Support with Medication Procedure

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To be issued to: (check as needed)	
☐ Board of Management ☐ All Staff ☐ ET/SLT ☐ Head Office Managers ☐ Head Office Staff ☐ Finance ☐ Housing ☐ Asset ☐ ICT	☒ OD ☐ Compliance ☐ All Care & Support ☒ C&S Managers (RM,OM, CSM) ☒ C&S Staff ☐ Contractors ☒ Agency Staff ☐ Unite the Union ☐ Employee Voices Group ☐ Other: _____
Method of Delivery (check as needed)	
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Version Control

Date	Owner	Version	Reason for Change
Aug 2024	Lesley McDonough	9.0	Provide emphasis on quality assurance processes
May 2023	Lesley McDonough	8.0	Cyclical Review
Feb 2022	Lesley McDonough	7.2	Further clarity regarding staff actions

Summary of Changes

Section	Change
6.0	Provided more explicit detail as to how often Care and Support Managers should be auditing an audit. Included that the audit is on AIMS and that photographs of MAR's are required to be legible.
14.0	Updated to reflect that only qualified medication assessors can undertake competency assessments with staff.
16.0	Included how quality assurance processes will feed into the on-going review of this procedure.

Support with Medication Procedure

Contents

1.0 Introduction

Care & Support teams providing any level of support to an individual in the management of their medication must refer to this procedure and its associated policy.

A supported person, or their legal representative, must request and consent to support with medication. Care & Support Managers (CSM)/Operations Managers (OM) must be clear that the support provided is an assessed need, with legal powers in place as required.

Ark must balance the right of an individual to manage their own medication as they see fit, with our responsibility to protect them from harm and abuse.

This procedure is designed to be flexible, reflecting the variety of ways Ark supports individuals with medication. CSMs/OMs must identify and implement the relevant sections of the procedure that apply to the service(s) for which they are responsible.

There may be circumstances where supplementary advice or guidance is required for Care & Support staff; for example, specifying who is a 'designated staff member' for specific tasks. It is the responsibility of the relevant CSM/OM to put this in place, subject to the approval of their Regional Manager or the Assistant Director (Care & Support).

1.1 What is meant by 'medication'?

We use the term 'medication' to cover:

- Over-the-counter (OTC) medicines; available without prescription and used without the supervision of a pharmacist. This includes common cold and pain relief medicines. OTC medicine suitable for use by the supported person must be agreed by their GP;
- Pharmacy (P) medicines; available without prescription but used under the supervision of a pharmacist. These medicines can only be obtained after the pharmacist has checked their suitability for use by the supported person;
- Prescription-only medicines (POM); only available when prescribed by the GP or other relevant medical professional;
- Items administered by injection or other invasive procedure.

2.0 Consent and capacity

Care & Support staff may only provide support with medication if the individual has consented to this. Supported people can consent to this unless they have been assessed as lacking capacity under the **Adults with Incapacity (Scotland) Act 2000**.

If the individual does not have capacity, their GP or relevant medical professional must authorise medical treatment through issuing an s.47 certificate.

An individual may also have a welfare proxy; a welfare guardian, welfare power of attorney, or a holder of an intervention order. An s.47 certificate must still be in place in addition to the consent of the proxy (see: **Appendix 1 – s.47 advice note**) in order for Ark to provide support with medication.

If an individual is not able to share their medical information when required (for example; making a doctor's appointment or seeking advice from a pharmacist) the welfare proxy can consent to Ark doing this on the individual's behalf. Alternatively, where there is no welfare proxy in place, an s.47 certificate must be issued by a relevant medical professional to authorise Ark doing this for the individual.

2.1 Covert medication

'Covert' medication means the administration of any medical treatment in a disguised form; usually by mixing with food or drink. The individual is unknowingly taking the medication as a result.

Covert medication is **not**:

- Giving medication mixed with food or drink to make it easier for the individual to take when they have given consent for this to happen;
- Giving medication via nasogastric tube / PEG feeding.

Covert medication should only be considered if the individual actively refuses medication but lacks capacity to understand the consequences of this and the treatment is necessary for their physical/mental health.

The medical professional primarily responsible for the individual's medical care should decide on the use of covert medication, with input from other relevant people (for example, staff, family, social worker, welfare guardian). The use of covert medication must be authorised by an s.47 certificate.

A covert medication pathway **must** be provided by the GP and stored in the individual's electronic Good Life documentation as well as a copy accessible to staff who will be responsible for administering medication covertly. It must be clear in their Good Life Support Plan/Risk & Vulnerability (R&V) which medicines are to be given covertly, and how to do so. There must be a stated date to review the use of covert medication.

2.2 'As required' medication

Any 'as required' medication used by the individual must be detailed in their Good Life support plan/R&V section 7, describing the circumstances in which it may be given. This includes medication prescribed for pain relief, anxiety, agitation, other behavioural issues and emergency medication for epilepsy.

'As required' medication prescribed for general use pain relief may be administered at the discretion of staff (for headaches and stomach pain, for example). Staff should refer to patient leaflet regarding when to consult the GP if pain persists.

