

- Information regarding a person’s medication and health must be treated confidentially and respectfully. All records must be stored securely where they cannot be accessed by unauthorised persons.
- Information about a person should only be disclosed with that person’s consent unless the home 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 nursing staff should ensure that the person is aware that such a refusal may compromise their safety if relevant information is not shared.
- If a person attends an appointment with a healthcare professional outside of the home it is important that information is available to that healthcare professional, unless the person has refused consent. This information should be given by the person themselves, wherever possible; however, nurses should ensure that the person (or the person accompanying them, if appropriate) has with them a copy of the current medication administration record (MAR) chart or is provided with the same details in another written form. Information should also be provided on recent changes to medication and changes to the person’s health and wellbeing, as appropriate.
- 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 lasting power of attorney for health and welfare (if one exists) should be sought, otherwise the decision will need to be made in accordance with the Mental Capacity Act.

4 Self-administration

- In line with the fundamental standards (particularly person centred care) and the NICE guidelines: Managing Medicines in Care Homes, people should be supported to take responsibility for their own medicines wherever possible if they wish to do so.
- On occasions a person may be able to exercise control over his/her medicines with some assistance from a trained and competent member of staff, for example

A person who has suffered a stroke and is unable to manipulate containers may choose to retain custody of their medicines and ask staff to assist at the time he/she chooses to take the medication.

Certain conditions such as asthma and angina require immediate access to medication to relieve symptoms, so self-administration of medication to treat these conditions should be encouraged.

A person may be able to safely manage the application of external creams but may elect to have staff administer tablets and other prescribed medicine.

This is not an exhaustive list, opportunities to maximise a person's independence should be taken whenever possible.

- Staff must carry out a robust risk assessment* with the person to assess their ability to self-administer their medication. It may also be appropriate to involve relevant healthcare professionals and family/carers.
- If a person is assessed as being able to self-administer their medication they should be asked to sign an agreement form* which details the arrangements. The person must agree that they will keep their medication secure at all times.
- If the person is to retain full control over their medication, including ordering and collection of the medication, then the home will need to keep an up-to-date record of the person's medication in their care plan. A MAR chart is not necessary.
- Where a person is only self-administering some of their medication, these medications must be included on the MAR chart and 'self-administering' written across the signature spaces for these items.
- A person who is self-administering their medication does not have to complete a MAR chart. They may choose to do so as an aid to remembering the medication, in this case a copy of the MAR chart should be provided for the person to keep and complete themselves.
- Where a person has requested that the home arranges the ordering and/or collection of prescriptions and medication, a trained and competent member of staff must keep a record of this to provide an audit trail. The record must contain the name of the person; the name, strength and form of the medicine; quantity of each medication ordered/received; the date of order/receipt and the signature of the member of staff. When the medication is given to the individual, staff must record the name of the person; the name, strength and form of the medication; the quantity given to the person; the date it was supplied and the signature of the member of the staff making the supply. *The MAR chart should be used to make these records against each medication the person is self-administering. A new MAR chart will be required for each cycle.*
- An agreement should be made with the person that allows nursing staff to monitor and review their ongoing ability to manage their medication. With the individual's agreement,

staff should undertake a 'stock take' of the person's medication with them on a regular basis, for example, when the medication is due to be reordered. The record of the quantity of medication received and supplied to the individual should be used to assess if the medication appears to have been taken as prescribed and to establish if the medication needs to be reordered. Monitoring of medication use should not unduly compromise the person's privacy.

- Staff should report any concerns regarding a person's ability to self-administer their medication to the registered manager/clinical lead.
- A lockable space must be provided in the person's room for the storage of medicines. This must be big enough to store all the medication appropriately (for example, bottles must be stored upright) and be accessible for the individual. Medication requiring cold storage will be stored in the home's secure medication refrigerator. Staff must ensure that the person can gain access to this medication on their request.
- It is the home's responsibility to ensure that the person understands that medicines must be kept safe and to ensure that this happens. If, despite discussion and the adoption of any reasonable measures which would allow the person to keep the medication securely, the person is unwilling or unable to do this, and the safety of other people living at the home is compromised, then the home may insist that they store the person's medication securely for them. This policy must be clear to the individual at the time they sign the agreement to self-administer their medication.
- Where people are self-administering insulin or any other medication with a syringe, a "sharps box" must be provided. These are available on prescription.
- To gain maximum benefit, medicines should always be taken at the prescribed times. Staff should reinforce the healthcare professional's advice on this. If a person is concerned about their medicines, a referral should be made to the GP or relevant healthcare professional.
- A person's ability to administer their own medication must be reviewed at least every six months, or sooner if there are concerns, and the review documented. Where necessary, a new agreement should be reached with the person if their wellbeing or safety, or that of other people in the home, is being put at risk by the current arrangements. This should include an assessment of capacity if it is felt this has changed. For people who are receiving respite care or those who are admitted for short stays the person's ability to self-administer their medication should be assessed on each admission.
- People should have the opportunity to involve others, such as family or friends, in discussions about their medication if they wish to do so.
- All discussions regarding medication should be handled sensitively.

5 Storage of medicines in the home

- The decision of where to store the medicines in the home should take into account the size of the home and nature of the medicines supplied to the home. Medicines could be stored centrally or in an appropriate locked cupboard in the person's room.
- Most medicines should be stored below 25°C and away from sources of heat and moisture. The directions on the product packaging, dispensing label or patient information leaflet should be followed regarding the storage conditions for each medication. Where staff are not sure, or there are problems with the storage, the pharmacist should be

contacted for advice. Examples of places **NOT** suitable for the storage of medicines include kitchens, bathrooms, toilets and sluices or next to heaters.

- All cupboards, trolleys and areas used to store or prepare medication 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.
- Medication must be date checked on a regular basis and out of date medication disposed of (see [section 19](#)). New supplies should be placed behind older supplies when medication is received, so that the older supplies are used first.
- Medicines for internal use must be stored in the locked cabinet/cupboard or trolley provided. Cabinets/cupboards used for medication storage must be of a robust construction, big enough to store the medication appropriately and have a good quality lock. If a trolley is used to store medication, it must be locked and tethered to a wall, or kept in a locked room to which only authorised staff have access, when not being used to administer medication. Adequate lockable storage must be provided at all times for all medication, including those supplied in a monitored dosage systems (MDS). This also applies to the new medication received at the change over period.
- Medicines for external use must be stored in a separate locked cupboard or physically separated from internal medicines on separate shelves in the main medicines cupboard.
- Medicines must be stored tidily so that it is easy to locate each individual's medication and to reduce the chances of it being mixed up with other people's medication.
- **The security of medicines must not be compromised by cupboards being used for non-clinical purposes, for example, storing money or valuables.**
- Pharmaceutical advice should be taken before any changes to storage arrangements are made.
- For storage of medication for a person who is self-administering their medication see [section 4 – self-administration](#).

5a. Controlled drugs

- Controlled drugs (CDs), that require safe custody and are not being self-administered, must be stored in a CD cabinet which meets the requirements specified in the Misuse of Drugs (Safe Custody) Regulations. The cabinet should be rawlbolted to a solid wall. If CDs are incorporated into a monitored dosage system then the whole system which contains the CD must be kept in the CD cabinet.
- People who are self-administering their prescribed CDs can hold their own individually dispensed supply of controlled drugs in their personal lockable, non-portable cupboard/drawer in their room.

5b. Medication requiring cold storage

- Medicines requiring cold storage must be stored in a dedicated, locked medicine refrigerator.
- The temperature of the medicine refrigerator must be monitored daily using the maximum and minimum thermometer and the maximum and minimum temperatures recorded*. The thermometer must be reset after each reading. The required temperature range is between 2°– 8°C.

