Family Nursing & Home Care

Home Care Service Medicines Policy

1 September 2021

Document Profile

Document Registration	Added following ratification
Type	Policy
Title	Home Care Service Medicines Policy
Author	Mo de Gruchy, in consultation with Home Care Manager and Operational Lead Adult DN Services
Category	Home Care
Description	This policy provides an up to date operational framework to include all activities associated with the routine use of medicines within the Home Care Service, including prescribing, dispensing and supply, storage and security, administration and disposal.
Approval Route	Organisational Governance Approval Group
Approved by	Bronwen Whittaker
Date approved	22 September 2021
Review date	3 years from approval
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Version control / changes made

Date	Version	Summary of changes made	Author
May-August 2021	1	Previous policy transferred onto new policy template Previous separate appendices now part of main policy document Previous SOPs now in separate document 'Home Care Service Medicines Management' Document title revised to clearly identify that this document only applies to care staff employed by the Home Care Service. Content reviewed and updated in line with the NICE Guideline Managing medicines for adults receiving social care in the community (2017), Jersey Care Commission Standards for Home Care (2019), FNHC Medicines Policy (2020) and FNHC Personal Care and Clinical Tasks in Adult Social Care Policy (2021)	Mo de Gruchy

CONTENTS

This policy was previously developed using the Family Nursing & Home Care Medicines Policy (2016) and Norfolk County Council's Medication Policy for Domiciliary Care Services. Permission was kindly given by Norfolk County Council to use their policy.

1. INTRODUCTION

1.1 Rationale

The Jersey Care Commission Standards for Home Care (JCC 2019) state that medicines will be managed in compliance with legislative requirements, professional standards and best practice guidance and that written policies for the management of medicines will be up to date, based upon best practice and cover all aspects of medicines management.

The purpose of this Medicines Policy is to provide an up to date operational framework that includes all activities associated with the routine use of medicines, including prescribing, dispensing and supply, storage and security, administration and disposal.

All care assistants working within the Home Care Service may be involved in the administration of medicines. Family Nursing & Home Care (FNHC) recognises the potential legal and clinical implications relating to the administration of medicines, including controlled drugs, therefore this policy has several aims:

- To have procedures in place to ensure safe systems of work, and therefore, protect patients and staff by reducing risk and the potential for error.
- Dispel confusion and provide clarity.
- Ensure all legislation and professional guidance is adhered to with respect to medicines.
- Provide a framework for teaching, training, audit and future development.

1.2 Scope

This policy only applies to FNHC staff working within the Home Care Service.

All other clinical staff including health care assistants working in the nursing teams and any nursing students undertaking part of their training with FNHC must follow the FNHC Medicines Policy.

This policy should be read in conjunction with the following:

- British National Formulary (current)
- Jersey Care Commission Standards for Home Care 2019
- Jersey Care Commission Personal Care and Clinical Tasks Guidance for Adult Social Care 2019
- Capacity and Self Determination (Jersey) Law 2018
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society 2019)
- Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society 2019)
- FNHC Consent to Treatment and Care Policy

1.3 Role and Responsibilities

Chief Executive Officer

The Chief Executive Officer has overall responsibility for ensuring that:

- the requirements for using this policy are met and that adequate resources are made available to meet these requirements
- arrangements are in place for safe medication management in the Home Care Service
- any system in place is the subject of periodic review by management

Head of Quality, Governance and Care

The Head of Quality, Governance and Care has a responsibility to:

- monitor the effectiveness of policies, systems and procedures regarding medicines management in adult Home Care
- monitor medication incidents recorded through the incident reporting system (Assure) and report monthly figures at the Operational Governance Meetings
- provide post incident support when required
- provide reports and trend analysis regarding incidents involving medication
- ensure that training is delivered and monitored with records of attendance continually updated; reporting levels of non-compliance at the Operational Governance meetings

Home Care Manager

The Home Care Manager has a responsibility to:

