Administration of Medication Policy

Statement of Purpose

To ensure Serenta Homecare are compliant with the Royal Pharmaceutical Society Guidance Handling Medicines in Social Care.

To ensure Serenta Homecare achieve the standards set by the Sheffield City Council Administration of Medication specification.

To ensure the administration of medicines is a regulated activity under the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This policy should be used in conjunction with CQC guidance for providers on meeting the regulations

Introduction

Serenta Homecare believes its services should support the individual client to be as independent as possible and that its staff should be user-led in how they deliver care.

Where a client has been prescribed medication, Serenta Homecare will offer support in ensuring their health is protected using the medication as prescribed.

This policy is designed to describe to Clients and staff, what they can expect, and what their responsibilities are, in relation to the management and administration of medication.

Serenta Homecare use electronic medication administration record (MAR chart).

Commencement of Clients Support Plan

Wherever possible, Clients will manage and administer their own medication. Where this is the case, staff will not complete MAR charts or take responsibility for administration of medication.

Their only involvement may be to assist with obtaining medication from the pharmacy if this is agreed in the care plan and a custom schedule is set weekly to enable this.

If a client's needs assessment identifies the need for assistance with medication, Serenta Homecare requires a written copy of the assessment, signed by a suitably qualified assessor (usually a Sheffield City Council social worker) and signed consent from the client through the Medication Authorisation Form. Self-funded Clients require signed consent forms though the Medication Authorisation Form. The content of this form will be reviewed annually during the Client review. See appendix 1.

Role of the Serenta Homecare Assessor - ASSESSING AND RECORDING WHAT TYPE OF SUPPORT IS REQUIRED

Prior to commencing provision of any medicines support Serenta Homecare assessor will assess a person's medicines support needs as part of the overall assessment of their needs

and preferences for care and treatment. They will also engage with the person and/or their family in assessing a person's medicine support needs. If the client is an SCC/CCG the support plan will have been obtained, this will outline the information required with regards to supporting the client with the administration of medication.

During assessment the assessor should request the person to sign the Medication Administration Authorisation Form. The Assessor should ask the person to nominate a Community Pharmacy that will be responsible for dispensing prescriptions, and this should be recorded on the Authorisation Form. Most people receiving regular medication will use a single pharmacy for all their prescribed medication. Where this has not been the case the Assessor should agree with the person a pharmacy that will be approached to take responsibility for dispensing prescriptions.

Where there are concerns about medication regimes, the Assessor should request a review by the GP or seek advice from the Community Pharmacist to ensure these are effective and efficient for all parties.

Where the administration of medication is required at specific time intervals, the Care Coordinator or Assessor should check the essential requirements with the GP or Pharmacist to see if the dosing schedule of the medications can be realigned. If the dosing intervals are an essential component of treatment, e.g., as in '4 times a day' regime for antibiotic treatment, and Serenta Homecare does not cover these requirements, the Assessor should increase the care package accordingly. 6 Monthly reviews of a client's medicines support will be made to check whether it is meeting their needs and preferences. or sooner if there are changes in the client's circumstances.

During the assessment the assessor will obtain details of all current medication, this will be sought from.

- An original prescription signed by a prescriber from primary care, which may be the right-hand side/counterfoil of the current prescription.
- A secondary care discharge prescription or outpatient prescription.
- A printed or written record obtained from the service user's GP detailing current prescribed medication.
- The pharmacy label on the current medicine container/box
- A copy of the current MAR chart from the previous care setting
- Where the pharmacy label on the medicine container/box is used there must be a check to ensure that the medicines are current and 'fit for purpose'. The label on the packaging must be clear and unambiguous and includes all the following:
- The client's name (checking that this is the correct person)
- The name of the medicine inside the packaging (also checking that it matches the medicine named on the label).
- The expiry date of the medicine (checking that this has not been exceeded).

Medication Allergies

As part of the initial medication assessment, the Assessor must establish whether the Client has any known medication allergies or sensitivities. This information should be obtained from the Client, their representative (where appropriate), or GP records.

Any known medication allergies must be clearly recorded within the Allergy section of the Client's Care Plan before medication support commences. If no known medication allergies are identified, this should also be documented.

Where a medication allergy is identified, the Assessor must ensure that the allergy is considered within the Medication Risk Assessment. The risk assessment should detail the identified allergy, the potential risks associated with administering the medication, the control measures required to prevent exposure, and the actions staff should take if an allergic reaction is suspected.

All Care Workers/Mental Health Support Workers must review the Client's Care Plan and Medication Risk Assessment before administering or prompting medication to ensure they are aware of any recorded medication allergies. Under no circumstances should staff administer a medication that is recorded as an allergy for that Client.

If a new medication allergy is identified, or a Client experiences a suspected allergic reaction to medication, the Care Worker/Mental Health Support Worker must:

- Stop administering the medication (unless advised otherwise by a healthcare professional).
- Seek immediate medical advice from the GP, Pharmacist, NHS 111 or contact 999 in an emergency.
- Inform the Line Manager without delay.
- Record the details in the Client's Care Plan Allergy section and ensure the Medication Risk Assessment is reviewed and updated accordingly.
- Complete an incident report in line with Serenta Homecare's Incident Reporting Policy.

Following the assessment

Following Serenta Homecare' initial assessment and prior to the clients planned start date all information gathered will be inputted into the clients care plan. This will be inclusive of a MAR sheet, Care Plan, Medication Risk Assessments, PRN protocol (if any) and Medication Authorisation Forms. Details will also be outlined in the Care Plan on how the client receives their regular medication e.g. Who is responsible for the re order of medication, who is responsible for the delivery/collection of medication. Further to this to this if Serenta Homecare are responsible, medication visits will be added into the client's plan. Should in circumstances a client's prescription not be aligned (medication running out before the scheduled visit) Medication re order forms (see appendix 2) will be submitted by the Care Worker/Mental Health Support Worker to the Serenta Homecare Office.

Use of a Compliance Aid

If the Assessor considers that the issue of a compliance aid may help a person to maintain independence, they should discuss this with the Pharmacist. Such aids should be used in preference to aid wherever practicable, as the promotion of independence is an underlying principle of the Policy.

Some people who usually have a MDS may need short-term assistance with their medication from a Care Worker until their condition improves; in these short-term situations, it may be necessary for the Care Worker/ Mental Health Support Worker to assist with medication dispensed in the MDS, for the purpose of rehabilitation, and to enable the person to regain their independence.