- If the temperature of the refrigerator is found to be outside of the required range the following actions must be taken as a matter of priority:
 - A pharmacist must be contacted to obtain information on individual products as some of the medication may need to be destroyed and replaced. The advice given should be recorded, including the name of the pharmacist.
 - Medication which can no longer be used should be removed from stock and disposed of (see [section 19](#) for procedure to use). Arrangements for a new supply of the medication should be made with the relevant GP's practice as a matter of urgency.
 - Any medication that can remain in use should be marked with any shortened shelf life advised by the pharmacist. Where necessary, a different refrigerator, monitored the same way as the medicine refrigerator, should be used to store the medication until the reason for the temperature fluctuation can be identified and corrected.
 - Arrangements should be made to have the refrigerator checked and repaired or replaced as soon as possible.
- The refrigerator must be cleaned and defrosted regularly. This should be documented on the refrigerator records.
- A separate refrigerator may not be a requirement in small homes unless there is a constant need to refrigerate regularly prescribed medicines, for example, insulin. If a separate refrigerator is not provided, any short course of medication prescribed, that requires cold storage, must be secured in a locked receptacle in the home's refrigerator, segregated from other contents, to prevent unauthorised access. The refrigerator should be monitored as described for a dedicated medicine refrigerator.

5c. Keys

- The keys for the medicines trolley, cupboards, CD cabinet, refrigerator and clinical area must be kept separate from other keys and not part of the master key system. The person in charge of the medication on that shift must hold the keys. All medicine keys must be handed directly from one designated member of staff to the next designated member of staff and not left in a 'safe place' or given to anyone else for safe-keeping.
- Any spare keys must be stored in an appropriate secure place where only designated staff have access to them.

5d. Storage of oxygen

- **If a person is prescribed oxygen the home must discuss storage and administration with the engineer from the company who supplies the oxygen. Their advice should be documented and followed.**
- A risk assessment must be completed for the storage and use of oxygen, in line with health and safety procedures.
- Oxygen cylinders should be stored safely, under cover and not subject to extreme temperatures. This should be in a dry, clean, 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/area where oxygen is stored or used, stating

“Compressed gas. Oxygen: No Smoking. No naked lights.”

- 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 with a trolley specifically designed for the cylinder size unless it is a small portable cylinder.
- Oxygen concentrators must be stored upright and plugged directly into the mains socket. Adequate ventilation must be provided around the concentrator. They must always be switched off when not in use.
- In the case of fire, it is the responsibility of staff to inform the fire brigade that oxygen cylinders and/or concentrators are present and where they are located. When evacuating people from the home, oxygen concentrators or cylinders left in the home should be switched off, where it is safe to do so, as part of the evacuation process.

6 Record keeping

- The standard of record keeping should ensure that records are properly completed, legible and current and provide a complete audit trail of medication. All records relating to medication should be signed and dated by the member of staff making them.
- The records should be factual, clear, accurate and respectful. The person, or their nominated representative, may request to see the records, so they should be easily understood and avoid jargon or abbreviations.
- 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 staff changes.
- Records must be maintained of all medicines brought into the home, for which the home is responsible, from whatever source; all medicines administered; all medicines disposed of or transferred from the home and any medicines carried forward from one cycle to the next. Collectively these should allow the quantity of medicines available for each person to be easily determined at any time.
- Record keeping for a person who is self-administering their medication is covered in [section 4](#).

6a. Admitting a person into the home and medicines reconciliation

- When a person is to be admitted into the home, whether from their own home, following discharge from hospital, from another service provider or where a person already using the service is returning to the home following discharge from hospital, the procedure below must be followed.
- Before a planned admission to the home it must be made clear to the person/their representative or the hospital/other service provider that the following requirements must be met regarding the person's medication or admission to the home may be refused.
 - Sufficient current medication must be provided to allow the person to take their required medication whilst the home establishes a new supply. For short stay/respite the medication provided should be sufficient to cover the whole stay wherever possible.
 - Prescribed medication must be supplied in the container as originally dispensed by the pharmacy/dispensing GP 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 a planned admission it should be determined if the person requires medication to be administered by a specialised technique, such as via an enteral tube. If this is the case, to allow the admission to proceed, the home must ensure that sufficient nurses who have up to date training on the specialised technique are available to meet this need or that arrangements are made with appropriate healthcare professionals to meet the need on a temporary basis while training is undertaken.
- Before a planned admission an agreement should have been reached with the person, following a robust risk assessment*, on how their medication is to be managed at the home. Where this is not possible, this must be done as soon as possible after admission by the nursing staff.
- The admission process for medicines should be undertaken by a nurse.
- On the day of admission nursing staff should establish if they have available to them the information detailed in [section 22](#) of this policy. This should be included on hospital discharge letters or the information from another provider. If the person is coming from their own home this should be provided by the person or their representative or GP. If there are any gaps in the information, nursing staff should attempt to obtain the information from the relevant person.
- Nursing staff should establish at the time of admission when the next dose of medication is due so that arrangements can be made to ensure the person does not miss doses of medication while the admission process is occurring.
- Where an emergency admission has been agreed, the person or their representative should be asked to bring any current medication with them wherever possible.
- For all people entering the home, nursing staff must establish which medicines the person has brought with them and check each medication to establish that
 - The correct person's name is on the medication label
 - The expiry date of the medication has not passed
 - The medication has been recently dispensed. (If the date on the label is old this may indicate that the medication is no longer being used.)
- Wherever possible, the current medication should be confirmed by comparison with written information from the person's GP (for example, repeat slip) or from the hospital discharge information. Discrepancies between the written information and the medication brought into the home must be checked with the relevant healthcare professional. Where a person already living at the home is returning from a stay in hospital, the discharge information and medication should be compared with previous records of medication and any unexpected changes queried with the hospital.

Where written information is not available (for example, emergency admission) the nurse must contact the relevant healthcare professional (for example, GP or hospital) to confirm the medicines that the person is currently taking.

The nurse must document in the person's care plan any information received when contacting a healthcare professional including

- The medication details (name, strength and form)
- The directions for administration
- The name of the person contacted, their job role and the name 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.

- The receipt of all medication must be documented ([see section 8- receipt of medication](#)). Where staff are to administer the medication a MAR chart will be required ([see section 6b](#)). For people who are self-administering their medication see [section 4 – self-administration](#) for recording required.
- Nurses must ensure that arrangements are made with the person's GP to ensure the continuity of supply of the medication, where this is necessary. Where the person is changing doctors, the nurse should ensure that the person is registered with the new GP as soon as possible and should check with the new surgery if they have any registration processes, such as "new patient health checks", and if so these should be followed to ensure that care can be transferred smoothly.

6b. Medication administration record (MAR chart)

- There must be a MAR chart in use for each person where staff are administering all or some of that person's medication. See [section 4 – self-administration](#) for records required for people who are self-administering their medication.
- The MAR chart must include **all** medicines taken by the person (prescribed, homely remedy, the individual's own bought medicines or complementary medicines/supplements) and used to record the administration of all medication by staff. Blank MAR charts* should be available at the home.
- Medication which is administered by visiting healthcare professionals or medication which is administered at the doctor's surgery or hospital, for example, depot injections, must also be included on the MAR chart. The chart should clearly state who is responsible for the administration of this medicine.
- The responsibility for producing MAR charts lies with the care home. Many pharmacies will produce printed MAR charts where they are dispensing the medication for that person and, if available, this service should be used. Items which have not been dispensed by the pharmacy or items which are started/changed after the MAR chart has been produced will not be included and it is the responsibility of the nursing staff to update the MAR chart as necessary. Nursing staff are also responsible for creating a new MAR chart for people entering the home for the first time or coming to the home for respite stays.
- The pharmacy produced MAR charts must be checked by the nursing staff as part of the receipt of medication process. Nursing staff must inform the pharmacy of any discrepancies identified to allow the pharmacy to amend the MAR for the next cycle, for example, regular medication not included, discontinued medication not removed from the MAR.

- Where MAR charts are handwritten by the 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 all details have been entered correctly.
- For each MAR chart in use for an individual, the following details must be included:
 - The full name and date of birth of the person and their room number
 - Start date (including the year) and day of the MAR chart
 - Any known drug allergy or “no known drug allergy” as appropriate
 - GP’s name
 - Name, form and strength of the medication
 - The directions for use of the medication
 - Any precautions or special requirements relating to the use of the medicine
 - The quantity of any medication carried forward from the previous cycle
 - Date of discontinuation of medicines, if appropriate

Information regarding bought medication should be taken from the manufacturer’s packaging or patient 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 healthcare professional. [see [section 6d](#) for further information on changes of dose]

Each medication must be entered on the MAR chart individually even if the medication is supplied in a multi-dose monitored dosage system prepared and sealed in pharmacy. Where a medication is supplied in more than one strength or form, each strength or form must have its own entry.