- Ensure that all staff are aware of this policy and to encourage and monitor compliance with it and its related guidelines, protocols and procedures.
- Review and update this policy and accompanying procedural documents at agreed intervals ensuring that any changes in legislation or practice are incorporated into this document
- Monitor the effectiveness of policies, systems and procedures for the safe management of medication
- Ensure working practices facilitate safety in line with legal and regulatory requirements
- Promote the delivery of high quality, compassionate, personalised care
- Release staff for training
- Monitor compliance with the training requirements for this policy

Senior Care Assistants

Senior Care assistants have a responsibility to:

- Provide leadership and foster a culture in which personalised care is delivered
- Facilitate compliance with this policy and its related procedural documents
- Undertake medication risk assessments and formulate care plans for the safe management of medicines administration
- Encourage reporting of all medication incidents through the incident reporting system
- Manage post incident reviews, debriefs and the implementation of lessons learned
- Ensure that, wherever possible, care assistants with the appropriate level of training visit clients requiring care relating to their medication
- Monitor compliance with this policy
- Take appropriate action where standards are not being met

Care assistants

Care assistants involved in medication management have a responsibility to:

- Adhere to this policy and its related procedural documentation
- Work in line with the latest version of the Code of Practice for Health and Social Care Support Workers in Jersey
- Work within their sphere of competence
- Identify and address any learning needs they may have in relation to medication management
- Report all medication incidents

2. POLICY

2.1 Principles of Medicines Management

The management of medicines by Home Care Service care assistants is based upon the Jersey Care Commission Standards for Home Care 2019. Whilst non-registrants are not subject to the same standards as Registered Nurses, safe systems of work must be in place to maintain the safety of clients.

FNHC recognises that the administration of medicine is diverse and complex and aims to ensure that all reasonable measures are taken to enable clients to have their medication at the times they need them and in a safe way that protects both them and staff.

FNHC supports the principle that clients should be encouraged to self-administer and self-manage their own medication wherever this is possible.

2.1.1 Shared Administration

Where possible, shared care arrangements should be avoided however, where medication administration is a shared task, a risk assessment must be completed with all relevant parties (including the client and where appropriate their family/carers) to prevent medication being missed or overdosing. Systems of work must enable the safe administration of all medication. (Home Care Service Medicines Management SOP 2)

2.1.2 Level 3 Administration by Specialist Techniques

The administration of medication by a specialist technique may be delegated by a Registered Nurse to care assistants. Specialist techniques include (but are not limited to):

- Rectal administration (e.g. suppository)
- Vaginal administration (e.g. pessary)
- Percutaneous Endoscopic Gastrostomy (PEG)
- Injections e.g. insulin
- Administering oxygen
- Medications via a 'pump' device

The delegating Nurse must ensure the care assistant has received appropriate training and be satisfied that they are competent to carry out the task and document a clear plan of care in the client's care records.

Care assistants must refuse to administer medication, including by specialist technique, if they do not feel competent to do so.

For further guidance about medication delegation see 'Personal Care and Clinical Tasks in Adult Social Care' document FNHC Personal Care & Clinical Tasks

2.1.3 Controlled Drugs

The Head of Quality, Governance and Care is responsible for overseeing the management and use of controlled drugs by all services provided by the Organisation.

Controlled drugs are divided into different schedules which correspond to their therapeutic worth and potential for misuse. Please note, 'schedule 2' controlled drugs e.g. morphine, fentanyl, oxycodone, are subject to special recording requirements.

If the proportion of morphine hydrochloride in a morphine oral solution is above 13mg per 5mls the solution becomes a schedule 2 controlled drug and needs to be managed accordingly. However, below this strength the morphine oral solution is considered a prescription only medicine (POM).