Ordering/Collection of Medicines

Details will also be outlined in the Care Plan on how the client receives their regular medication e.g., who is responsible for the reorder of medication, who is responsible for the delivery/collection of medication. Further to this to this if Serenta Homecare are responsible Medication visits will be added into the clients plan and schedule. Should in circumstances a client's prescription not be aligned (medication running out before the scheduled visit) Medication re order forms will be submitted by the Care Worker/ Mental Health Support Worker to the Serenta Homecare Office.

Some Pharmacists will offer a prescription collection (from the GP practice) service and a delivery service for dispensed prescriptions to the Clients home for 'house bound' Clients – the Assessor should discuss options with the nominated pharmacy.

Persons Discharged from Hospital

When a client is discharged from hospital there will be an attempt to resume the original package of care. The Hospital Pharmacy may provide a MAR chart with the discharge medication, provided that there is sufficient notice of the discharge, and that nursing staff clearly indicate that support at home is to be provided. If there is not sufficient time before discharge to prepare a MAR chart it may be possible to forward this to Serenta Homecare NHS secure email system. All Clients discharged from hospital with a change in medication will require an updated MAR chart. These changes can be obtained as above.

If the person did not receive assistance with their medication before admission but it is assessed that they will need this on discharge, their task will need to be part of the Care Plan and the client should be discharged with a MAR chart/MAR forwarded to Serenta Homecare NHS secure email system. All clients discharged with a package of care provided at home, which includes administration of medication will require the creation of an MAR chart, medication risk assessment/care plan.

Care Worker/Mental Health Support Worker Training

- All Serenta Homecare Care Workers will be trained in medication upon induction. This will include Medication Practice for Homecare on care skills academy and medication face to face training. This will be refreshed annually.
- New Staters will be enrolled into Serenta Homecare 12-week development programme
- Care Worker/ Mental Health Support Worker Medication Competencies will be assessed Yearly. (See appendix 3)

The role of the Care Worker/Mental Health Support Worker

Storage of Medicines

Care Workers should ensure that all medication is stored in the agreed designated area as described in the client's medication risk assessment, out of sight and reach of children.

It is acceptable to store medicines requiring refrigerated storage in a domestic refrigerator. However, do NOT store medicines, in or immediately adjacent to, the icebox of a refrigerator or in the freezer compartment of a combined fridge freezer. Do not store medicines adjacent to food. Store medicines, if possible, in a door compartment that can be reserved for medicines.

The label on the medicine should indicate any special storage conditions e.g., the need to store in a refrigerator. Storage arrangements should be noted on the Clients Care Plan.

For SCC clients the assessor will note on the service procurement document if there is a need to make alternative arrangements to store medications in a locked container where this need has been identified by a risk assessment. This information will be transferred into the client's Care Plan/Medication risk assessment.

Administering Medication

Care Workers/ Mental Health Support Worker may only administer medication when they have received appropriate training and where the person has given their authorisation. Serenta Homecare have a duty to assess the competence of our Care Workers/ Mental Health Support Worker in assisting with medication. All administration must reflect the Six Rights:

- Right person
- Right medicine
- Right route
- Right dose

- Right time
- Persons Right to refuse

If the Care Worker gives any medicines or prompts the client to take their medicines without being requested (by the client) to do so, this activity must be interpreted as administering medicines which can be either:

- Prompt and observe (Level 1), or
- Administer (Level 2)

Details of each client's levels will be recorded within the Care Plan/Medication Risk assessment.

With the client's authorisation and instruction detailed within the care plan. Care Workers may assist a person to take their medication which has been prescribed by the person's GP or other authorised prescriber responsible for aspects of the Clients care.

All Care Workers/ Mental Health Support Worker who have undertaken the appropriate training and demonstrated competence on the management of medicines may aid with medication taken by mouth (oral preparations e.g., tablets, capsules, and oral liquids) and medication applied externally to the skin e.g., ointments, creams, and lotions.

Care Workers/ Mental Health Support Worker must only administer prescribed medication from containers clearly labelled with the client's name, the name of the medication and dosage and which have been supplied by a pharmacy, hospital, or dispensing GP's practice.

Care Workers/ Mental Health Support Worker should carefully follow any special instructions on the label of the medication, such as ensuring the medication is taken as directed before or after a meal. This information will be on the MAR chart.

If medication is labelled with imprecise or ambiguous directions, e.g., 'take as directed', 'take as before', 'apply to the affected part', clarification will be detailed within the MAR chart, site locations will be referenced from the Body Map. If further clarification is required, the Care Worker/ Mental Health Support Worker must contact their Line Manager.

Care Workers/ Mental Health Support Worker must not directly administer medication from multicompartment compliance aids or other compliance aids made up by family members or friends of the Client.

The Client has a right to refuse their medication as detailed within the Six Rights.

The Care Worker/ Mental Health Support Worker should immediately inform their Line Manager if they observe any possible adverse reaction to medication and should contact the GP, Pharmacist or the NHS 111 service (if neither the prescriber nor pharmacist are available). In case of emergency, the Care Worker/ Mental Health Support Worker should contact 999. Care Workers/ Mental Health Support Worker are in a good position to advocate on behalf of the person and feedback queries and concerns about the Clients health to the GP or Pharmacist.

Care Workers/ Mental Health Support Worker should inform their Line Manager if they have any concerns about the Clients health regardless of whether they are involved in the administration of medicine.

Assessors and Care Workers/ Mental Health Support Worker must always treat people with dignity and respect. Clients must be involved in any discussions with regards to their medication and they must be enabled to make decisions. There must be respect for Clients personal preferences and lifestyles.

Oral Medicines

Administration of oral medication for the purposes of these guidelines means: removing medication from container and directly administering.

Medication should not be handled and solid dose forms e.g., tablets and capsules should be passed to the Client in an appropriate container e.g., a medicine pot. Where the Care Worker/ Mental Health Support Worker must place the dose in the Clients mouth, the Care Worker should wear non latex disposable gloves.

Sometimes it may be necessary to administer a half of a tablet. Tablets may only be cut using a recognised or approved tablet cutter. The pharmacy may be prepared to do this and so should be asked. Where the pharmacy is not willing to cut tablets in half, this task must be undertaken by trained staff, wearing non-latex gloves. Staff are not permitted to return the unwanted half of a tablet to the pack as this is considered secondary dispensing. Instead, this should be safely disposed of as per spoilt doses. In such cases the GP should be asked to provide sufficient quantities.