There must be a detailed protocol written and signed by the prescribing medical professional where 'as required' medication has been prescribed for anxiety, agitation, other behavioural issues and emergency medication for epilepsy. It is never at the discretion of Care & Support staff when to administer this 'as required' medication.

Note that 'as required' medication may have a sedative effect and amount to restraint. See: **CS06 Reducing Restrictive Practice.**

3.0 Types of support

3.1 Prompting

This is reminding a person of the time and asking if they have taken, or are going to take, their medication. The person is still in control of the medication and may decide not to take them or take them later.

3.2 Assisting

A supported person may be able to retain control of their medicines but need assistance with simple practical tasks. Assisting with medication may include:

- Ordering repeat prescriptions;
- Picking up prescriptions from the GP surgery;
- Collecting dispensed medicines from the pharmacy;
- Bringing packs of medicines to the person at their request so the person can take the medicine;
- Opening bottles or packaging at the request and direction of the person who is going to take the medicine;
- Reading the labels and checking the time at the request of the supported person;
- Ensuring the supported person has a drink to take with their medication.

3.3 Administering

If an individual cannot take responsibility for managing their medication, Care & Support staff will use the '6 Rs' described by NICE (2014):

- The right person
- The right medicine
- The right dose
- The right time
- The right route
- The right to refuse

Administration of medication can be one or a combination of the following:

- Deciding which medicines have to be taken or applied and when;
- Being responsible for selecting the medicines;
- Giving the person medicines to swallow, apply or inhale, where the person receiving them does not have the capacity to know what the medicine is for or identify it;
- Giving medicines where there is a judgement that a degree of skill is required to be exercised by the worker to ensure it is given in the correct way (e.g. eye drops).

The level of support the individual requires with each task must be recorded in their Good Life Support Plan/(R&V) and on the Medication Administration Record (MAR) chart. Note that this must also include the type of support provided; prompting, assisting or administering.

4.0 Care Planning

4.1 Good Life Support Plan/Risk & Vulnerability (R&V)

The ability of the supported person to manage their own medication should be assessed initially using the Good Life Support Plan/ (R&V). This must consider, for example; their ability to recognise their medications, if they understand what they are, how they are used and the risks of under- or over-dose. This assessment may include other relevant people like family, legal guardians and other professionals involved in the person's care.

Where any residual risks remain that cannot be supported by Care & Support Staff, a Risk Management Plan must be completed.

It is vital that support with medication is the correct amount required and should seek to build on the individual's skills, abilities and confidence. It is not appropriate for Care & Support staff to do tasks for the individual that they are able to do independently; this may

amount to unnecessary restriction of the supported person's right to self-determination, see: **CS06 Reducing Restrictive Practice**.

All support needs and preferences must be documented in the supported person's Good Life Support Plan/ (R&V); see: **CS02 Care Planning.**

It is the responsibility of the Care & Support staff accompanying the individual to a health appointment to ensure that the information is gathered and recorded. The details of why medications are prescribed, the length of the prescription, potential side-effects and any follow-up appointments required will be recorded in the relevant Health Recording form on AIMS (Ark Information Management System).

Care & Support staff members are also responsible for ensuring that the supported person is aware of these details. This may include providing information in an accessible format to aid understanding.

Patient information leaflets regarding all medication should be kept in an envelope next to the individual's medication to ensure Care & Support staff members have immediate and easy access to this information. These leaflets must be updated every 3 months.

4.2 Condition-specific support planning

Individuals with long-term health conditions, for example; asthma, diabetes or epilepsy must have robust protocols in place in their electronic Good Life documentation as well as a copy accessible to staff who will be responsible for administering medication for the management of their condition. This must include any support needs, medication needs and other support required specifically for the management of that condition, for example; peak-flow readings, fluid balance charts or dietary advice. Risks as a result of the condition must be recorded and managed through **CS02 Care Planning.**

4.3 Good Life Support Reviews

Supported people must have a Good Life Support Review at least every 6 months, see**: CS02 Care Planning**. In addition to this, supported people must have a medication review with their GP/health professional at least annually.

Individuals prescribed medication that has a sedative effect and could be considered restrictive must have its use reviewed at least every 6 months; or a period agreed by the prescribing medical professional and any welfare proxy.

5.0 MAR charts

The MAR is the record of the administration of the supported person's medication. All supported people must have a MAR unless they self-medicate.

Pharmacies may supply MAR charts. If this service is not available, Care & Support services must use the Ark MAR chart, (see: **Appendix 2)**. It is important to note that the MAR does not replace or act as a prescription. The prescription or written direction from the prescriber is what authorises Care & Support staff to administer the medication, with the MAR exactly reflecting the prescriber's instructions. It is best practice to keep a copy of the prescription.

MAR charts must be kept and stored in accordance with **G24c Retention of Documents.**

Medicines received from the pharmacy should be labelled with the following information:

- The name of the medication or its common name;
- Directions for use;
- Precautions relating to the use of the medication.