Staff must comply with the legal requirements for controlled drugs and locally approved Standard Operating Procedures (SOPs) Home Care Service Medicines Management

2.1.4 Hazardous Medicines

Drugs used for cancer chemotherapy, antiviral drugs, hormones, some bioengineered drugs and some other miscellaneous drugs are considered to be 'hazardous drugs' by the National Institute for Occupational Safety and Health (NIOSH) 2014. However, they caution that due to the emergence of new-generation pharmaceuticals other categories of medicines may also include hazardous drugs.

Some hazardous drugs can pose a risk to care workers therefore staff must exercise an awareness of these drugs and the risks. NIOSH have developed a list of drugs considered to be hazardous. The most up to date version can be found on the 'Centers for Disease Control and Prevention' website CDC/NIOSH. Not all drugs on the list will be harmful to care workers and for those that do pose a risk, the actual harm will depend on what is done with the drugs (NIOSH 2014).

Where staff are required to administer a hazardous drug that poses an actual risk to them, a risk assessment must first be carried out and discussed with the Home Care Manager.
Sources of information regarding medicines safety include pharmaceutical companies, online resources e.g. Electronic Medicines Compendium and the Medicines Information Unit at Jersey General Hospital.

Safety precautions must be clearly documented in the client's care record and communicated to all relevant personnel involved in their care

2.1.5 Paraffin-Based Skin Emollients

Staff should be aware of the potential fire-hazard from paraffin-based skin emollients particularly where these are used in large amounts. The MHRA (2018) states that "Warnings about the risk of severe and fatal burns are being extended to all paraffin-based emollients regardless of paraffin concentration. Data suggest there is also a risk for paraffin-free emollients. Advise patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them".

Prior to the use of such products, a documented risk assessment should be carried out which should include the safety advice given to clients.

The client's clothing and bedding should be changed regularly (ideally daily) because "tests and research have shown that the dried-on cream makes the fabric more flammable and the resulting fire burns quickly and intensely, resulting in serious injury or death" (MHRA 2018)

Where clients are known to be self-medicating with such products, appropriate safety advice should be offered and documented.

2.2 Training

Care assistants administering medication must be appropriately trained and are responsible for maintaining their knowledge and skills in this area. The level of training required will depend on the level of support that each client is receiving, as per table below.

Access to regular refresher training will be made available for all care assistants and assessment of competence in practice should be reviewed on at least an annual basis.

Should concern be raised regarding a care assistant's competence e.g. following a drug error, refresher training should be undertaken followed by reassessment of competence.

A record of care assistants' training will be maintained by the FNHC Education and Development Department.

Level of Medication Administration	Training Required
1: General support or assistance	Completion of the service area's induction training in medication
2: Administration	Successful completion of an NVQ/QCF/RQF Level 3 Administration of Medication Unit before care assistants can administer medication On-going updating, supervision and assessment of practice will be provided. The frequency of reassessment will be determined by the Home Care Manager
3: Administration by specialist technique	The care assistant must receive appropriate training by a Registered Nurse and be deemed competent in the task of administering medication by a specialist route for the named person The care assistant must receive ongoing support from a Registered Nurse from the delegating team.

3. PROCEDURES

3.1 Assessment of medication management needs

When Home Care Services are commissioned through Health and Community Services, an assessment of the client's medication needs will have been undertaken. However, on admission to the caseload, a more detailed assessment will need to be undertaken by the Senior Care Assistant.

When undertaking an initial assessment of client needs, their ability to manage all aspects of their own medication, including the administration of medication, should be assessed using the approved FNHC Medication Assessment & Risk Assessment document (Appendix 1).

Unless the client is self-medicating, a record should be made in the client's medication care plan of all medication currently being taken including 'over the counter', herbal and 'as required' medication and this record should be updated at least six monthly, after any significant change in the client's condition or following discharge from hospital.

The level of support required for each type of medicine should be assessed, as follows:

Level 1: General support or assistance to self-medicate
Level 2: Administration
Level 3: Administration by specialist techniques (by care assistants)

N.B. Clients may require more than one level of support, for example, they may be self-caring with oral medicines but require Level 1 support for their eye drops.