- Charts should enable a running total of medicines to be maintained. This balance should be reconciled with actual stock on a regular basis, for example, at the end of cycle, and any discrepancies reported to the registered manager and investigated immediately.
- Each time a medicine is given the person administering the medicine must record this by placing their initials in the relevant space on the MAR chart for each specific medication. Records must be made at the time of administration, for each person, after visually witnessing the person taking their medication **NOT** at the end of the medication round or before the medication is administered.
- The MAR chart should indicate the time frame in which the medication should usually be given. This should be agreed with the person taking into consideration the directions on the label and the person’s lifestyle. Advice should be sought from the GP when necessary. If medication is administered outside of the agreed time frame for some reason then the actual time the medication is administered must be recorded as this may affect the timing of subsequent doses.
- For medication which has several doses in a day with a minimum time interval required between doses, for example, paracetamol containing products, the actual time the medication is administered must be recorded.
- If medication must be given at specific times (for example, Parkinson’s medication) this must be clearly indicated on the MAR chart. If it is not given at the correct time, the actual

time it is given must be recorded and the reason for the discrepancy explained in the person's care notes.

- If the medication is not administered for some reason a code must be used, which is explained on the MAR chart, to document the reason it has not been given. See also [section 21 - arrangements for short periods away from home](#) and [section 17 - refusal of medication](#).
- The MAR chart should also be used to indicate when medication which is only given infrequently is due, for example, medication given weekly or monthly *and to indicate the date of any blood tests due, for example INR tests for warfarin.*
- Information about the way the person prefers to take their medication, or specific support a person may need to take their medication, should be included with the MAR chart and in the person's care plan.
- Any available supporting information about allergies and the type of reaction experienced should be recorded in the person's care plan.

6c. When required and variable dose medication

- When a medicine is prescribed on a "when required" (PRN) basis the MAR chart must be supplemented by a protocol* which clearly describes the circumstances in which the "when required" medicine should be given. The protocol must include the name, strength and form of the medication; the reason the medication is prescribed; the directions for use; the maximum dose and interval to be left between doses (if applicable) and the expected effects of the medicine. Clear information should be included on how staff are to recognise that the "when required" medication is needed including non-verbal signs, where appropriate. The prescriber should be contacted for further information if necessary. The protocol should be written by the nursing staff, signed and dated, and kept with the person's MAR charts. The protocol should be reviewed by a nurse at least every 6 months, or sooner if circumstances change.
- The administration of the "when required" medication should be recorded on the MAR chart or by using a supplementary recording sheet*. The actual time that the medication is given must be recorded along with the staff signature. A running balance should be maintained for audit purposes. A record should **only** be made if the medication is given.
- When variable dose medication is prescribed (for example, give ONE or TWO tablets) it is essential that the actual dose given is recorded. This should be done on the MAR chart or, where considered necessary for clarity, a supplementary recording sheet* could be used. There should be a protocol in place, similar to that used for "when required" medication, which details how the dose to be given should be determined. The protocol should be written by nursing staff who should contact the prescriber for more information, if required. The protocol should be kept with the person's MAR chart. The protocol should be reviewed by a nurse at least every 6 months, or sooner if circumstances change.
- If a supplementary sheet is used to record "when required" or variable dose medication, this should be kept with the MAR charts. The main MAR chart should be annotated across the signature space with the instruction 'see supplementary sheet' so that all staff involved in the administration of medication use the same record.

6d. Changes in medication

- If a person's medication is changed the MAR chart **must** be updated by the nurse. The change must also be noted in the handover information so that it is passed on the next shift. Where necessary care plans should also be reviewed and updated to reflect the changes.
- The original entry on the MAR chart 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 detailing the change which has occurred and the name of the healthcare professional authorising the change. The nurse making the change should sign and date the entry. A corresponding entry should be made in the person's care plan.
- 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 nurse making them and checked by a second trained and competent member of staff who should also sign the record.
- Where the change is authorised by a healthcare professional visiting the home and a new prescription is not required, it is good practice to ask them to check and sign the amendments to the MAR chart or to write the information in the care plan to provide confirmation of the change in writing.
- If a verbal change of dose is requested by a prescriber, for example, during a telephone call, this should be fully documented on the MAR chart and in the person's care notes by the nurse taking the message, including the name of the authorising prescriber and date the change was made. Ideally, the verbal message should be repeated by the prescriber to a second trained and competent member of staff, if available. The prescriber should be requested to provide written confirmation of the change of dose as soon as possible.
- Text messaging regarding a person's medication must only be used in exceptional circumstances and only when the number the text is sent from is known to be that of a prescriber involved in the person's care. Staff must not use their personal mobiles to receive texts about a person's medication. The information received should be recorded in the person's care plan by the nurse receiving it and the entry should be checked by a second trained and competent member of staff to ensure it is correct. The entry should include the details of the text, the name of the prescriber sending the text, the number the text was received from and the date and time the text was received. Both members of staff should sign and date the entry. The MAR chart must be updated as necessary. The text must then be completely deleted from the phone. The prescriber should be requested to provide written confirmation of the change of dose as soon as possible.
- Any medication held by the home which has been discontinued by a healthcare professional should be disposed of in accordance with the home's policy. (see [section 19 – disposal of medication](#))
- The pharmacy/dispensing GP should be informed of any changes to the medication and asked to remove any discontinued medication from the next MAR chart, if appropriate.

6e. Creams/ointments and nutritional supplements

- When creams, ointments or nutritional supplements are prescribed an entry must be made on the MAR chart. The administration of these products must be recorded on the MAR chart, supplementary sheet*, or fluid chart as is most appropriate. If a separate record is used the MAR chart should be annotated across the signature space with a note

directing staff to the correct record so all staff involved in the administration of medicines use the same record. If the supplementary sheet is not kept with the MAR chart during the cycle, a note should also be made on the MAR to indicate where it is located.

- At the end of each cycle, the supplementary records should be collected and stored securely with the relevant MAR chart.

6f. Controlled drugs (CD)

- For medicines that are controlled drugs, and subject to CD recording requirements, the care home must also keep a separate CD register, in addition to the record on the MAR chart. 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 person. A running balance must be included in the register for each medicine.
- The CD register must be used to record the receipt, administration, transfer or disposal of CDs.

Nursing staff must ensure that

- The name, strength and form of each CD, as given on the dispensing label, is written at the top of the page along with the name of the person to whom the medication belongs. Each receipt, administration, transfer or disposal of the stated controlled drug for the named person must be recorded on this page.
- The receipt of the medication is recorded in the CD register on the day it is received into the home. The date of receipt, the quantity received and where the medication was received from should be clearly documented on the appropriate page. The nurse making the entry should sign it to provide an audit trail.
- The administration of each dose is recorded on the appropriate page of the register **as well as** on the MAR chart. The entry must include the date and time the dose is given, the actual dose given and the signature of the nurse administering the medication. Wherever possible, a second trained and competent member of staff should witness the process of selecting and administering the CD and also sign the CD register. (Only the nurse administering the medication should sign the MAR chart.) If, **in exceptional cases**, a second suitable member of staff is not available, the nurse administering the CD should double check themselves and make an entry in the witness signature space noting that a suitable witness was not available on that occasion.
- The transfer of any CD is recorded in the CD register and the appropriate transfer of medication documentation. This would include returning medication to the person or their representative on leaving the home; transfer to the person if they are self-administering their medication; transfer to another service provider or hospital. The record should be made on the appropriate page in the register and must include the date of transfer, the quantity transferred, the place or person it was transferred to and the signature of the nurse arranging the transfer. The transfer should be checked by a second suitably trained and competent member of staff who should also sign the register as a witness. See also [section 22 – transfer of medicines](#).
- The disposal of any CD is recorded in the CD register as well as in the medication disposal record. ([see section 19a – disposal of controlled drugs](#))

- The running balance for each CD is checked against the medication in the CD cabinet and updated when new supplies are received, administered, transferred or disposed of including zero balances where appropriate. Any discrepancies identified should be dealt with as detailed below.
- Any mistakes in the documentation in the CD register are amended by use of a signed and dated footnote or marginal note linked to the identified error. Crossings out, overwrites or deletions must not be made in the CD register. Correction fluid must not be used.
- An index is kept in the register and kept up to date. This should show the name of the person, the name, strength and form of the CD and the current page number of the record.
- When a page is completed the information is transferred to a new page and a note is made at the bottom of the completed page indicating the page number that the record has been transferred to. The first entry on the new page should be a dated and signed entry indicating which page the balance has been transferred from and the balance transferred. The index must also be updated.
- The balances in the CD register should be checked regularly by a nurse and a second trained and competent member of staff and reconciled with the actual medication in the CD cabinet. An entry should be made in the register on the appropriate page to indicate that a check has taken place.
- Any discrepancies found between the recorded balance in the CD register and the actual medication in the CD cabinet should be reported to the registered manager and investigated immediately. The MAR chart and medication disposal/transfer records should be checked to try to identify if the discrepancy is due to a documentation error. The running balance should be inspected closely to ensure that an inadvertent calculation error has not been made.