Tablets should never be crushed, no capsules opened, without the explicit instruction of the prescriber and/or the supplying pharmacist, details will be held in the Clients care plan/medication risk assessment.

Some medication must be dissolved or dispersed in water before administration. This will be indicated on the label.

Tablets and capsules are best taken with enough water to aid swallowing. This is especially important with capsules.

Doses of liquid oral medication must be measured using a 5ml medicine spoon, an oral syringe, or a graduated medicine measure all of which are supplied by the pharmacy. Where the Client has trouble in taking liquid medicine from a medicine spoon or measure, an oral syringe may be required. Care Workers should contact their Line Manager if the person is experiencing difficulties with liquid oral medicines.

External Preparations

Creams, ointments, and lotions should only be applied by Care Workers/ Mental Health Support Worker where the skin area to be treated is unbroken. Care Workers/ Mental Health Support Worker must contact their Line Manager if they have concerns regarding the application of external preparations. However, in the management of Moisture Associated Skin Damage (MASD) where the skin may be broken, care workers may apply prescribed external preparations as part of the MASD pathway. (See appendix 4)

Care Workers/ Mental Health Support Worker must wear disposable, latex free gloves when applying external medication (e.g., ointments, creams, lotions, or patches).

Care Plans and Creams, Ointments and Lotions

Care plans/MAR chart should contain enough information of amounts to be applied, where to be applied (quoting the site number from body chart).

Where patches are prescribed, these should be accompanied with a Body Chart (see appendix 5) which will be kept with the Clients Home File). Upon administration of a patch a Patch Application Form (see appendix 6) must be submitted via access care planning, quoting the site number from the body chart. Note that the site used for patches must be rotated as per the prescribers' instructions.

If the label becomes detached from the container, is illegible, or has been altered, medication must not be administered. Advice should be sought through the Line Manager who should seek further advice where necessary. In the first instance this should be the supplying pharmacy. Out of normal working hours advice can be sought from the GP Collaborative (by ringing the Clients own GP) and via the NHS 111 service.

Medicines have an expiry (use-by) date. The expiry date must be checked to ensure that the medicine may still be used. In most cases where medication is supplied in the manufacturer's packaging the printed expiry date will apply. However, this is not always the case (e.g., eye drops and eye ointments – refer to pack label.). Care Workers/ Mental Health Support Worker should write the date of opening on the pack and note any labelled guidance on product expiry.

The Care Worker/ Mental Health Support Worker must inform their Line Manager about any medication that has expired. The Line Manager must contact the Clients GP to ascertain if the medication is still required, in which case the GP will be requested to issue a new prescription. The Care Worker/ Mental Health Support Worker must enter the details on the Clients visit notes and the expired medication should be returned to the pharmacy.

Administering 'when required' Medicines PRN

Most medication will be prescribed for administration on a regular basis. Some treatments may be prescribed on a PRN or an 'as and when required' basis. Care Workers/ Mental Health Support Worker will be given sufficient information to determine if a dose being requested by the person is appropriate. If in doubt the Care Worker/ Mental Health Support Worker must contact their Line Manager who must contact the GP practice for clarification. Any such 'as and when required' dose should have information about the reason for the medication, the recommended dose, the recommended frequency and the maximum doses in 24 hours. Each individual PRN medication will have a PRN protocol (see appendix 7) The reason for assisting with a dose of 'as required' medication should be recorded on the Clients daily notes.

Where a Client has multiple painkillers within their PRN section Care Workers/ Mental Health Support Worker will review painkillers from the PRN section and review which

painkiller has been administered in previous visits, Care Workers/ Mental Health Support Worker should if able ask the Client if the pain has been resolved or in cases where a Client is non-verbal details of verbal cues will be detailed within the care plan, in order to determine which painkiller/painkillers is to be administered in the current visit.

Before assisting with PRN medication, the Clients MAR chart, and visit notes must be checked to see if anyone else has administered PRN medications and that the recommended dose will not be exceeded. If in any doubt the Line Manager should be contacted for advice.

Care Plans and PRN's

The PRN Protocol section of the care plan should contain enough information to support staff to administer PRN medicines as the prescriber intended. This should include:

- details about what the medicine is for
- symptoms to look out for and when to offer the medicine
- whether the person can ask for the medicine or if they need prompting or observing for signs of need, for example non-verbal cues.
- The PRN protocol should be reviewed in line with the client care plan review. Are PRNs are given regularly? If so, has a medicines review taken place by their GP?
- Where there is more than one option available, for example multiple painkillers, the order in which they should be tried should be made clear. For example, paracetamol first, then codeine if pain not resolved. Where a Client has multiple painkillers Care Workers/ Mental Health Support Worker will review painkillers from the PRN section and review which painkiller has been administered in previous visits, Care Workers/ Mental Health Support Worker should if able ask the Client if the pain has been resolved or in cases where a Client Is non-verbal observe for example non-verbal details of non-verbal cues will be detailed within the care plan in order to determine which painkiller is to be administered in the current visit.

Administering Variable Doses

Some medication is prescribed on a reducing or variable dosage regime and the Care Worker/ Mental Health Support Worker must always refer to the MAR chart for information of the variable dose. In circumstances which will be detailed within the MAR chart, a client may have the capacity to decide a variable dose e.g. PARACETAMOL These details should include the following and be detailed within the visit notes:

- Quantity administered
- The time of administration is recorded on the clients MAR sheet they will have the administration times specified already.
- Reason for administration (e.g., back pain)

In circumstances where a client is non- verbal/lacks capacity to make specific decisions, they will remain at the centre of the decision-making process and a decision will be made in their best interest.

Where warfarin is the variable dose the dosing information will be sent from the anti-coagulant clinic. Dose instructions will normally be faxed/Sent via NHS secure email to Serenta Homecare before 5pm on the day of the INR blood test, MAR cherts/ care plans will be updated.

Administering Controlled Drugs

Although the assistance with the administration of controlled drugs follows the steps for the administration of any other medication, care should be taken with storage to minimise any risk of inappropriate access to the medicines.

Prescriber Directions to Amend Dose

Any change in the dose of previously supplied medication should be communicated to Serenta Homecare by the prescriber. The Client would need a new medication label to indicate the change or alternatively the alteration can be made to the label but would need to be signed and dated by the clinician. New dosing instruction would need to be inputted onto the MAR chart.