Support Levels for the Administration and Management of Medication (originally adapted from Norfolk County Council Medication Policy for Domiciliary Care Services 2014)

Level	Description	Examples
Level 1: General Support or Assistance	General support or assistance is the tasks that staff carry out to help a client self-medicate. The important principle for general support is that ***the client is able to instruct the staff member what to do***. The client must therefore have the capacity to do this. General support may include: • physical assistance • occasional infrequent prompts	**Physical assistance:** e.g. unscrewing lids, popping medicines out of a blister pack (however, only if the staff member is told by the client which tablets to pop out). For care to remain at level 1 the client (not the staff member) "takes responsibility for confirming that they are taking the right medicine at the right time." **Occasional infrequent prompts:** these may sometimes be required for the client to be able to self-medicate. However, if the need to prompt increases and regular prompts are required then the person's ability to self-medicate should be reassessed. NB During periods of illness there may be a need for medication to be administered (level 2) i.e. the staff member temporarily takes responsibility for ensuring that the patient has the right medicine at the right time. **Also:** • reading dispensing label to the client • ordering and collecting medicines • returning unwanted medicines to the pharmacy
Level 2: Administration	When staff are providing level 2 tasks ***they are taking responsibility*** for ensuring that the client receives their medication at the correct time and in doing so confirming the '6 Rs'	Examples of level 2 tasks include: • Frequent observed verbal reminders to take medication • Selecting the correct medicines for administration • Leaving out medication to be taken later (if safe following risk assessment) • Administration of oral medication (including controlled drugs) • Measuring out doses of liquid medication (where the staff member is responsible for ensuring they have measured out the correct amount) • Applying topical medications

Level	Description	Examples
		• Applying transdermal patches (including controlled drugs) • Applying medication to the eye, nose or ear After receiving further training from a healthcare professional, FNHC Care assistants may undertake the following: • Administration of buccal midazolam • Administration of rectal diazepam • Administration of adrenaline for anaphylaxis via an auto injector device only • Giving medicines via a nebuliser • Administration of glyceryl tri-nitrate (GTN) For the above routes, the registrant who delivers this training will not remain responsible for the competency of the Care assistant, if the medication is administered as a 'rescue' medication
Level 3: Administration by specialist technique	Medicines that may be administered by Care assistants by 'specialist techniques' would normally be administered by a Registered Nurse. Where appropriate, a registrant can delegate these tasks to named Care assistants providing: • the Care assistant receives appropriate training by a registrant and is deemed competent in the task • the Care assistant has ongoing support from the registrant • the registrant ultimately remains responsible for the delegated task Care assistants should refuse to administer medication by specialist technique "if they do not feel confident in their own competence."	'Specialist techniques' include (but are not limited to): • Rectal administration (e.g. suppository) • Vaginal administration (e.g. pessary) • Percutaneous Endoscopic Gastrostomy (PEG) • Injections e.g. insulin • Administering oxygen • Medications via a 'pump' device

Where staff are required to administer medication (Levels 2 & 3), a care plan should be available in the care records. However, the care plan should not include details of the medicines unless there is a documented rationale why this has been necessary e.g. to provide clarity/avoid confusion.

A General Practitioner (GP) liaison letter (appendix 2) should be emailed to the client's GP advising of Family Nursing & Home Care's involvement in the client's medication and requesting that any medication changes be communicated in writing to the Senior Care Assistant.

A letter (appendix 3) should also be emailed to the client's nominated pharmacy requesting that medication is supplied in the original packaging with a corresponding pre-printed Medication Administration Record (MAR) sheet. This can also be requested over the phone by the Senior Care Assistant.