The information on the prescription, the label from the pharmacy and the MAR chart should all correspond. It is the responsibility of the Care & Support staff to ensure that these are correct and to seek clarification if needed.

All prescribed times for medication administration must have an entry in each box and must not be left blank. See **7.0 Medication errors.**

5.1 Timings

If the instructions on the prescription are similar to 'take two times per day' rather than specifying times, Care & Support staff then have some flexibility to administer at times and intervals that suit the supported person's preferences and routines. An appropriate window of time should be recorded in the Good Life Support Plan/R&V to ensure that doses are appropriately spaced to avoid the risk of overdosing. Staff should contact the GP/Pharmacy or, NHS24 if out of hours, for advice if the appropriate window of time is missed for advice and complete Health Recording – medication advice and information section on AIMS. Where the same medication is required to be administered multiple times throughout the day, for example Paracetamol, and there are no specific times, staff should record on the back of MAR the exact time the medication was taken, so staff can administer at appropriate times.

5.2 Signing in medication

It is the responsibility of the Care & Support staff member supporting the individual on receipt of the medication to ensure that it is checked-in correctly and that any errors are rectified. Missing or incorrect medication must be followed-up with the chemist/GP immediately.

A new MAR from the pharmacy should state what has been dispensed and the amount. The Care & Support staff member checking-in the medication should record the amount actually received and initial and date the MAR to confirm they have checked-in the medication.

Any medication left over from the previous dispensing that is still prescribed for use (e.g., 'as required' pain relief) should be carried forward into the stock for the current period.

5.3 Administration

Care & Support staff should record administration once they have confirmed the supported person has taken the medicine. They must initial the box on the MAR for the correct date and appropriate time band. See**: 5.1 Timings.**

If the medicine was not given, or was refused, the appropriate code from those listed on the MAR should be entered and full details recorded on the back of the MAR and GP/Pharmacy or NHS 24 (if out hours) should be contacted for advice. Any advice given should be recorded in the Health Recording – medication advice and information section on AIMS. This does not apply to "As required" medication as recording for this medication only occurs when it has actually been taken (also referred to as "positive administration").

5.4 Recording 'as required' medication

We would want to know the exact time the medication was administered such as Paracetamol, Diazepam etc. to ensure there is no risk of overdosing and the result from the administration. This will be the case for medication used to treat behavioural symptoms such as anxiety.

The outcome of administering 'as required' medication should be detailed on the back of the MAR (use the suitable code from the front of the MAR sheet) or on a separate recording sheet if this is used within the service.

It should also be detailed in the medication section on AIMS under Good Life Support Plan/R&V Medication.

"As required" medication must be counted and recorded on the medication stock audit sheet **(**see: **Appendix 3)** at least once per day if it is not administered or each time it has been administered. A running balance must not be recorded on the MAR.

5.5 Recording 'original packaging' medication

Some pharmacies only provide medication in the original packaging (as opposed to Blister Packs). If there are more than 2 administrations of the same medications (only in original packaging) on the same day, a stock audit sheet must be completed. Care & Support staff will physically count the medication to ensure it corresponds with the previous amounts stated on the stock audit sheet after administration. The remaining amounts must be recorded on the stock audit sheet after every administration. A running balance must not be recorded on the MAR but on the stock audit sheet instead.

If there are one or two administrations of the same medication (in its original packaging) in the same day, staff must physically count the medication remaining and a running balance must be kept on the MAR, recorded on the box at the bottom, after the last administration of the day a stock audit sheet must not be used in this case.

5.6 Spoiled/Refused medication

If the individual has capacity to understand the need for their medication and refuses to take it, Care & Support staff must respect this decision and their GP/Health professional informed (with the individual's consent).

If the individual does not consent to sharing this information with their GP/Health professional general advice and guidance should be sought from a health professional without disclosing any personal information.

In all of the above cases advice from the health professional should include specific detail on how long it is safe for that person not to receive medication before taking further action. This must be recorded in an incident report and in Health Recording – medication advice and information section on AIMS. It must be recorded in the individual's Good Life Support Plan/ (R&V) and Risk Management Plan where appropriate.

Care & Support staff should note that continued refusal to take medication may be an Adult Support and Protection issue (see: **G36 Keeping People Safe** and **G57a Adult Support & Protection**).

If medication that is in blister packs becomes soiled staff can use medication from the furthest away day within the blister pack to allow the supported person to have their medication. Please note that all the medication from the blister from the soiled medication must be discarded and returned to the pharmacy. The medication from the blister used in replace of the soiled medication must all be used to ensure the correct tablet is given.

Staff should never take out individual tablets from a blister and then re-cover as these are already soiled once opened. If no medication is available to replace then advice should be sought from GP/Pharmacist/NHS 24. Any communication from Health Professionals will be recorded in the appropriate Health Monitoring section.

Medication removed from packaging (refused) and not taken must be recorded appropriately on the MAR using the correct code (e.g. R for refused) and returned to the pharmacy for disposal. If medication has been dropped this must be recorded on the MAR using the correct code (e.g. O for other) and reason on the back of the MAR.