Where the discrepancy can be resolved an entry can be made in the CD register correcting the error. The entry should include a cross reference to any supporting documentation, the signature of the nurse making the entry and the date of the entry. The entry must be marked as being “retrospective”.

If no supporting documentation or information can be identified to resolve the discrepancy then the registered manager must consider reporting the incident to CQC. It should also be determined whether the incident should be reported to the police. If the incident is reported to the police CQC **must** also be notified using the appropriate form as advised by CQC. Where appropriate, the incident may need to be raised as a safeguarding alert and if so CQC **must** also be notified.

6g. Administration of medication by healthcare professionals

- Registered managers have a duty to ensure that appropriate medicines records are maintained. If district nurses or other healthcare professionals are involved in the administration of medicines at the home, they should be asked to sign the home’s records, as well as their own paperwork, to ensure that the home has a complete record of medication administered. If the medicine is a controlled drug the healthcare professional should be asked to complete the MAR chart **and** the controlled drug register.

- If the healthcare professional will not or cannot sign the home's records, staff should ask for access to the healthcare professional's own record of administration. This record should be photocopied and the copy kept with the relevant MAR chart. A code should be used on the MAR chart to refer to the healthcare professional's record.
- If the medication has been administered at a hospital or GP's surgery or similar, a code should be used on the MAR to indicate that the person has attended the appointment and the medication has been reported to have been given.

6h. Document retention and disposal

- Records must be retained securely in a place where only authorised staff have access.

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.

- Confidential records must not be disposed of with the normal waste. They should be shredded so that they cannot be retrieved or a confidential waste disposal company should be used.

7 Obtaining medicines

- It is essential that no person is without medication because it has not been ordered in time. All staff involved with the administration of medication have a responsibility to ensure that the nurse with designated responsibility for ordering medication (or their deputy) is informed via the handover procedure and direct communication if a person is running low on their medication so that it can be ordered in good time. If necessary, all staff involved in the administration of medication should be able to order immediately needed medication.
- Medication must be ordered by the home, this task must not be delegated to the supplying pharmacy/dispensing GP.

7a. Ordering procedure

- The medication must be ordered early enough in the cycle to allow for the time required by the surgery, pharmacy and home to complete their required tasks in the process.
- The regular order should be initiated by the nurse with designated responsibility for medicines or their deputy. The registered manager must ensure alternative arrangements are in place to initiate the order if the designated person is not available. At least two nurses must be able to order the medication using the home's procedure although the actual ordering can be done by one nurse.
- Dedicated time must be set aside for the regular order to be done without distractions.
- Before requesting any medication the current MAR chart should be checked for any medication which has been changed or discontinued. Current supplies of medication already at the home should be also be checked especially for "when required" medication; creams and ointments; inhalers and liquids. Only medication which will be needed next cycle and for which there is insufficient medication to last the length of the next cycle at expected usage levels should be ordered.
- The expiry date of medication should be considered as some medications have a short shelf life once opened. Also, "when required" medication which is used infrequently, for example, GTN sprays for angina, may go out of date before they are completely used. The

expiry date/shelf life of the medication must last to the end of the next cycle, if it does not the medicine should be reordered.

- Medication should be ordered by requesting it from the surgery using either the most up to date repeat medication slip or online ordering as instructed by the surgery. If a medication is required which is not yet on the repeat slip or online record a note should be sent to the surgery attached to the repeat slip or in the note space for online ordering. A record of the medication ordered must be retained by the home including any notes sent. The record must contain exactly what was ordered for each person, the date of the order and the initials (signature) of the nurse making the order.
- The home should make arrangements to see the prescriptions/dispensing tokens for the regular medication before they are dispensed. The prescriptions/dispensing tokens should be checked against the record of medication ordered to ensure that all items ordered have been prescribed and that any changes to medication made mid cycle are reflected in the prescription. Any discrepancies noted must be resolved with the prescriber.
- Staff should complete the declaration on the back of the prescription/dispensing token where necessary for any person who is unable to do this themselves. The prescriptions/dispensing tokens should then be submitted for dispensing.
- The nurse must alert the pharmacy/dispensing GP to any medication which is on the prescription/dispensing token which is not required that cycle so that it is not dispensed. The surgery should also be informed so they can update their records.

7b Mid cycle medication

- Care must be taken to ensure that medication prescribed mid cycle does not run out. Where the medication is to be continued long term the GP should be asked if they will prescribe a one off quantity which will bring the medication into line with the regular ordering cycle. The nurse should advise the GP of the quantity required.
- Until the medication can be brought into line, or where it is only intended to continue for a specified period of time, a running stock balance should be kept on the MAR chart and the medication reordered, if appropriate, when there are 14 days left. This should be done by the nurse with designated responsibility for ordering medication (or their deputy) wherever possible, but all staff administering medication must be aware of the stock balance and ensure that the information is passed to the nurse with designated responsibility for ordering medication when the appropriate time is reached. This must be done via the handover sheet and by direct communication with the designated nurse. Where this is not possible, the member of staff responsible for the administration of the medication must order the medication themselves and ensure that this communicated and documented clearly.
- If not already collected/received by the home, the order must be followed up no later than three working days, or sooner if necessary, after it is made to ensure that the prescription has been issued. The prescription should be checked against what was ordered and any discrepancies resolved with the surgery.
- Where medication is to be reviewed before continuing, it is the responsibility of the nursing staff to ensure that arrangements are made with the prescriber to review the medication before it runs out.

7c. Acute prescriptions

- Acute prescriptions are items which are prescribed in response to an illness, for example, antibiotics for an infection.
- The nurse should ensure that they check with the prescriber how the medication is to be taken and how long the course is to continue. Nurses must draw the attention of the prescriber to any allergies that the person has.
- It is essential that such medication is obtained as soon as possible after it is prescribed and this should be on the same day.
- The medication when received should be recorded on the MAR chart as given in [section 6b](#) and the receipt documented as in [section 8](#).

7d. Emergency supplies of medication

- In the event it is discovered that a person is without their medication, urgent action must be taken to establish a supply of the medication as soon as possible.
- The GP (or out of hours service, if necessary) should be contacted to request an urgent supply of the medication giving the reason why this is needed. Nursing staff must make arrangements to ensure that the prescription is dispensed as soon as possible. The pharmacy/dispensing GP should be contacted to explain the situation.
- In some circumstances, pharmacists are able to make emergency supplies of medication. This is at the discretion of the pharmacist and is not possible for all medication. There may be a charge for this which the home will need to meet.
- If the person will miss doses of their medication before it can be obtained, nurses should use their professional knowledge and judgement and take the advice of a relevant healthcare professional regarding the action to take. This may necessitate contacting the out of hours GP for advice or the duty pharmacy if the regular pharmacy is closed. If the nurse does not contact a relevant healthcare professional the reason should be recorded in the person's care plan. The nurse is professionally accountable for this decision. The person and/or their nominated representative should be informed of the situation, as appropriate to the person.
- The incident should be reported to the registered manager and investigated to establish why it occurred and to prevent reoccurrence in the future if possible.
- Where harm has been caused due to the lack of medication a safeguarding report will need to be raised with the local safeguarding team and CQC informed on the appropriate form.
- The incident must be fully documented in the person's care records.
- **This procedure must not be used to replace good ordering practices.**

8 Receipt of medicines

- All medicines received by the home for an individual, whether prescribed or purchased, from whatever source must be recorded by the nurse. The record must show
 - Date of receipt
 - Name, strength and form of medicine
 - Quantity received
 - Name of the person for whom the medicine is prescribed
 - Signature of the member of staff receiving the medicine

Care should be taken to include medicine brought in from the person's own home, discharge medicines from hospital and also medicines prescribed mid cycle.