N.B. if the client has just been discharged from hospital, the list of medication signed by the discharging physician may only reflect the changes made to the pre-admission medication and may not be a complete picture of the client's prescribed medicines. Where this documentation is hand written and therefore may be difficult to read, clarification should be sought from the discharging ward or the hospital pharmacy who has dispensed the medication.

3.2 Obtaining supplies of medication

Arrangements should be in place to ensure that there is an uninterrupted supply of medicines available for clients. These arrangements should be recorded on the 'Medication Assessment and Risk Assessment' form (appendix 1) and in the client's medication care plan.

Clients should be asked to identify their pharmacy of choice and, wherever possible, to only use this pharmacy. This is to ensure continuity of records which will help in the event of a query. This rationale should be explained to the client/family by the Senior Care Assistant.

How a client orders and obtains their medication should be identified as part of the initial medication assessment/risk assessment (appendix 1) and if help is required, documented in the medication care plan.

Clients or their relatives should be encouraged to organise the ordering and collection of their medicines including taking prescriptions to the pharmacy.

Only in exceptional circumstances and following a documented assessment of the risks, should staff be involved in collecting a client's medication.

Care assistants must ensure that a MAR chart is provided where this is required.

Proof of identity in the form of an FNHC identification badge will be required when senior/care assistants collect any medication, including Controlled Drugs.

When transporting drugs, they should be out of sight away from direct sunlight.

Medication must be taken straight from the pharmacy to the client's home i.e. other visits/stops must not be made when carrying medication.

In exceptional circumstances e.g. if the client's home environment is challenging, client's medication can be bought to Le Bas for checking prior to delivery to the client's home. The reasons for this must be recorded in Section D of the Medication Assessment and Risk Assessment' form (appendix 1). Medication must never be stored at Le Bas.

Any member of staff transporting medication should ensure that they have informed their motor insurance company that they may undertake this activity.

3.3 Storage of Medication

In the client's home, staff must leave medication in a safe place which is known and accessible to clients (if appropriate) and to those supporting the safe administration of the medicines. Details of the location should be documented in the medication care plan.

If, following risk assessment, it is not appropriate for the client and/or their relatives/carers to have access to the medicines, a plan for its safe storage should be made in consultation with the client, their family (where appropriate), the patient's GP and any other relevant health professionals and care providers.

The decision should be clearly documented in the client's medication care plan along with a date to review at least annually and if circumstances change (see also FNHC Violence Aggression and Unacceptable Behaviour Policy re use of Restrictive Intervention).

Medication should be stored according to the manufacturer's instructions. Where staff are unsure of the correct storage conditions, advice should be sought from the dispensing pharmacy.

Medicines should be stored in the packaging/container supplied by the dispensing pharmacy and all current medication should be stored together in a suitable container such as a plastic box.

Clients should be encouraged to purchase their own medication storage receptacle however where this is not possible, these can be purchased through the FNHC Stores Department.

No unused or out of date medicines should be stored with the client's current medication. These should be returned to the issuing pharmacy at least every 28 days.

Advice should be sought from the dispensing pharmacy when there are concerns that a medicine may not have been stored correctly. This medication should not be administered without direction from a pharmacist regarding its suitability for use.

3.4 Administration of Medication

3.4.1 Consent and the right to refuse

Consent must be obtained every time medication is administered, as per FNHC Consent to Treatment and Care Policy.

Clients have a right to refuse medication and whilst their choice must be respected, encouragement to take their medication can be given.

Where the client still chooses not to take their medication, this must be recorded on the MAR using the appropriate code and also recorded in the daily care record. The Senior Care Assistant should be informed.

Regular or persistent refusals should be reported to the prescriber and GP (if GP is not the prescriber). However, where a "critical medicine" (section 3.4.5) is refused the prescriber and GP must be informed.

Where the client lacks capacity or there is a concern regarding their capacity to make informed decisions about their medication, the prescriber and GP (if not the prescriber) must be asked to assess the client (section 3.4.12).