5.7 Returns

At the end of the 28-day cycle the quantity of any remaining medications which can be carried forward to be used the next month if they are still prescribed e.g. “as required” pain relief must be recorded, and any unused or discontinued medicines returned to the pharmacy for destruction. In all cases this is to be recorded in the relevant boxes on the MAR to evidence this.

Once details of the items for disposal are recorded on the MAR chart, they should continue to be stored securely in the supported person’s home until they are returned to the pharmacy.

Where possible any medications returned to the pharmacy should be recorded in a ‘returns’ book with the signatures of staff returning the medications. In supported living accommodation these can be returned to the pharmacy and receipt for proof of return should be obtained.

5.8 Medication changes

There are various types of changes that can happen:

- New mid-cycle medication;
- Changes in existing medication dosage;
- Changes in administration times of existing medication; OR in the number of administrations per day (also called “frequency”).

Care & Support staff must challenge any unclear changes made to medication records whether made by colleagues, doctors or pharmacists.

Changes must **never** be made to labels on packaging from the pharmacy.

In each case, new entries should be made on the MAR.
All entries are dated and identifies the staff member who made the changes.

5.8.1 New mid-cycle medication

If a new medication is prescribed midway through the MAR cycle (usually 4 weeks cycle), information about the medication should be exactly transcribed from the prescription and the dispensing label onto the MAR.
Latin abbreviations like “PRN” should not be used and information should be written in capital letters.

A horizontal line should be drawn on the MAR in the boxes for any days prior to the first administration of the new medication.

Additionally, the name of the person who transcribed the information, the date and directions from the prescriber should be hand written in capital letters on the MAR.
Staff must ensure they do not write over any other information.

For example, for a new medication administered on 12th June for the first time but prescribed on the 11th June, a staff called LM will hand write a note on the MAR, showing: “12/06/22 LM – SEE GP HEALTH RECORDING 11/06/22”.

5.8.2 Changes in dosage of existing medication

A change of dose will usually need a new prescription, particularly if the dose is increased. However, if the change can be accommodated by current stock and verbal instructions have been given by the prescriber, the dosage may be changed.

Care & Support staff must still ask the prescriber for written confirmation of the change. Email confirmation should be printed and kept with the MAR.

If the staff do not obtain a written confirmation, the member of staff must ensure that the details of the GP who made the change and reason for change are documented in the appropriate Health Recording section on AIMS.

On the MAR, discontinue the entry of the medication which dosage is being altered as described in **section 5.9,** below. Staff must ensure they do not write over any other information.

The staff member making the changes must make a legible handwritten note on the MAR detailing the date the entry was made, and initial who has written the note, as well as "SEE GP HEALTH RECORDING, DATE OF GP NOTE". For example, "12/06/22 LM – see GP health recording 11/06/22". The full reason and details of the change must be written in the supported person's Health Recording –section on AIMS.

The medication with the altered dosage should be recorded as it would with a new medication (follow instructions on section 5.8.1 above).

The remaining stock from the discontinued entry may be brought forward (under "Balance b/f on the MAR) if this is still usable and added to any new stock received.

5.8.3 Changes in Administration times or frequency

Discontinue the original instruction and write a new one (see: **section 5.9**).
Do not score out or change a time on the original entry and do not continue to use it.

If the frequency is being changed, the prescriber must confirm this in writing as per section 5.8.2 "Changes in dosage of existing medication" above.

If the original prescription stated something like 'one three times per day', the GP would not need to be involved as Care & Support staff have some discretion in timings (see: **section 5.1 Timings** above).

Ask the prescriber to follow-up verbal instructions to discontinue a medication in writing. Ensure all entries are dated and identifies the staff member who made the changes.

5.9 Discontinued items

A horizontal line should be drawn through any recording boxes remaining in the row on the day the medication is discontinued.

Additionally, a clear handwritten note must be added on the MAR clearly detailing the date of when the medication was discontinued, the staff's initials (staff who made the change) and where you will find information confirming the change.

For example, if a medication is discontinued on the 1st May 2023 due to a change in its dosage, frequency or administration times prescribed by doctor on the 29th April, the note will show : 'DISCONTINUED LM 01/05/2023 LM – SEE GP HEALTH RECORDING 29/04/2023".

Staff must ensure there is a clear audit trail detailing why the medication has been discontinued and by who in the appropriate Health Recording section on AIMS.

5.10 Missed doses and overdoses

If it is found that medications have not been dispensed, or additional doses have been administered, staff must contact the supported person's GP or NHS 24 for guidance. The advice received should be recorded in the individual's Health Recording – medication advice and information section on AIMS, with the name of the GP/ medical practitioner and the time the advice was given.

All missed doses or overdoses must be treated as an incident, see: **HS04 Incident Reporting** and are considered medication errors, see: **section 7 Medication errors**.

Incidents involving missed doses or overdoses of controlled drugs are notifiable to the Care Inspectorate and may also be reported to the police if it is suspected that the medication has been lost or stolen.

6.0 Auditing

Ark is not responsible for the safety or security of the medication for any individual who self-medicates.