Emergency Supplies

Although there are provisions in place (see appendix 2) to ensure there is sufficient medication for the Client, there may be occasions where the Client supply has run out. There is a provision under the NHS to obtain an 'Emergency Supply'. The Line Manager or other member of staff should contact '111' who will send a request to a convenient pharmacy able to make a supply.

Other Administration Techniques

The following medications must NOT be administered by Care Workers/ Mental Health Support Worker:

- Injections
- Suppositories
- Pessaries
- Enemas
- Internal rectal creams
- Internal vaginal creams
- The application of dressings involving wound care
- The application of medication to broken skin except where this applies to the application of barrier products (i.e., MASD Pathway and the Medi Derma-S Products) (see appendix 4)

The administration of these medicines is the responsibility of a health care professional (e.g., a District Nurse).

Administration of Medicines via Enteral Feeding Tubes (PEG/PEJ)

When specific skills are needed to give a medicine via a PEG or PEJ tube, this task should only be delegated to a Care Worker/ Mental Health Support Worker when:

- There is local agreement between health and social care that this support will be provided by a Care Worker
- The Care Worker is trained suitably by an appropriate health care professional

Care Workers are trained with a Nutrica Nurse which will be completed 3 yearly.

A care plan will be in place to cover medicines administration via an enteral tube covering the relevant issues. The directions on the label/MAR chart/Care Plan should clearly identify how and when the medication should be administered via the PEG tube. This includes all activities e.g., crushing and flushing.

Non-Prescribed Medicines

Upon initial assessment Serenta Homecare will enquire about the Clients use of non-prescribed medication, recording the outcome on the Non-Prescribed Medicines (NPM) form (see appendix 8) Copies of the NPM form will be filed with the signed Medication Authorisation Form. Copies will reside within the Clients home and office file.

Care Workers/ Mental Health Support Worker are permitted to assist Clients with the administration of non-prescribed medication in addition to prescribed medicines, providing that advice has been sought from the person's GP or Pharmacist to check for drug interactions or contra-indications. Care Workers/ Mental Health Support Worker are not permitted to assist with the administration of non-prescribed medicines if a NPM form has not been completed by an Serenta Homecare Assessor, in such cases where a Clients requests that a Care Worker/ Mental Health Support Worker assists with the administration of non-prescribed medicine Care Workers/ Mental Health Support Worker should seek further advice from their Line Manager.

Details (including the time and the dose) of any non-prescribed medication that is administered to the person must be recorded on the Clients MAR chart. Note that it is the responsibility of Serenta Homecare to ensure that such items are listed on the MAR chart.

Before assisting with non-prescribed medications, the Clients MAR chart, and visit notes must be checked to see if anyone else has administered non-prescribed medications and that the recommended dose will not be exceeded. If in any doubt the Line Manager should be contacted for advice.

The GP should be requested to prescribe all medicines taken on a regular basis (if available on an NHS prescription).

Care Workers/ Mental Health Support Worker must not offer advice on non-prescribed medicines and remedies as it may be dangerous to do so.

Out of date/Unused

Unused, out of date medication, or medication no longer required, must be returned to any community pharmacy, with the Clients authorisation. Where there is no informal carer (e.g., a family member) who can be responsible for the return of medicines no longer required, the Care Worker/ Mental Health Support Worker must obtain approval of their Line Manager to return the medicines to the pharmacy. Where medicines are returned evidence will be required in the form of a pharmacy signature using Medicines Returned Form. (See appendix 10.)

Disposal of Spoilt Doses

Where a single dose of medication has been removed from the container but is not used, it should be disposed of by placing in a suitable container, envelope or disposable glove and taking to the community pharmacy. Once taken to the pharmacy for disposal a Medicines Returned Form must be completed. (See appendix 10). Details of medication disposal must be recorded in the Clients visit notes.

If the person requests that a spoilt dose is not destroyed (e.g., after having been dropped on the floor) and that the dose be administered, the details must be recorded in the Clients visit notes and the Care Worker/ Mental Health Support Worker should report the administration of the spoilt doses to their Line Manager immediately. This situation may occur if the spoilt dose is the only dose remaining.

Where the person lacks capacity to decide the safety of taking a spoilt dose, the Care Worker/ Mental Health Support Worker should follow the guidance, dispose of the dose appropriately and report any problems to their Line Manager.

Disposal of Sharps

Care Workers/ Mental Health Support Worker are not responsible for the use of or disposal of sharps (syringes or needles). This applies to unused as well as used sharps.

Refused Medication

If a client refuses their medication, the Care Worker/ Mental Health Support Worker should consider waiting a short while before offering it again. They should ask about other factors that may cause the Client to refuse their medicine. This must be reported to the office immediately and should also be noted on the MAR chart using the relevant code.

Covert Administration

Covert administration is the term used when medicines are administered in a disguised format, e.g., in food, drink or via a feeding tube without the knowledge or consent of the Client receiving them. As a result, the Client is unknowingly taking a medicine. Every person

has the right to refuse their medicine, even if that refusal appears ill-judged to staff who are caring for them.

Covert administration is only likely to be necessary or appropriate where a client actively refuses their medicine but is judged not to have the capacity to understand the consequences of their refusal and the medicine is deemed essential to the Clients health and wellbeing.

Covert administration of medication should only be undertaken following an appropriate assessment completed by a Professional to establish the person's capacity to make decisions. Discussions must be held with the Clients social worker if applicable and the Service Plan updating to reflect covert administration. Details must be documented within the Care Plan/medication risk assessment to give clear instruction of how medication is to be covertly administered.

Recording Administration

A MAR chart must be maintained by the Care Worker/ Mental Health Support Worker for each Client who is receiving administration of their medication from a Care Worker/ Mental Health Support Worker.

The MAR chart and visit notes must be examined on each occasion the Care Worker/ Mental Health Support Worker attends the Clients home, prior to administration. This is to note any changes in medication and to ensure that the medication has not already been administered.

A Care Worker/ Mental Health Support Worker must confirm that a dose has been administered by selecting the appropriate code on the MAR chart.

Care Workers/ Mental Health Support Worker who are attending time critical visits for medication administration purposes must check the previous visit times to ensure sufficient time gaps have been allowed.