- *The record must be made on the MAR chart in the designated space under each medication entry.*
- Where medication has been ordered by the home, the medication received must be checked against the record of medicines ordered. Any discrepancies, including unexpected changes or missing items must be resolved with the pharmacy/dispensing GP and the prescriber contacted, if necessary, to ensure continuity of supply.
- If the medicines received into the home differ unexpectedly from those received for the same person in the past, nursing staff must check with the pharmacist/GP's surgery/hospital as appropriate before administering the medication.
- See [section 6f](#) for the extra requirements for recording of the receipt of controlled drugs.
- A patient information leaflet (PIL) should be supplied with each medicine (including those supplied in monitored dosage systems) and these should be made available to the individual and staff administering medication. If a PIL is not supplied, please request this from the pharmacy/dispensing GP.
- The medication received must be stored in a locked cabinet, refrigerator or CD cabinet as appropriate. The new supply must not be left unsecured.
- Medication purchased by the home must also be recorded. See [section 11](#) for recording of homely remedies stock.

9 Labelling of medicines

- For staff to administer a prescribed medicine it must have a dispensing label attached by the pharmacy/dispensing GP containing the following information:
 - Person's name
 - Date of dispensing
 - Name, form and strength of medicine
 - The quantity dispensed
 - Directions for use
 - Precautions relating to the use of the medicine (if applicable)
 - Name and address of the place where it was dispensed.
 - Keep out of the sight and reach of children.

Other details may also be included at the discretion of the pharmacist.

- Where the directions state 'as directed' or 'as before' or similar phrasing nursing staff must contact the prescriber to clarify the directions. The full directions should be documented in the care plan along with the name of the healthcare professional providing them. The directions should also be written on the MAR chart and any supplementary chart in operation. The prescriber should be asked to write full instructions on the prescription so this can be included on the label by the pharmacy/dispensing GP for future supplies.
- In the case of multiple containers, each container must be labelled. If the medication is contained in several smaller containers within a labelled outer container, the small containers must be left in the labelled outer container. For medications which have an inner and outer box (for example, eye drops, inhalers, creams), the pharmacy/dispensing

GP should be requested to apply the label to the item instead of, or as well as, the outer container.

- If the label becomes detached from the container or illegible the prompt advice of the person who made the supply should be sought.
- The name of the person must not be written on boxes of prescribed medication in order to make them easier to identify in the cabinets/ trolley. Identification of the correct medication for each person must be by means of the pharmacy label.
- On rare occasions, it may be appropriate for nursing staff to add the name of the person to whom the medication belongs to an item in order to ensure that it is used for the correct person. For example, prefilled insulin pens which come in a labelled box containing several pens. In this instance, the insulin pen in use cannot be returned to the labelled box as the storage requirements are different.

Care home staff must never alter the labels of dispensed medicines.

10 The administration of medication

- Medication must only be administered by a registered nurse or a trained and competent member of care staff to whom the task has been delegated by the responsible nurse.
- Staff involved in the administration of medicines must only give medication which they are competent to administer.
- Medicines must be administered strictly in accordance with the prescriber's instructions. Nurses also 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 concerns.
- Medicines prescribed for one person must never be given to another person, or used for a different purpose.
- Medication must be administered in a way which respects the dignity and privacy of the person. The wishes of the person should be documented and complied with wherever possible.
- When medication is being administered distractions should be limited as far as possible. All staff should support the person administering medication in this by deferring questions and telephone calls etc. until after the medication administration process is complete, unless it is urgent that the incident is dealt with at that time. For example, the phone call is in regard to medication changes.
- When administering medication staff must
 - Wash their hands before administering the medicine
 - Read the instructions on the MAR chart including checking for any specific preferences/information for the individual
 - Check that the prescribed dose has not already been given or cancelled
 - Select the medicine required by reference to the MAR chart
 - Check the label on the medicine against the MAR chart entry. Where there is a difference satisfy themselves as to the dose to be given by referring to the care plan or the person's GP, as necessary
 - Ask the person if they want their medication, unless otherwise stated in the person's care plan

- Prepare the medication for administration double checking
 - The name of the person receiving the medication
 - The name, strength and form of the medication
 - The dose
 - The way the medication is to be administered
 - Check the identity of the person receiving the medication
 - Assist the person into an appropriate position, if needed.
 - Administer the medicine, offering a glass of water as appropriate.
 - Record the administration on the MAR, after visually witnessing the person taking the medication, by placing their initials in the correct space on the MAR chart or completing the supplementary chart, as appropriate.
 - OR
 - Record that the medication has not been taken by using an appropriate code which is explained on the MAR chart.
- The member of staff who removes the dose from the original container must personally administer it to the person.
 - 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.
 - Medication must not be removed from the original container in which a pharmacist or dispensing GP supplied it until the time of administration except in **very exceptional circumstances** following a robust risk assessment (see also [section 10a - left for later medication](#) and [section 21 - arrangements for short periods away from the home.](#))
 - Staff should not come into direct skin contact with a person's medication. Solid dose oral preparations should be directly transferred from the dispensed container into a small pot 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. Syringes intended for injections should not be used to measure oral liquids. Gloves should be worn for administering such items as creams, suppositories, pessaries and any other medications as determined by the responsible nurse.
 - 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 medicines are transported around the home it must be done in a secure manner, using a medicines trolley or locked box. It must be possible to quickly lock away the medication in the event of an emergency. The medicines trolley must be locked by the person administering the medication when they need to move away from it, for example, to administer the medication to a person.
- The time of administration must be carefully considered for each medication for each person. Advice from the GP or pharmacist must be sought if directions are not clear or if issues arise. Specific directions regarding taking the medication with or without food, or with other medication, must be adhered to even if this does not coincide with the medication rounds. Some medication must be given at specific times which should be specified on the dispensing label (for example, Parkinson's medication). It is essential that such medication is given on time. Where necessary, a list of medication which is to be administered outside of the usual medication round times should be kept as a reminder for staff. See also [Section 6b – Medication administration record](#)

10a Left for later medication

- In general, medication must not be left for the person to take later unsupervised; however, there may be **exceptional circumstances** where a person requests that staff do this.
- A risk assessment must be completed which considers the person's willingness and ability to keep the medication secure, the length of time the medication will be left before they take it and whether they will actually take the medication. All possible options must be discussed with the person, for example, giving night time medication at a later time. The outcome of the assessment must be documented in the person's care plan.
- If it is agreed that the person's medication can be left for later self-administration, the medication should be selected by a trained and competent member of staff and left for the person to take as agreed in the care plan. The member of staff must not sign the MAR chart as they will not be able to confirm that the medication has been taken. A code should be entered on the appropriate space on the MAR chart and defined at the bottom of the MAR chart to indicate which medication has been left for later.
- Under no circumstances should medication be left for a person to take later unsecured in shared areas of the home, for example, medication should not be left in a medicines pot on the dining room table.
- The arrangement must be reviewed at 6 monthly intervals or sooner if circumstances change.

10b When required medication and variable dose medication.

- Medication prescribed "when required" should be administered in accordance with the needs of the person within the directions given by the prescriber. This may not be at the usual medication administration times. Staff should be aware of the protocols (see [section 6c](#)) for "when required" medication and be alert for indications that they are needed. It is essential that recording the administration of "when required" medication is done as given in [section 6c](#).
- Before administering "when required" medication it is essential to check when the last dose was given to ensure that there is an appropriate interval between doses.

- Variable dose and “when required” medication should be supplied in original packaging and not part of a monitored dosage system.

10c Anticipatory medication

- There may be occasions where a person is prescribed medication which is only to be started in specific circumstances, for example, people who are nearing the end of life, people prescribed antibiotics and/or steroids for recurrent severe chest infections due to an underlying medical condition.
- If a person has such medication, there must be an accompanying management plan, provided by the healthcare professional, which covers the use of this medication. A record should be made in the person’s care plan that the person has anticipatory medication prescribed. The medication should be stored in the locked medication cabinet but it should be clear that this medication is only to be used in accordance with the agreed plan.