3.4.2 Medicine compliance aids

Medicine compliance aids (MCAs) help clients to self-administer and are not an appropriate type of medication supply when the administration is being undertaken by Care assistants.

Involvement in MCAs should normally be restricted to Level 1 support e.g. popping the medication out of the MCA when the client is able to otherwise self-administer.

If a compliance aid is thought to be necessary, the client's ability to safely use it must be given careful attention and its continued appropriateness needs to be monitored.

Where a compliance aid is considered appropriate, the type dispensed, labelled and sealed by a pharmacist should be used.

In exceptional circumstances where care assistants are required to administer medication from an MCA, there must be tablet identifiers written onto the labels by the dispensing pharmacy. This is to enable identification of each drug so the care assistant can record separately on the MAR each medicine administered.
N.B If a care assistant is required to select and open a particular section, this would be considered as a Level 2 activity.

Care assistants must never undertake Level 2 administration from a compliance aid filled by family/friends. Level 1 support e.g. prompting is however permitted from such unlabelled devices.

Changes to medicines within a compliance aid must only be made by the supplying pharmacy. FNHC care staff must not attempt to do this.

3.4.3 Crushing medication

It is generally not acceptable to crush medication or to add medication to food or drink as this may alter the properties of the medication.

If this is required to make medication more palatable or easier to swallow (and alternative preparations are not available) this requires authorisation from both the prescriber and guidance should be sought from the dispensing pharmacy on how to prepare medicines in this way and documented in the client's medication care plan.

The prescriber and supplying pharmacy should be asked to add the directions for crushing tablets/opening capsules to the dispensing label. N.B the pharmacy will only add directions to crush the medication if the prescriber writes them on the prescription.

Where tablets are required to be crushed, the correct equipment should be used e.g. pill crusher.

3.4.4 Splitting tablets

Tablets scored by the manufacturer may be split however advice should be sought from the supplying pharmacy to check if the non-scored tablet is safe to split.
The supplying pharmacy should split tablets when this is required for achieving the correct dose.

Where splitting the tablet is done to help the client swallow it, the care assistant may assist the client to do this. A proper tablet splitter should be used.

3.4.5 Critical medicines

In 2010 the National Patient Safety Agency (NPSA) issued a 'Rapid Response Report' calling for NHS and independent sector organisations who admit patients for inpatient treatment to, "identify a list of critical medicines where timeliness of administration is crucial" (National Patient Safety Agency, 2010).

Whilst this recommendation did not extend to community care providers, it seems reasonable that Family Nursing & Home Care (FNHC) should develop such a list in order to reduce harm from omitted or delayed medicines.

The list developed by FNHC specifically for the Home Care Service (see Appendix 4) reflects the medicines most commonly encountered by FNHC Home Care staff. It is not exhaustive, as clients may present at any time with a medicine that requires timely administration.

Where critical medicines have been omitted or had their administration delayed, this must be reported via the Assure System and treated as a patient safety incident.

3.4.6 "As required" (PRN) medication

"As required" (PRN) medication is used in the treatment of short-term or intermittent conditions and may not need to be administered every time regular medicines are given.

Where "PRN" medication is required, the 'When Required (PRN) Medication Protocol' form (appendix 5) must be completed and kept with the client's MAR.

Prior to administering any PRN medication, the care assistant must check when the last PRN dose was given.

Administration should be recorded on the PRN section of the MAR and also a record made in the daily care notes that includes the exact time the medicine was given, the dose and the reason for the administration.

Where changes in the frequency (increasing or decreasing) of the administration of PRN medication are noted, this may highlight a need for the client to be reviewed by their GP or other relevant prescriber.

It is unnecessary to dispose of PRN medication at the end of a month if it is still in use and still in date.

3.4.7 Variable dose medication

Where medication is prescribed with a variable dose (e.g. 5-10mls), the client should be asked what dose they wish to take. It is not for the care assistant to make this decision. The dose administered must be clearly recorded on the MAR.