Prompt Medication Recording

If you are prompting medication, you are administering. The same checks need to be in place, the same record keeping needs to be completed, the same level of knowledge is required to fully support the client-even if you only prompt from a monitored dosage system. The monitored dosage system must be prepared by the pharmacy or a dispensing GP for you to legally prompt or administer from it and whilst they have a responsibility to ensure that it leaves the pharmacy with the correct medication inside, you still have the responsibility to ensure that the right person gets the right dose of the right medicines by the right route at the right time. Prompted medication is required to be recorded on MAR chart using the correct coding.

It should be noted that some Clients may be independent with some medications, for example oral medications, but may need assistance with others, for example to apply (administer creams). A MAR chart will be provided for any aspect of medication administration for which the Client requires assistance from a Care Worker/ Mental Health Support Worker.

Audits

10% of completed MAR charts will be audited by Senior Care Worker/designated person, to check that the MAR is completed accurately and if any discrepancies are identified action will be taken.

Reporting Errors and Discrepancies

Errors occur when medication is not administered according to the instructions given. This may include:

- Administering the wrong medicine
- Administering the wrong dose
- Omitting to administer the medication
- Omitting to record

Errors can occur, Serenta Homecare have a robust incident reporting system (appendix 9) which is to be incited should a medication error happen. Staff must report all errors so that the Care Workers/ Mental Health Support Worker and Serenta Homecare learn from mistakes and prevent errors in the future.

Care Workers/ Mental Health Support Worker must not make a judgement on the impact that the error may have on the Client. All facts must be clarified before action is taken. They should seek advice from the Line Manager. Advice should be sought from the appropriate clinician, e.g., the Clients dispensing pharmacy, a late-night pharmacy, or the Clients GP.

Discrepancies must be investigated appropriately, and a conclusion drawn as to the underlying cause. This may be an omission to record/administer. The discrepancy may also involve the loss of medication which may be due to theft, and which must be reported to the police.

Medication errors must be reported regardless of who made the error or who it is perceived made the error where this has affected the Client in their care.

Appendix 1

MEDICATION AUTHORISATION FORM

It was agreed at an assessment with a social worker or care manager that a home care provider will help to administer your medication.

To be read and completed by the service user or their authorised representative[1]:

I give authorisation for care workers from my home care provider to assist with the administration of medication as prescribed by my GP or other authorised prescriber.

If applicable, I also give authorisation for my care workers to administer non-prescribed medication in accordance with the agreed non-prescribed list[2].

I understand that:

- Care workers can only administer medication recorded on the Medication Administration Record (MAR chart) at the prescribed level.

- Anyone who administers my medication, including, for example, my carer or a family member, will record the details on the MAR chart. Administration of any non-prescribed medication will be recorded in the home care provider's log book.

- My care workers will follow the guidance set out in the Sheffield Medication Policy.

I agree that:

- I will make available to my care workers / home care provider the MAR chart and any other records relating to my medication.
- I authorise my care workers / home care provider to communicate with my GP, pharmacy or any other prescriber about my medication and issues that arise.

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[1] The form should only be completed by a representative of the service user by exception, for instance due to a physical or cognitive impairment.

[2] http://www.sheffield.gov.uk/content/sheffield/home/disability-mental-health/medication-policy.htmlv

- My details can be shared with my pharmacy to enable them to produce a MAR chart for use within my home.

- Where necessary I will give as full information as possible to my care workers / home care provider about my medication including what I have and have not taken.

- I will cooperate with my care workers / home care provider to enable them to safely administer my medication, ensuring that my medication is appropriately stored. I will also enable them to appropriately dispose of medication that is no longer prescribed, out of date or is spoilt and cannot be used safely.

- My home care provider will keep my MAR chart when it is completed for audit purposes.

NAME	
SIGNATURE	
DATE	

Please refer to pages 3 and 4 to see the information your home care provider will share with your pharmacy.

A Medication Authorisation Form is to be completed in full on the first occasion an individual requires support with medication administration as part of a home care package.

In the event a client transfers to a new provider, the original Form remains valid. In the event of any changes, the pharmacy must be informed (see page 5).

All providers will adhere to the Sheffield Medication Policy when administering medication: http://www.sheffield.gov.uk/content/sheffield/home/disability-mental-health/medication-policy.html

SERVICE USER NAME	
LAS[3] ID	
DATE OF BIRTH	
ADDRESS	
CONTACT TELEPHONE NUMBER	
If there is another individual(s) i.e. carer or family member who it is more appropriate to contact, please detail below:	
NAME	
RELATIONSHIP TO SERVICE USER	
CONTACT TELEPHONE NUMBER	
NAME	
RELATIONSHIP TO SERVICE USER	
CONTACT TELEPHONE NUMBER	

GP	
SURGERY	
NOMINATED PHARMACY	

HOME CARE PROVIDER	
CONTACT TELEPHONE	
DATE SERVICE TO COMMENCE	

[3] Previously known as CareFirst number until Sheffield City Council IT system change on 08/10/18.

MEDICATION LEVEL[4] (as per support plan)	
MDS (NOMAD) TO BE USED[5] (please ✓)	

THE SERVICE USER REQUIRES SUPPORT WITH (please ✓applicable boxes):	
ALL MEDICATIONS	
CREAMS	
PATCHES	
OTHER (please state):	

NAME OF STAFF MEMBER COMPLETING FORM	
ROLE	
SIGNATURE	
DATE	

The Form must be completed by the home care provider at the point of undertaking the initial assessment with the service user and sent to the specified pharmacy and the service user's GP by one of the following methods:

- In person
- Fax
- Post

The pharmacy will only supply MAR charts upon receipt of a fully completed Form.

The home care provider will ensure a copy of the Form is retained in the following locations:

- The service user's file in their property
- The service user's file at the provider's local office

To be completed by the Pharmacy:

NAME	
ROLE	
SIGNATURE	

[4] Pharmacies will supply a MAR chart for adults aged 18 and over in receipt of home care funded by the Council (including both in-house services and any organisation delivering services on behalf of the Council) who is assessed as requiring support at Level C, i.e. where the Care Worker is responsible for 'removing medication from the container and directly administering' the medication.

[5] Monitored Dosage Systems (known as a NOMAD) should only be used by exception where an individual requires support at Level C. The pharmacist will supply a separate, standardised MAR chart for the care worker to record administration of medication from the MDS.

DATE OF RECIEPT	

REVIEWING & UPDATING THE AUTHORISATION FORM

In the event that any of the details on the form change, the home care provider will inform the pharmacy at the earliest opportunity, recording the details in the box below:

DESCRIPTION OF CHANGE	DATE PHARMACY INFORMED	METHOD	SIGNATURE

The home care provider will review the content of the form at least annually, as part of their formal review of the individual's care package, informing pharmacy as described.