11 Use of homely remedies

- There is a recognised duty of care to be able to make an appropriate response to symptoms of a minor nature, for example, toothache. A decision may be taken by a nurse, using their professional judgement and in accordance with a homely remedies policy, for minor ailments without necessarily consulting the person’s GP.
- The homely remedies policy* lists the conditions for which homely remedies can be used and which medicines can be used. A copy of the homely remedies policy should be kept with the MAR charts. The homely remedies policy must be agreed with the GPs who have patients living at the home before homely remedies can be used for people who are that GP’s patients. Any exceptions for individuals should be documented in the person’s care plan.
- Nurses who are willing to administer homely remedies should sign the record sheet* to declare that they are competent to do so and acknowledging that they are accountable for their actions.
- If a homely remedy is given, it must be administered from the original packaging as purchased from the pharmacy and in accordance with the dosage instructions on the packaging or patient information leaflet. The administration must be recorded on the person’s medication administration record (MAR) chart.
- Care should be taken to ensure that any homely remedies given are not contra-indicated and do not interact with the person’s prescribed medication, nurses may wish to liaise with the supplying pharmacist.
- Homely remedies must not be given for periods of longer than 48 hours without referral to the GP.
- Homely remedies must be stored securely in a locked medicines cupboard, separate from prescribed medication.
- Medicines used as homely remedies must be purchased by the home for that purpose and must not be labelled for individuals. Medication which has been prescribed for an individual must not be used as homely remedies stock.
- An accurate record of stock* must be maintained for all homely remedies. Each homely remedy must be recorded on a separate page. The record must include the full details of the medication, the date it was received/disposed of and the quantity received/disposed

of. Each administration should be recorded on the homely remedies record, including the date and quantity administered and the name of the person to whom it was administered, as well as completing the person's MAR chart. A running record of the stock balance should be maintained. A stock check, including checking the expiry date of the medication, should be carried out at the end of each medication cycle and the quantities reconciled with the running balance. Any discrepancies must be investigated immediately. The stock check should be documented on the record of homely remedies stock. Each entry should be signed by the person making it.

12 Bought medication.

- A person who is self-administering their medication who wishes to buy their own remedies for minor ailments or to use complementary medicines or supplements should be encouraged to speak to a pharmacist or GP to ensure that there are no interactions between the bought medication and their prescribed medication. For the documentation and storage of the bought medication see [section 4 – self-administration](#).
- Where a person requests that staff administer a bought medication (including alternative or complementary therapies), the nurse should discuss this with the GP before administering any doses. The discussions must be recorded in the person's care plan and signed and dated by the nurse making the record. Administration of these medicines must be recorded on the person's MAR chart. (see [section 6b – medicines administration record](#))
- These medicines are the property of the person and are not part of the homely remedies policy. They should only be used for the person who has requested and purchased them. They should be stored in the locked medicines cabinet/trolley with the person's prescribed medication.
- As with homely remedies, these medications must only be administered in accordance with the directions on the packet or patient information leaflet from the original container as purchased. In no circumstances should more than the stated dose be administered.

13 Administration of medication using specialised techniques

- For medication which is administered via a specialised technique, for example, via enteral tubes or syringe driver, the nurse must have up to date, documented training on that method of administration. Nurses must only administer medication by routes in which they are competent.
- A record of any training should be kept in the employee's personnel file.
- Nurses can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so. Nurses **must** inform the registered manager if this is the case. Further training and development opportunities should be provided where appropriate.
- Where medication is to be administered by a method not covered in the patient information leaflet, such as via an enteral tube, the prescriber should be asked to confirm in writing that medication should be administered by this method, for example, by adding 'via enteral tube' to the prescription. Advice should be sought from a pharmacist and documented, on the specific procedure to be used for each medication.

14 Administration of emergency medication

- Emergency medication is medication which is required to be administered urgently to control the rapid decline of a person's condition or in a life threatening situation. Examples include the administration of buccal midazolam to stop seizures and adrenaline by injection in severe allergies.
- The healthcare professional initiating the medication should provide a health care plan which details of the name, strength, form and dose of medication to be administered and the route of administration; the circumstances in which the medication should be administered; details of the expected outcome of the medication administration; what to do if the medication does not work or cannot be administered and what further steps may be required if the medication is administered successfully. This plan will be specific for the individual. It should be included in the person's care plan and be available to all staff who may need to administer the medication.
- Where the emergency medication is administered via a specialised technique then the procedure in [section 13](#) will also apply and must be followed.
- If the administration of an emergency medication is to be delegated to a member of care staff they must have received appropriate training and been assessed as competent by the delegating nurse including the use of any invasive or specialised routes of administration, if appropriate.
- Written consent for staff to administer emergency medication must be obtained from the person. If the person lacks capacity to give consent, the person with lasting power of attorney for health and welfare (if one exists) should be consulted or a best interests decision should be made, in accordance with the principles and processes of the Mental Capacity Act. It is important to establish consent before the medication is needed, as due to the nature of the emergency the person may not be able to give explicit consent at the time the medication is needed.
- Wherever possible the home will have sufficient staff on duty who are able to administer the emergency medication if needed. **In the event that there is no suitably trained member of staff available to administer the medication the emergency services must be called.**
- A robust risk assessment must be undertaken for each individual requiring emergency medication to establish the most appropriate storage and transport requirements for the medication when at the home and when away from the home.
- Every attempt must be made to respect an individual's dignity and privacy when administering emergency medication especially if in a public place. If the situation is immediately life threatening, the emergency medication should be administered, within the criteria set by the doctor, whilst providing the maximum privacy possible. In other circumstances staff may need to decide if calling the emergency services or going to the nearest accident and emergency department would be more appropriate.

15 Concerns about a person's health.

- If there are any concerns raised regarding the person's health (including concerns about possible side effects from medication) the nurse on duty should assess the person and contact the GP or out of hours service, as appropriate. Nurses may choose to treat minor ailments in accordance with the homely remedies policy – see [section 11](#). The wishes of the person should be taken into account.

- A record must be made in the person's care plan including the problem identified, the action taken and the advice and name of the healthcare professional contacted. The record should be signed and dated by the nurse making it.
- Where agreed by the person, their nominated representatives should be informed if a person is unwell or has suffered side effects from a medicine. For a person without capacity, the person with lasting power of attorney for health and welfare should be informed (if one exists).
- Information on side effects of a medication can be found in the patient information leaflet supplied with the medication and can be checked by staff or the person themselves.
- Nurses should report adverse drug reactions to the MHRA via the yellow card scheme.

16 Medication review

- It is the responsibility of the person's GP to ensure that an appropriate medication review occurs on a regular basis. The review may not always be conducted by the GP themselves.
- If the home has no record of a review of the medication occurring within the previous 12 months, the GP should be contacted to ask if a review would be appropriate. The response of the GP should be documented in the person's care plan.
- Relatives or nominated representatives should be included in the review if this is wished by the individual. If there is a person with lasting power of attorney for health and welfare for a person without capacity then they should be invited to the review.
- If the person requires support with medication, a nurse able to provide appropriate information to the healthcare professional undertaking the review should be available. (See also [section 3 – confidentiality and sharing of information](#))
- The review may also include other healthcare professionals relevant to the person's care (multidisciplinary review). This will be decided by the person leading the review.
- The date of the review and the name of the healthcare professional undertaking it should be recorded in the person's care plan. Any outcomes from the review should also be documented and actioned updating any care plans and the MAR chart if necessary.
- Nurses working at the home should also keep a person's health and welfare under review and seek the advice of the GP where appropriate.

17 Refusal of medicines 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 short time before going back to the person and re-offering the medicine. If the person still refuses to take their medicine, this must be recorded on the MAR chart, using the 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 also be documented in the care plan. 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) this does not need to be documented on the MAR chart; however, 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 any medication. This may help in assessing potential options regarding the medication.
- If a person is having difficulty swallowing their medication, or wishes them to be administered other than whole capsules or tablets, 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. This must include the person's GP and any person with lasting power of attorney for health and welfare (if one exists) as a minimum.