After each medication administration for that day (3 administrations or more of the same medication – Care and Support staff must physically count the amount of medication remaining after administration and record on the medication stock audit sheet if in original packaging (see: **section 5.5 Recording 'original packaging' medication**)

After the last administration for that day (2 administrations or less of the same medication) – Care & Support staff must physically count the amount of medication remaining after administration and record on the running balance section on the MAR if in original packaging (see: **section 5.5 Recording 'original packaging' medication**).
Please note staff must not record the running balance on the MAR.

Stock checks of "as required" medications should also be physically counted and recorded on the medication stock audit sheet (see: **section 5.4 Recording 'as required' medication**).

At the end of every shift, stock checks of Schedule 2 controlled drugs should be recorded in the controlled drug register and countersigned by a 2nd member of staff (or, depending on the service model, the next staff member providing support to the individual). If there is no Schedule 2 controlled drugs then there is no requirement for a controlled drugs register. The medication stock audit form can be completed at the end of each shift with only 1 signature. (See: **section.9 – controlled drugs**).

Any discrepancies in the stock of controlled or 'as required' medication must be reported to the CSM/OM as soon as possible. This must be reported to the Care Inspectorate and may need reported to the Police for investigation if lost or stolen (see: **9.4.1 - Schedule 2 Controlled Drugs Register**).

Weekly – A member of the key team will complete a weekly medication audit on AIMS and is responsible for ensuring any actions are completed. Once completed the key team will pass the audit to the CSM/OM to be checked and countersigned.

Staff completing the audit will ensure that the MAR is legible when taking photographs to uploads to AIMS for the audit. If the MAR is not clear a physical copy of the MAR may be requested and should therefore be retained and stored securely.

Care and Support Managers or Operations Managers (where applicable) will be responsible for reviewing 25% of the audits received to ensure these have been completed accurately by the staff member. Each week different supported people's medication audit should be complete so in a 4-week period all supported people who receive support with managing their medication would have Manager sign off and overview at least once.

Where a discrepancy has been identified on the audit by the staff member the CSM/OM will complete a full audit of that audit. Focus should also be made where new staff are completing audits or there has been recent changes to the supported persons support around medication to ensure compliance.

When re-ordering - The key team should ensure expiry dates on medications are checked as part of the medication ordering process. Medicines approaching their expiry date should be returned to the pharmacy for disposal and recorded on the MAR.

Any staff training issues identified through the audit process will be actioned by the relevant line manager.

7.0 Medication errors

Any medication errors must be recorded as an incident. Medication errors could include:

- Not initialling the MAR on administration of medication;
- Failing to accurately record the stock held;
- Missed doses of medication;
- Overdose of medication.

It is the responsibility of the Care & Support staff member who notices an error to complete an incident report and advise the CSM/OM. The CSM/OM is responsible for investigating the incident and following up with the staff member involved. In the absence of the CSM/OM staff may be asked to physically check if medication has been given in order to ensure accurate information is provided. The CSM/OM must identify and record any remedial actions taken. See: **HS04 Incident Reporting**.

If staff notice that another staff member has not initialled the MAR it is their responsibility to check whether the medication was administered. They must record with the appropriate code on the back of the MAR detailing findings and confirming the completion of an incident report. For example “MAR not signed, medication given and incident report completed”.

If a supported person is responsible for their own medication, Care & Support staff must still report any instances they note of medication not taken as prescribed, as per **section.5.10– Missed doses and overdoses** of this procedure as soon as staff become aware of a missed/overdose. Note the supported person may need a re-assessment of their capability to manage their own medication as a result of this.

7.1 Disciplinary Investigations

Where possible Ark seeks to take a supportive and learned approach to medication errors however we also recognise the potential consequence(s) medication errors can have on our Support People. Medication errors will therefore be assessed on a case by case basis and next steps will be dependent on a variety of factors.

For example a medication error made by someone in their probationary period may be due to a lack of knowledge and / or training and be more appropriately addressed through informal actions such as additional training or a reflective account.

A further example could be a medication error by someone who has been with the organisation for over 2 years due to not following the correct procedure leading to a supported person requiring medical treatment. This type of error may be more appropriately addressed through a formal process such as disciplinary investigation and potential disciplinary hearing.

Please note that the above examples of errors are intended as a guide, it may, for example, be appropriate to take disciplinary action against someone in their probationary period dependent on the severity of the error.

The outcome for the Care & Support staff member responsible for the error will be dependent on the outcome of the investigation. See: **HR18 Disciplinary**.

8.0 Storing medication

If the supported person is unable to manage their own medication, it is the responsibility of the service to ensure the safety and security of their medication. This means it should be locked in a secure container, for example; an electronic safe or locked drawer in a discreet location in the individual's home. See: **CS06 – Reducing Restrictive Practice.**

For supported people living in a care home, the individual's medication should be stored in a locked container or drawer in their bedroom.

If a supported person self-medicates, or receives some support with medication but has capacity, Care & Support staff should encourage the individual to store their medication as described above (note that this may involve providing information about this in an accessible format), however, this remains the individual's choice which must be respected.