	DATE	SIGNATURE
Review 1		
Review 2		
Review 3		
Review 4		

ENDING THE SERVICE

The home care provider must inform the pharmacy when they no longer require a MAR chart for this service user by completing the following table and returning the form to the pharmacy via one of the methods described on page 4:

SERVICE USER NAME		
LAS ID		
DATE OF BIRTH		
POSTCODE		

	Please ✓ the reason that a MAR chart is no longer required for this service user:	
	INDEPENDENT WITH MEDICATION	
	HOSPITALISATION (LONG TERM)	
	ADMISSION TO CARE HOME	
	DECEASED	
	OTHER (PLEASE STATE):	

Appendix 2

Medication re ordering Form

Please list what medication requires re ordering Including the medication name*
please indicate how many days worth of the medication is left in the property

Check the rest of the medication*
It takes 4 days to receive a ordered medication if a service user is running out of one tablet could you please check the rest of the medication to see if a full prescription will require ordering

Please attach photos if appropriate

Reported By:

Name*

Date issue was reported*

Approx. time*

Signature*

Appendix 3

Medication Competency Assessment

The medication competency is divided into two parts

Part 1 – The Observation

The medication assessor will observe the member of staff as they undertake the process of administering medication.

Part 2 – The Competency questions

The medication assessor will ask the staff member the series of questions to assess the staff members understanding, guidance is given to the answers but is for the assessor to assure themselves that the staff member has the required level of understanding. There is also space for the assessor to add any additional questions to assess understanding if necessary.

Principles of the observation

Care Certificate – Standard 13 – Health and Safety	
13.5 Understand medication and healthcare tasks	
13.5 a	Describe the agreed ways of working in relation to medication
13.5 b	Describe the agreed ways of working in relation to Healthcare tasks
13.5 c	List tasks relating to Medication and Healthcare procedures that they are not allowed to carry out until they are competent

Medication Competency Assessment

Name of staff member:	Job title
Workplace Address:	
Name of Assessor:	**Job title**

Training and Policy

Has the staff member completed training on the safe handling of medications (e-learning)	**Yes**	**No**
Does the staff member know how to access the medication policy?	**Yes**	**No**
Has the staff member read the medication policy?	**Yes**	**No**

Administration of Medication – Observation

Preparation and Hygiene		
Did the member of staff make sure that everything was properly prepared before starting to administer the medication? E.g. prepare a drink for the person	**Yes**	**No**
Did the member of staff wash their hands before starting to administer any medication and follow appropriate hygiene measures whilst administering the medication? E.g. wear gloves when applying creams.	**Yes**	**No**

Consent		
Before preparing or administering the medication did the member of staff obtain the person's consent?	**Yes**	**No**
If consent was not obtained was this part of a documented protocol for this person, such as covert administration, and is the member of staff satisfied that the correct procedures have been followed in the best interests of the person?	**Yes**	**No**

Selection and preparation			
Before selecting, preparing or administering any medication did the member of staff read the MAR chart accurately?	**Yes**		**No**
Was the medication selected checked against the correct MAR chart including checking the person's name on the label and MAR?	**Yes**		**No**
Was the correct medication and dose selected at the correct time? Was consideration given to timing in terms of food or other directions on the label?	**Yes**		**No**
Was the medication prepared according to the directions and information on the MAR chart or any accompanying protocol?	**Yes**		**No**
Did the member of staff use the appropriate measure for any doses of liquid medication? e.g. oral syringe, graduated measuring cup?	**Yes**	**No**	**N/A**
Administration			
Did the member of staff check the support plan to see how the individual prefers to take their medication or demonstrate that they knew this information and administer the medication accordingly?	**Yes**		**No**

Did the member of staff offer information, support and reassurance throughout to the person, in a manner which encourages their co-operation, promotes dignity and which is appropriate to their needs and concerns?	**Yes**	**No**

Please tick which medications have been witnessed?					
Tablets/Capsules		Inhalers/devices		Sachets/powders	
Liquids		Eye drops		Ear drops	
Creams and Ointments		Patches		Other please state:……..	

Administration continued			
Did the member of staff visually witness the individual taking all their medication?	**Yes**	**No**	
If the medication was not taken was the appropriate advice sought and documented?	**Yes**	**No**	**N/A**
If the medication was not taken was it dealt with as given in the medication policy?	**Yes**	**No**	**N/A**

Record keeping		
Did the member of staff sign the MAR chart immediately after the medication was administered?	**Yes**	**No**
If the medication was not given was an appropriate code entered on the MAR chart?	**Yes**	**No**

Accessing information		
Does the staff member know who to contact if they need advice on medication?	**Yes**	**No**
Does the staff member know what to do if they suspect an individual is suffering side effects from a medication?	**Yes**	**No**

Questions:	Indicators	Answered correctly	
What would you do if you administered the wrong medication to a service user?	• Contact GP,NHS 111, 999 • Inform Line manager or OOH support • Inform service user and offer reassurance • Complete an incident form • Inform service users key people if applicable • Record in service users notes and discuss at handover	**Yes**	**No**

What would you do if you found that previous medication was not administered?	• Inform Line Manger/OOH Support • Contact GP, pharmacy, NHS 111 • Inform service user and offer reassurance • Complete an incident form • Inform service users key people if applicable • Record in service users notes and discuss at handover	**Yes**	**No**
Questions continued:	**Indicators**	**Answered correctly**	
What would you do if a service user declines their medication?	• Follow any administration strategy detailed in the service users care plan • Clearly record refusal of medication on MAR • Record in care notes • Inform line manager/OOH support who will determine whether to seek further advice from GP/Pharmacy or if there is an immediate risk to the service users health • Call GP if there is a consistent refusal	**Yes**	**No**
What would you do if you dropped the medication on to the floor?		**Yes**	**No**

	• Administer a replacement tablet from the pack • Contact GP/Pharmacy to arrange a re-placement • Record that the medication was dropped and handover • Prepare the discarded medication for return to pharmacy as dictated by the pharmacy		
You are assisting a service user with their medication, the dose marked on the MAR chart is unreadable, you think it should be 2 tablets twice a day, what should you do?	• Do not give the medication until advice has been sought from the pharmacy or GP • Put a new MAR chart in place once confirmation has been sought • Record actions in the service users care notes • Complete an incident form • Alert Manager to the issue	**Yes**	**No**