The best interest's decision must include whether the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) also apply. The decision reached and reasons for it should 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 administration of 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.
- Nurses should be aware that crushing tablets, opening capsules or placing medication in food or drink often means the medication is being administered via an off-label route and the nurse will be professionally accountable for this. It is essential that the appropriate advice is sought and documented regarding the method of administration.

18 Management of medication errors and incidents

- It is recognised that, despite high standards of good practice and care, mistakes may occasionally happen. 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. For registered nurses this will include referral of the incident to the Nursing and Midwifery Council.

- In the event that a medication error or incident has occurred the procedure below must be followed:
 - Ensure the person is safe
 - Nurses should use their professional judgement and knowledge, including available reference resources, to assess the person and the potential consequences of the error or incident. The nurse should contact the GP/out of hours service and outline what has happened. The instructions should be confirmed with the GP/out of hours service and followed, including any monitoring required. The instructions should be recorded in the person's care plan and include the name of the healthcare professional spoken to and the time and date the conversation took place. If the nurse does not contact the GP/out of hours service, the reason should be documented in the person's care plan. The nurse is professionally accountable for this decision.
 - Explain to the person, in a manner appropriate to the individual, what the error was and any possible side effects. Apologise for the error and provide support and reassurance for the person.
 - 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.
 - Report the incident to the registered manager.
 - Where a person has been assessed as lacking capacity, the person with legal authority to act on behalf of the individual concerned must if informed if one exists, for example, a person with lasting power of attorney for health and welfare. 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.
 - The error must be recorded in the person's care plan, in detail. The information should also be passed over at shift changes.
 - If the error is the administration of the wrong person's medication, ensure that the person who should have had the medication has had their correct medication and that arrangements are in place to obtain replacement medication for this person to replace the dose(s) wrongly given to a different individual.
- An incident record must be completed and an assessment of how the incident occurred undertaken by the registered manager and the member of staff concerned and documented. Any actions identified to prevent reoccurrence should be put in place.
- Consideration should be given as to whether a safeguarding alert needs to be raised with the local authority regarding the incident.
- 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 a safeguarding alert must 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.
- Consideration must be given to the need for further action in relation to supporting the member of staff involved. This will depend on the nature of the incident and could include for example: providing extra training, reassessment of competence, whether there is a need to stop the person from undertaking medication duties and/or suspend them from all duties. This should be done within the bounds of relevant employment law. In cases of negligence or repeated poor practice by a registered nurse, referral to the Nursing and Midwifery Council may be necessary.
- 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.

19 Disposal of medicines

- The home has a duty of care to ensure that all waste is disposed of safely. This includes disposing of medicines safely.
- Medicines that are no longer required, including refused and dropped/damaged doses of medication, should be disposed of via a licensed waste handling company. Medication may no longer be required because the expiry date is reached, treatment is completed or discontinued or the person dies. Bought medication (whether homely remedies stock or a person's own) should also be disposed of via the licensed waste handling company when no longer required.

Medication such as liquids, creams, inhalers and "when required" preparations which are still in use **must not** be disposed of at the end of the 28 day cycle if they are still within their expiry date. The balance must be carried forward onto the new MAR.

- **Following the death of a person the medicines must be retained for at least seven days in case the Coroner's Office requires them.** In the case of an active investigation the Coroner may request that medication is kept for longer periods. Such medication should be kept securely, separate from in use medication, clearly marked as 'Retained at Coroner's Request' until permission is given to dispose of the medication. If the medication is requested to be given to the Coroner's Court or police as part of the investigation, a complete record of the medication transferred must be kept at the home.
- All medication disposed of (including doses left in the MDS system) must be recorded to ensure a fully accountable system.

The record of disposal must detail the following:

- Date of disposal
 - Name, strength and form of medicine
 - Quantity disposed of
 - Name of the person for whom the medicine was prescribed
 - Reason for disposal
 - Signature of the nurse arranging the disposal.
 - A second nurse or suitably trained and competent member of care staff should check the record and sign as a witness.
- Medicines should not be removed from the packaging for the purposes of disposal. For example, liquids should be disposed of in the bottles (ensuring that the bottle will not break); solid dosage forms should be left in the blister packs. It is acceptable to remove the outer cardboard packaging or the reusable components of a MDS system. Controlled drugs can be removed from all packaging for denaturing. Any information which could identify the person whose medication it is should be removed or deleted before placing in the medication waste bins.
 - Waste medication must be stored in a locked cupboard, separated from the medication in use, in the waste medication bins provided by the licensed waste handling company.
 - Some medicines are classed as hazardous waste and nurses should ensure that waste medicines are segregated correctly. Advice should be obtained from the licensed waste carrier, documented and followed. Where necessary, depending on the total volume of all hazardous waste produced (not just medicines) homes may need to register as a hazardous waste producer with the Environment Agency. Information should be obtained from the Environment Agency.
 - Waste medicines transferred to the licensed waste handling company must be accompanied by the appropriate waste transfer note or waste consignment note, as appropriate. The home must retain copies of this documentation for at least two years for a waste transfer note and three years for a waste consignment note. It is the home's responsibility to ensure that the documentation is completed correctly but advice should be sought from the licensed waste handling company.
 - Homes should conduct (or have in place) a pre-acceptance waste audit which includes information regarding waste medicines. This must be renewed every five years. The home should also conduct an internal annual audit to ensure the requirements are being met and identify any changes.
 - It is the responsibility of the home to ensure that waste disposal requirements are complied with. Further advice can be found in the Department of Health document: Environment and sustainability. Health Technical Memorandum 07-01: Safe management of healthcare waste.

19a Disposal of controlled drugs

This advice relates to controlled drugs which are dispensed and labelled for an individual. If the home holds stocks of controlled drugs please contact the Medicines Management Social Care Support Team for advice as an authorised witness is required for disposal of such CDs

- When a CD is disposed of, a record must be made in the home's record of disposal and, where the CD is included in the register, the CD register must be also be updated.

- The record in the CD register must be made on the page which details the name, strength and form of the medication being disposed of for the correct individual. It must state the date the medication is disposed of and the quantity disposed of. It is essential that the running balance is updated to reflect the destruction of the CD, including zero balances where appropriate.
- Disposal must be undertaken by a nurse and a trained and competent member of staff both of whom must sign the entry detailing the disposal of the CD.
- Prior to destruction controlled drugs requiring safe custody must be stored in the CD cabinet, separated from the medication in use, and clearly marked as “awaiting disposal do not use”.
- Before transfer to the licensed waste handling company the medication should be denatured using a CD denaturing kit purchased for that purpose. The directions on the kit should be followed. Depending on the kit used, there may be a time period required to denature the CD completely. The kit should be stored in the CD cabinet until denaturing is completed. If the nurse is unsure of how to dispose of a specific controlled drug the advice of a pharmacist must be sought and documented.
- The home should have a T28 exemption registered with the Environment Agency for this activity. Advice should be obtained from the Environment Agency.

20 Arrangements for people in short term care

- The principles and standards for the care and control of medication for people receiving short term care are the same as for people in receipt of longer term/permanent care. Therefore, all aspects of the home’s procedures need to be followed.

People coming into the home for respite care should be actively encouraged to continue to self-administer their medication if they are doing so at home. This will help maintain the person’s independence and control over their medication. Staff should use the opportunity to assess how the person is managing their medication. Any concerns should be raised sensitively with the person and their GP.

21 Arrangements for short periods away from the home

- The home has a duty to ensure that a person has access to their medication when they will need to take it when they are away from the home, for example, attending day care services or on a social outing with relatives.
- The trained and competent member of staff who is arranging the transfer of medication should establish who will be responsible for the medication whilst the person is away from the home. This could be, for example, the person themselves (following a robust risk assessment), a representative or staff from another service such as day care.
- The supply as originally dispensed by the pharmacy or dispensing GP, whether in traditional packaging or monitored dosage system, should be transferred to the person who will be responsible for the medication whilst the individual is away from the home. If the medication is in a monitored dosage system, the member of staff arranging the transfer should ensure that the person who will be responsible for the medication knows how to use the system correctly and should document in the person’s care plan that they have provided this advice.