A supported person living in a care home who does not wish to store their medication as described above should be encouraged to keep their bedroom door locked. Care & Support staff must explain to the individual the risks of their medication being accessible to others in the care home should they not choose to store it securely.

Medication must be stored under the conditions that ensure their quality. The storage instructions are found either on the product itself, or the patient information leaflet accompanying it. Care & Support staff must comply with these instructions.

Storage conditions for most medication can be met by domestic fridges (between 2 and 8 degrees centigrade), or storage that is not above 25 degrees centigrade.

In care homes where there is a regular need for medications to be refrigerated, it is acceptable to have a separate and secure fridge for this purpose. In smaller services, medicines may be stored in the domestic fridge. It must be in a lidded container, easily recognisable to staff and/or supported person and on a separate shelf. There must be a fridge thermometer present to ensure that the correct temperature is maintained.

9.0 Controlled drugs

9.1 - List of Controlled Drugs

Some drugs must be controlled by law to prevent misuse. This means that they must be managed following specific processes. These drugs are called "Controlled drugs" (CD). Staff in social care may support someone who needs controlled drugs and therefore must know how to manage such drugs.

The government regularly publishes the list of all controlled drugs. As this can change, please consult their website to find the latest list
https://www.gov.uk/government/publications/controlled-drugs-list--2/list-of-most-commonly-encountered-drugs-currently-controlled-under-the-misuse-of-drugs-legislation
As you will see on the government website, controlled drugs are classified by Class (A, B C etc…) and Schedules (1, 2, 3, 4…).

A controlled drug register is required for Schedule 2 controlled drugs. This can be provided by the prescribing pharmacy to care home residents; other supported people will need to buy it.

9.2 – How do support workers know their supported person is on Controlled Drugs?

In some situations, the pharmacy will make it clear to whoever picks up the medication that these are controlled drugs or not. However, this is not always the case and therefore, support workers should always enquire whether or not the drugs supplied are controlled drugs (ask pharmacy or manager for example). They must also find out what schedule the controlled drugs belongs to, so they know if it requires a Register (for schedule 2 drugs) or not, as discussed above.

This information must be recorded on the person's Good Life Support Plan/R&V on AIMS. Note: If an individual is prescribed 'as required' medication that is a controlled drug, the exact circumstances of administration must be detailed in their Good Life Support Plan/R&V on AIMS. They must also clearly state who must be informed of the administration.

9.3 - Storage of Controlled Drugs

There is no statutory requirement for all controlled drugs to be locked away; this depends on the class and schedule of the controlled drug used. However, Ark is mandating that all Controlled drugs are kept in a secure, locked cupboard with appropriate record-keeping to ensure the safety of staff and supported people.

9.4 - Recording of Controlled Drugs

At the end of every shift, if not administered, stock checks of **Schedule 2** Controlled Drugs must be recorded in the controlled drug Register. Generally 2 members of staff should sign the register. However, where 2 members of staff cannot be present at the same time, the next person on shift must check if the amount written down is correct.

If the medicine is a controlled drug with a Schedule 1, 3, 4 or 5, there is no requirement for a controlled drugs register. Instead, a medication stock audit sheet must be completed.

9.4.1 - Schedule 2 Controlled Drugs Register

As stated above, any staff who checks in any medication, from a pharmacy, containing a Schedule 2 Controlled Drug must maintain a Controlled Drugs Register. Sometimes, the prescribing person completes the register but sometimes they may delegate the task of completing the register to the support worker; however, the prescribing person remains responsible for supplying the Controlled Drugs.

The register must:

- Be either a computerised system or a bound book (which does not include any form of loose leaf register or card index);
- Be separated into each class of drug;
- Have a separate page for each strength and form of that drug, with this recorded at the top of each page;
- Have the entries in chronological order and made on the day of the transaction or, if not reasonably practical, the next day;
- Have the entries made in ink or in a computerised form in which every entry can be audited;
- Not have cancellations or alterations;
- Ensure any corrections are made by a signed and dated entry in the margin or at the bottom of the page;

- Be kept at the premises to which it relates (for example separate registers for each set of premises) and be available for inspection at any time;
- Not be used for any other purpose;
- Be kept for a minimum of two years after the date of the last entry.

The following must be recorded in the register when Schedule 2 CDs are checked in on receipt from the pharmacy:

- Entries must be in chronological order;
- Date received;
- Name and address of supplier, for example, wholesaler, pharmacy;
- Quantity received;
- Entries must be made in ink.

Any movements of Schedule 2 controlled drugs (example: if the supported person goes to family house for weekends, or day centres etc.) must be recorded on the Controlled Drugs Register (how much was taken away, how much was returned, who did the checks).

A running balance of Controlled Drugs stock should be also kept on the Register.

The aim of maintaining a running balance in the register is to ensure irregularities are identified as quickly as possible. The running balance of drugs remaining should be calculated and recorded after each transaction and balances should be checked with the physical amount of stock at regular intervals.