Any other information – Record any discussion between the staff member and assessor

Outcome:

Please tick appropriate outcome ✓

Staff member demonstrates competence to administer medication unsupervised	Staff member demonstrates competence to administer medication unsupervised with the exceptions identified below	Staff member requires further supervision or training in order to administer medication unsupervised at this time
□	□	□
Actions/exceptions identified:	**Actions/exceptions identified:**	**Actions/exceptions identified:**

Staff member comments

Staff Signature		Staff Name		Date	

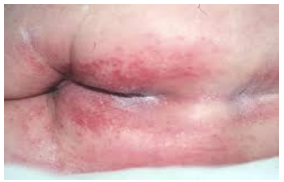
Assessor Signature		Assessor Name		Date	

Appendix 4

Prevention & Management of Moisture Associated Skin Damage (MASD) Pathway

WHAT IS THE PRIMARY TREATMENT AIM FOR SKIN BARRIER PROTECTION?

PREVENT




Moisture-associated skin damage from incontinence, wound exudate or perspiration

↓

Intact Skin +/- Erythema

↓

ACUTE: Cleanse with an emollient cleanser or soap substitute

COMMUNITY: Continue with routine cleansing

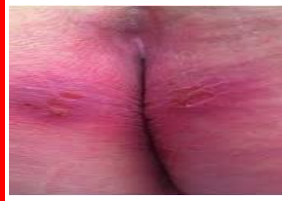
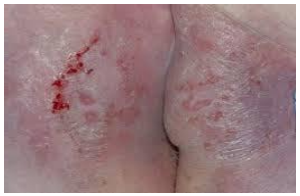
↓

<u>Incontinence:</u>
Prevent Skin Damage from incontinence with **MEDI DERMA- S** Total Barrier **Cream**

<u>Wound Exudate/ Prespiration:</u>
Protect from wound exudate and perspiration with **MEDI DERMA-S** Total Barrier **Film**

Inform Registered Nurse

PROTECT

Mild to moderate skin damage from incontinence, wound exudate or perspiration

↓

Erythema/Dermatitis or Moisture Lesions

↓

ACUTE: Cleanse with an emollient cleanser or soap substitute
COMMUNITY: Continue with routine cleansing

↓

Protection with **MEDI DERMA-S** Total Barrier **Film**

If severe skin damage or skin integrity is deteriorating, please discuss with

REPAIR

Severe skin damage from incontinence, wound exudate or perspiration

↓

Erthyma/Dermatitis or Moisture Lesions

↓

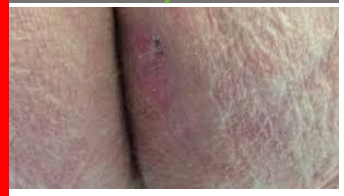
ACUTE & COMMUNITY: Cleanse with **MEDI DERMA-PRO** Foam & Spray Incontinence Cleanser

↓

Protect with **MEDI DERMA-PRO** Skin Protectant Ointment

Once repaired, continue to follow pathway

RESOLVE/RESTORE



Skin Hydration and maintain restored skin integrity

↓

ACUTE: Cleanse with an emollient cleanser or soap substitute
COMMUNITY: Continue with routine cleansing

↓

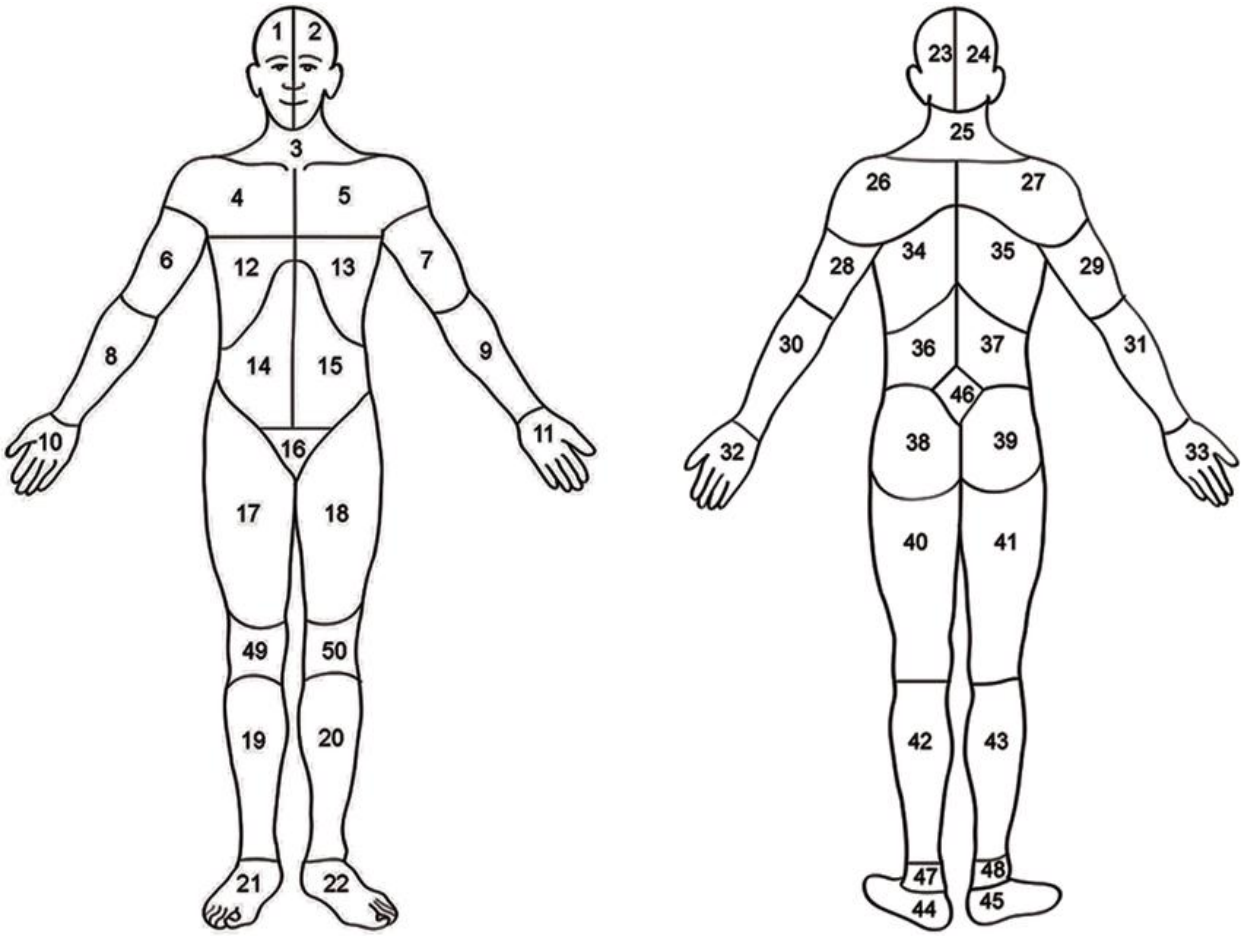
Prevent with **MEDI DERMA-S** Total Barrier **Cream**