- The member of staff must keep a record of the details of the medication transferred, including the name of the person; the name, strength, form and quantity of the medication transferred; the date of the transfer and who the medication was transferred to.
- Where the person has regular planned absences, such as attendance at a day care service, it may be appropriate to contact the GP to establish if it is possible to move the timing of the dose to avoid administration whilst away from the home or if another medication may be available which does not require administration at that time.
- If the dose must be taken whilst away from the home, the pharmacist/dispensing GP could be contacted to ask if a separate supply is possible to cover the times the person is away. If this is not possible the original dispensed supply should be used.
- In **exceptional circumstances only and following a robust risk assessment**, it may be necessary to place an individual dose of medication (for example, the lunchtime dose) into a daily compliance aid. Such arrangements remove an important safety element of being able to check the dispensing label at the time of administration and there is a risk of making an error in selecting the medication. However, in some circumstances these risks may be less than those of providing the full quantity of medication in the dispensed packaging.

Such exceptional circumstances may include:

- Where a person could safely take responsibility themselves for individual doses of medication when away from the home if placed in a compliance aid, but is not able to manage this if the full quantity in the original packaging was supplied.
- Where the person, or person who will be responsible for the medication whilst away from the home, is unable to access the medication from the packaging as supplied by the pharmacy or does not understand the monitored dosage system in use.
- Where having the full quantity of medication may present a risk to the person or there is an established risk that the medication will not be returned at end of the period away leaving the person with no medication.
- The advice of the pharmacist should be sought and documented to confirm that the medication will be stable in the compliance aid for the time it is to be stored there.
- The compliance aid should be specific to the individual, robust and closable to prevent medication falling out.
- The individual (or the person responsible for the medication whilst away from the home) should be advised to keep the medication secure and to return the compliance aid to staff on return to the home.
- Where possible, the person themselves should be involved in transferring the medication to the compliance aid with the support of a trained and competent member of staff. Otherwise, a nurse and a second trained and competent member of staff should prepare the compliance aid with the second member of staff checking each action.

- Nurses should ensure that the compliance aid is labelled appropriately to the same standard as a pharmacy label as described in the NMC Standards of Medicines Management – standard 16.
- If staff from the home are accompanying the person and responsible for the medication, they should select the correct medication themselves and prepare the compliance aid with the support of the nurse, as appropriate. The staff member should carry the medication securely and on return to the home complete the MAR chart. Staff who need to administer medication when away from the home should have appropriate training to allow them to do this safely.
- Any such arrangements must be agreed with the registered manager and the person whose medication it is and documented in the person’s care plan.
- Staff must not sign the MAR chart for medication which they have not administered. A code must be used, which is explained on the MAR chart, to indicate what has happened, for example, “medication taken on social leave”.
- The member of staff arranging the transfer of medication must ensure that the person who will be responsible for the medication has accurate, up-to-date information regarding
 - The name, form and strength of the medicines taken with them
 - Clear directions and advice on how and when the medication should be taken and what dose to take
 - The time of the last dose and time that the next dose is due for the medication taken with them
 - A contact number for the home/GP regarding queries about the medication.
- A copy of the current MAR chart and any relevant supplementary charts should be provided to the person who will be responsible for the medication and the member of staff arranging the transfer should ensure that this person knows how to obtain information from the chart.
- A trained and competent member of staff must check on the person’s return to the home that any medication which needs to be returned has been received and they must record the quantity of each medication returned back to the home.
- Any doses which should have been taken whilst the person was away from home but have not been taken should be recorded in the person’s records and disposed of in accordance with [section 19](#). The advice of the GP should be sought by the nurse on duty regarding the missed medication, as appropriate.

22 Transfers of medication to new provider or hospital

- When a person transfers to a new provider or to hospital the following information must be sent with them by a trained and competent member of staff.
 - The person’s details, including full name, date of birth, NHS number (if known), address and weight, where appropriate (for example, frail older people)
 - GP’s details
 - Details of other relevant contacts defined by the person and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)

- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced where known
- The medicines the person is currently taking, including name, strength, form, dose, timing and frequency and how the medicine is taken (route of administration)
- Changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- Other information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine (adherence support)
- A copy of the current MAR chart and any associated supplementary charts/protocols should be sent to provide the details of the current medication.
- The home must keep a complete record of the medication transferred.

The record must include

- Date of the transfer
- Name, strength and form of medicine
- Quantity transferred
- Name of the person for whom the medicine was prescribed
- Where the medication was transferred to.
- Signature of the member of staff who arranged the transfer of the medicine.
- Where appropriate, signature of a second member of staff witnessing the transfer

This record should be made on the person's MAR chart. If the medication is a controlled drug entered in the CD register, the transfer must be recorded in the CD register also (see [section 6f-controlled drugs](#))

23 Drug alerts and safety warnings.

- These are sent via e-mail and the home must ensure that Medicines and Healthcare Products Regulatory Agency (MHRA) has the correct e-mail address.
- E-mails must be checked daily by the designated person and on the receipt of a safety warning/drug alert the e-mail should be printed out and the nurse on duty should check if there is any stock of the named medicine/medical device within the home.
- The advice on the safety warning/drug alert must be complied with and the actions taken recorded. This could include removing any affected medicine or medical device from use. Where necessary, the nurse should make arrangements for a replacement supply of medication.
- Where the drug alert requires the batch number of a medicine to be checked, this should be done. If the batch number of a medicine is not available at the home, the advice of the supplying pharmacist/dispensing GP should be sought.
- If there are no medications/medical devices specified in the notification at the home, this must be recorded on the safety warning/drug alert along with the nurse's signature and the date and this should be placed in the appropriate file.
- Drug alerts/safety warnings should be kept for two months from their date of receipt or to the date specified on the alert.

24 Complaints and concerns

- The home 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.
- People living at the home 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 home's complaints procedure must be given to the person and/or their nominated representative when the person moves into the home 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 should be kept by the home, 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.

25 Training

- Medicines must only be administered by registered nurses or by designated and appropriately trained staff who have had their competency assessed and to whom specific tasks have been delegated. The registered manager is responsible for ensuring arrangements for training staff are in place and ensuring that regular reviews of competency are carried out. The delegating nurse is responsible for assessing the competency of the care staff to whom a task is delegated. Regular reviews of competency should be undertaken at least annually or more frequently, if necessary. Nurses must keep their skills and knowledge up to date and should provide evidence of ongoing professional learning and development.
- As part of the induction training, new care staff members will be informed that they cannot administer any medication until they have received training and had their competency checked for the tasks to be delegated to them by the responsible nurse.
- Newly appointed nurses must receive training on the use of the medication administration system used in the home and the documentation and recording used at the home.
- All staff administering medication, including care staff to whom specific tasks have been delegated, will need to have read and understood the homes medication policy and

procedures. Staff should sign the [signature record sheet](#) to indicate that they have read and agree to comply with the medication policy and procedures.

- The home will provide regular refresher training for staff in order to ensure that skills are up to date and reflect current best practice.
- The home will provide up to date reference sources including the following:
 - A copy of the Handling of Medicines in Social Care RPSGB 2007
 - A copy of CQC Guidance for providers on meeting the Regulations
 - A copy of the NICE guidelines: Managing Medicines in Care Homes.
 - A copy of the current BNF or access to the online version of the BNF.
 - A copy of the NMC Standards of Medicines Management

26 Audit

- Regular audits* should be carried out by the registered manager, or an appropriate person nominated by the registered manager, to ensure that processes for medication management are being followed correctly including documentation and recording, and storage of medication.
- The documentation should be used to check that the physical amount of medication held by the home matches that given by the records. As a minimum, the medication for 10% of the people living at the home should be checked every three months. If discrepancies are identified these should be investigated immediately.
- If problems are found, audits should be carried out more frequently. The number of people whose medication is audited should also be increased. This should continue until the home can demonstrate that the problem has been resolved.
- Where a discrepancy is found in the audit that indicates that a medication error has been made which has not been previously identified the procedure in [section 18](#) should be applied. If the error is not recent and there are no current urgent concerns about the person's health there may be no need to contact the out of hours GP; however the person's GP should be informed as soon as possible.

Signature Sheet

I have read and understood the safe handling of medicines policy and procedures and will administer medication in accordance with this.

Date	Name of staff	Staff signature