The CSM/OM should audit controlled drugs held in the service every week. Any discrepancies in the administration or auditing of controlled drugs must be reported to the Care Inspectorate by the OM/CSM within 24 hours, and to the police if suspected lost or stolen. **HS04 Incident Reporting** must be followed. Any missed or overdose of controlled drugs is subject to **section.5.10- Missed or overdoses** above. The Health & Social Care Partnership and any welfare proxy must also be advised.

9.4.2 – Schedules 1, 3, 4 or 5 Controlled Drugs recording

If the medicine is a controlled drug with a Schedule 1, 3, 4 or 5, there is no requirement for a controlled drugs register. Instead, a **medication stock audit form** must be completed and CSM/OM should also conduct audits on this form.

9.5 - Disposal of controlled Drugs

Schedule 2 Controlled Drugs must be given back to pharmacy for destruction, after 2 support workers have signed it and dated it.

The pharmacy will then issue a receipt and this must be logged on the Controlled Drugs Register.

9.6 – Controlled Drugs in vials/bottles (multi-dose)

Pharmaceutical companies try to ensure that every bottle of medicine is precisely filled but some small variability may occur. This may result in discrepancies regarding the amount of Controlled Drugs used when taking into consideration the volume remaining in the container.

You must avoid having discrepancies between the amounts recorded as used, the volume of product left in the vial and the total stated volume. The filling volume of a product is set and checked to ensure that it is as stated on the label on the vial/bottle. There is minimal variation in fill volume of the product.

When injecting the drug, there will also be some wastage within the needle and hub of the syringe each time the product is withdrawn. If numerous doses are withdrawn, there will be considerably more product lost to this 'dead space' than if fewer doses are given. It is not possible to quantify exactly how much product might be wasted in the syringe hub and needle. There are international manufacturing standards which specify the maximum amount of 'dead space' that is permitted in needles and syringes of different sizes and gauges. You can obtain this information from manufacturers or wholesalers. In general, the smaller the gauge of needle or size of syringe, the less wastage occurs.

Some services use insulin syringes to minimise wastage. This is acceptable although it is important to ensure that the syringe allows accurate measurement of the dose in millilitres.

Other potential factors that may increase wastage are:

- The use of a separate, larger bore needle to withdraw the product from the vial before changing to a smaller needle to administer the product;
- The process of expelling air from the syringe prior to injection.

How to minimise wastage and how to record it? You must carefully select the injection equipment and use good technique to reduce wastage due to dead space in syringes. You must record the volume (dose) withdrawn on each occasion and write off the vial as

unusable (destroyed) in the register once there is no useable volume remaining. The recording of small discrepancies that can be explained by wastage due to dead space is not considered a breach of the legislation; provided that inspectors are satisfied appropriate measures are in place to comply with the requirements of the Misuse of Drugs Regulations.

10.0 Invasive procedures

'Invasive procedures' means items or activities like:

- PEG feeding;
- Injections (Insulin, for example);
- Rectal Diazepam;
- Enemas;
- Pessaries to treat internal fungal infections;
- Topical cream applications to intimate areas.

Each service will decide whether or not Care & Support staff will be involved in any type of invasive procedure. If the decision is not to provide support with invasive procedures, this will be following agreement that such medication will be administered by the GP, district nurse, or other appropriate health professional.

Care & Support staff members may only be involved in administering invasive procedures if:

- The proposal has been discussed fully with the supported person (or welfare proxy), relevant family members, carers and the GP;
- The outcome of the discussion above recorded fully in the individual's Good Life Support Plan/R&V;
- The required training has been provided, using specialist external trainers where required (for example, NHS);
- The CSM/OM and the trainers are satisfied that the required level of competency has been reached;
- Ongoing refresher training is agreed and provided, as required by current regulations or relevant best practice;
- A written protocol is developed and agreed by Ark and any relevant stakeholder. It must clearly state each stakeholder's responsibilities.

Regular invasive medications will usually be ordered as part of the main medication order and details recorded in the individual's Good Life Support Plan/R&V.

The CSM/OM must ensure that appropriate sharps disposal equipment is provided, and staff members are trained in its use, if they administer injections. See: **HS10 Control of Infection** for further guidance on sharps and sharps incidents.

The CSM/OM must liaise with their Regional Manager and Ark's Compliance and Improvement Business Partner to ensure that the necessary level of insurance cover is in place to administer a particular invasive procedure. The CSM/OM must also advise the Compliance and Improvement Business Partner when the service no longer administers a particular invasive procedure to ensure that Ark's insurance cover is adjusted if required.

11.0 Oxygen

If an individual requires use of an oxygen cylinder, for example with a sleep apnoea machine, this will only be provided if:

- The proposal has been discussed fully with the supported person (or welfare proxy), relevant family members, carers and the GP;
- The outcome of the discussion above recorded fully in the individual's Good Life Support Plan/R&V;
- A Risk Management Plan has been completed;
- The required training has been provided, using specialist external trainers where required (for example, NHS);
- The CSM/OM and the trainers are satisfied that the required level of competency has been reached;
- Ongoing refresher training is agreed and provided, as required by current regulations or relevant best practice.