In Darkly pigmented skin, MASD may be more difficult to identify. Please pay attention to any skin changes where moisture may be a contributory factor

Appendix 5

Numbered Body Map

(Numbers to be used for reference when administering topical medications, prescribed patch applications and reporting concerns in relation to skin integrity)



Client Name:

Client's Date of Birth:

Appendix 6

Patch Application Form

Clients Name*

Date*

Time*

Name of Application*

Please detail the name of the patch being applied

Old patch removed*

YES ☐ **NO** ☐

If no, please state why

State Number*

State the number referencing from the body map in the client's property where the patch has been removed and applied. Please note that the site used for patches must be rotated.

Name of Care Worker*

Signature*

Appendix 7

PRN Protocol

Clients Name*

Date of Birth*

Allergies*

Medicines*	Route of Administration*	Dose*	Frequency*	Minimum time interval between doses*	Max 24 hour Dose*

Reason for Administration*
When it should be given / signs and symptoms / behaviours / triggers / type of pain / condition being treated by medication

Expected / Desired Outcome*
Signs / Observations that it has worked

Other Medication being taken to be aware off*
Possible interactions

Special Instructions / Additional Information

Name of Staff Member completing Form*

Signature*

Date*

Review Date*

This form is to be reviewed every 6 months in line with the care plan review

Appendix 8

Non-Prescribed Medication

Copy and keep with all copies of the Service User's Authorisation Form

To be completed by Assessor or Care Worker's Line Manager

The Good Practice Guide permits carers to assist persons with the administration of non-prescribed medication providing that advice has been taken from the person's GP or Pharmacist checking that it is suitable and does not affect any medication the person is already taking. Where the person lacks capacity, information should be sought from their family, carer, LPA, advocate or whoever has the required information.

The person should be asked the following questions in relation to non-prescribed medication:

 Do you take any medicines that are not prescribed for you by your GP? ☐ YES ☐ NO
(or dentist/nurse prescriber/pharmacist prescriber)

If Yes: Do you take non-prescribed medicines Regularly? ☐ Y☐ NO

Occasionally? ☐ Y☐ NO

 What non–prescribed medicines do you take regularly, (e.g. vitamins, herbal products)

Regular Medicine	Recommended dose	Dosage interval	Maximum dose in 24 hours	Authorised Yes / No	Authorised by GP or Pharm

 What non-prescribed medicines do you take occasionally (e.g. Paracetamol for pain relief, dioralyte for diarrhoea, E45 Cream / Aqueous Cream for dry / itchy skin)?

Occasional Medicine	Recommended dose	Dosage interval	Maximum dose in 24 hours	Authorised Yes /No	Authorised by GP or Pharm

N.B: Indicate against each medicine listed if the continued use of the non-prescribed medicine has been approved by the Service User's GP or Pharmacist. The GP should be requested to prescribe all medicines taken on a regular basis (if available on an NHS prescription)

Appendix 9

Incident / Accident / Medication Report Form

please write clearly

Please tick as appropriate: Incident ☐ Accident ☐ Medication ☐

Address where the incident took place:					
Location at Address: e.g. bathroom, bedroom					
Date of Incident:		**Time of Incident:**		**Duration of incident**	

Who was involved in the Incident?			
Name	**Date of Birth**	**Their Role:** *Service User/staff/other*	**Contact Number** *only if applicable*

RESPONDING, RECORDING AND REPORTING:						
Did the incident/accident/meds error involve: *Tick all that apply*						
Manual handling		Equipment / Failure		Fire		**Other**
Injury		Physical Intervention		Transport		
Violence/aggression		Theft		Fatality		
A slip, trip or fall		Health		Burns/Scalds		
Ingestion/choking		Hospital admission		PRN Medication/ Chemical Restraint		
Near Miss		Medication error				

Detail of Incident/Accident/Medication error: (W*hat happened, external agency involvement, witness details, details of any injuries, detail of medication error, medication name, dosage, overdose or under dose etc.)* ***If Continuation Sheet (page 3) is used please tick here*** □

Action Taken: *(Have any control measures been put in place? What has been done? First Aid, GP, Police called, Ambulance, Hospitalisation. Risk assessment and support plan updated? Management Notified?)*		
Action	**By Who**	**When**
Outstanding Actions:		

Actions / Reported to	**Yes**	**No**	**Name / Reference**	**Date**
Manager / Coordinator / CSO Notified:				
Registered Manager Notified:				
On Call / Out of Hours Contacted:				
CQC Notified:				
Adult Social Services Notified:				
RIDDOR				
Other (specify)				

Signed by the person completing this form:	
Print Name:	**Job Title:**
Signature:	**Date:**
Line Manager signage:	
Print Name:	**Job Title:**
Signature:	**Date:**

This form should be completed within 24 hours or as soon as reasonably possible after an incident. You should ensure that this completed form is given to your line manager or handed into the office.

Incident / Accident / Medication Error Continuation Sheet

Date of Incident:		**Time of Incident:**	
Name of person completing form:		**Date:**	
Sign:			

Detail of Incident/Accident/Medication error: (W*hat happened, external agency involvement, witness details, details of any injuries, detail of medication error, medication name, dosage etc.)*

Appendix 10

Medication Disposal Record

Name of Client		Date of Birth	

Date of Disposal/ Return to Pharmacy	Name of Medication	Strength of Medication	Quantity of Medication Disposed/ Returned	Name of Pharmacy Medication Disposed/ Returned to	Name of Staff Member Disposing/Returning Medication	Signature

Document Control

Date Approved: June 2026 Target Audience: All Serenta Homecare Staff Review Date: June 2027 Author: F Beardsmore