The CSM/OM will check with the Compliance & Improvement Business Partner regarding insurance cover.

The CSM/OM will inform Housing and Assets (if in an Ark property) or their Landlord to ensure there are no restrictions to the storage of oxygen in Occupancy or Tenancy agreements. Staff should also check with the supported person's home insurance provider to ensure they have adequate cover.

In care homes, The CSM/OM will liaise with the local fire brigade to ensure:

- A designated storage area is identified on the building's floor plan
- Signage is on the individual's bedroom door and oxygen storage area door to advise firefighters of the presence of an oxygen cylinder in the event of a fire

The usage of disposable items must be accurately logged so they made re-ordered promptly from NHS suppliers.

The CSM/OM must ensure local procedures are in place regarding washing filters, mask-wearing, use of dressings, and so forth.

12.0 Emergencies

If an individual has a condition that may require action in an emergency; for example, epileptic seizure or a diabetic coma, this should be identified in the High Risk Alert section on AIMS, fully detailed in their Good Life Support Plan/R&V and any required protocols from relevant health professionals in place. A Risk Management Plan may also be required if there are residual risks. See: **CS02 Care Planning**

Should a supported person develop a condition that may require action in an emergency, relevant health professionals and other stakeholders (for example, the individual themselves and any legal proxy) should be involved in the assessment, with resultant decisions and actions clearly recorded in the Good Life Support Plan/R&V. This should be identified in the High Risk Alert section on AIMS and Risk Management Plan may also be required if there are residual risks.

If it is agreed that this is part of the support from Ark provided to the individual, designated staff members will be trained to deal with the emergency situation and will receive regular refresher training as required. This may involve assessment of the staff members to ensure continued competence.

The CSM/OM must ensure that Care & Support staff members understand the types of emergency situation in which they can and cannot become involved.

13.0 Personal purchases

If a supported person has responsibility for their own money, they may buy OTC medicine while also receiving prescription medication. This may not pose any risk, but Care & Support staff should be aware of the possibility of an adverse reaction to combining medications. Care & Support staff should seek guidance from the individual's GP or NHS24 and record this on the relevant health recording section on AIMS.

Care & Support staff should discuss the risks of combining prescriptions with OTC medicine with the supported person, and monitor its usage if possible (in line with the medical advice given).

If a Care & Support staff member has any concerns about the individual's ability to understand the risks involved, they must advise the relevant CSM/OM. The CSM/OM must then contact the Health & Social Care Partnership to raise this concern as this may require the individual's capacity to be re-assessed.

14.0 Training

Care & Support staff will be trained in the safe administration of medication by a CSM/OM or other suitably qualified trainer. Training will be delivered with standardised materials, although specific subjects may differ depending on the needs of the Care & Support service.

The trainer will ask the OM/CSM to complete a “Pre-medication training questionnaire” to ensure the training is tailored to the service and staff have completed the necessary steps beforehand.

Training in the medication systems in use in a service will be part of new staff members’ induction process. No staff member will be permitted to administer medication without the training.

In order to be competent, Care & Support staff members must:

- Complete E-learning Module called “Ark: Medication Theory”;
- Attend Face to Face session called “Medication Practical Session”. To be ran or refreshed no more than 4 weeks after the E-learning;
- Undertake an assessment called “Medication Assessment”. To be completed at the end of the Practical Session;
- Undertake an observation and discussion between a qualified medication assessor and staff using the “Medication Competency Assessment” document. To be ran no more than 4 weeks after the practical session.

This will be refreshed every 3 years and staff expected to:

- Complete the E-learning Module called “Ark: Medication Theory”;
- Undertake the assessment called “Medication Assessment”.

The CSM/OM will ensure that all staff members receive the necessary training in:

- Ordering, receipt, administration and recording of routine and ‘as required’ medications;
- Undertaking invasive procedures (where required);
- Managing specific conditions, for example; epilepsy and refresher training (where required);
- Handling emergency situations (where required).

15.0 Confidentiality and records Management

Medical information – including diagnoses of long-term or enduring conditions – is private to the individual and may not be shared by Care & Support staff without consent, see: **Section 2 Consent and Capacity** above.

All information will be held and processed in accordance with **G13 Openness & Confidentiality** and **G24 Privacy & Data Protection**.

All records, forms and so forth relating to a supported person's medical information will be held for the duration of the service, and at least 3 years after its termination, see: **G25 and G25a Records Management**.

16.0 Implementation and Review

16.1 Implementation

Care & Support Managers/Operations Managers are responsible for the implementation of these procedures by their Care & Support staff.

16.2 Review

Ark Regional Managers' group is responsible for the review of these procedures, at least every 3 years. Any changes to the associated procedure as a result must be submitted to the Policy & Procedure Review Group for approval.

Managers within Care and Support will continue to review health and Safety Quarterly reports and quality assurance processes to ensure this procedure and it's associated policy is in line with best practice guidelines and regulatory requirements.