Where the client is unable to make this decision, advice should be sought from the prescriber, supplying pharmacy or relevant healthcare professional and clearly recorded in the care record.

3.4.8 Administration of warfarin

Care assistants must be aware that the administration of warfarin carries risks due to specific dosing requirements that are determined by regular blood tests, known as the "INR".

Clients on warfarin should have what is known as the "Yellow Book" (an "Oral Anticoagulant Therapy Pack") and in this book the results of the INR blood test and dosage of warfarin should be recorded.

Care assistants should check the "Yellow Book" or any other relevant record e.g. an "INR Chart" for the dose of warfarin to be given each day.

Warfarin doses should be expressed in "mg" and not in the number of tablets required. Care assistants must be aware of the different strength tablets available and be mindful that a combination of tablets may be required.

The supplying pharmacy should be requested to label the warfarin to be taken as per dosing schedule/Yellow Book.

The client's GP/GP Surgery/anticoagulant service must be requested to notify the Home Care Service as soon as possible of any dose change (see also section 2.8.3)

Where the "Yellow Book" is available, the results of the INR test and new warfarin dose may be recorded during the visit to the surgery/clinic. However, if this doesn't happen, the GP Surgery/anticoagulant service should email the results to the relevant Senior Care Assistant. These results should be put along with the client's MAR as soon as is practicable.

However, should warfarin need to be administered before this happens, the Senior Care Assistant may message the care assistant the updated warfarin dose, via the secure CarePlanner® app (also see section 2.8).

The use of verbal messages should only happen in exceptional circumstances and should not be used to communicate routine dose changes.

The frequency of INR testing should be recorded in the 'Yellow Book'. When awaiting the results of the INR test/dose change, the current dose of warfarin should continue to be given.

Where the 'yellow book/INR chart' are likely to be temporarily unavailable, a record of the current dose should be made in the care record on the last two administrations immediately prior to the client having their INR test undertaken.

It is the responsibility of the Senior Care Assistant responsible for that client to prompt this action and confirm that it has been carried out. The record of these two doses should be confirmed to be the same by the care assistant administering the warfarin without the benefit of the 'yellow book/INR chart'.

Care assistants must not administer warfarin without the Yellow Book or other appropriate dosing schedule (see exception above) nor where there is concern that the most up to date results/dose are not available. The Senior Care Assistant should contact the GP Surgery/anticoagulant service to clarify the correct dose required.

3.4.9 Administration of medicines via an enteral feeding device

The administration of medicines via an enteral feeding device may be undertaken by care assistants as a Level 3 (Specialist Technique) activity (see section 2.1.2).

Staff should be aware of the risks associated with administering drugs via enteral feeding devices.

Only a few medicines are actually licensed for enteral administration therefore most medication will be administered outside of its product licence.

Staff should exercise heightened awareness for adverse reactions resulting from the 'off-label' administration of medication via the enteral route.

If medicines are to be administered via an enteral feeding device and this is outside of the medicine's product license, it is important everyone involved in the prescription, supply and administration of the medicine is aware in case of any adverse effects resulting from administration via this route.

Suitable formulations for medicines administered via the enteral route include liquids or soluble tablets. Where these are not available, it may be necessary to crush a tablet or open a capsule however the advice of a Pharmacist must always be sought before this is done

3.4.10 Non-prescribed medication

Care assistants may be requested by clients to administer non-prescribed medication. Such medicines should be purchased from the pharmacy that supplies the client's prescribed medication.

Care assistants must not offer advice on treatment options for complimentary and/or alternative therapies. Clients should be advised to seek advice from their GP.

Prior to any non-prescribed medication being administered, the "Administration of Non-prescribed Medication" form (appendix 6) must be completed following discussion with the client's GP or pharmacist suppling the client's prescribed medication.

If the advice from the GP/pharmacist is not to administer the non-prescribed medication, this should be clearly documented on the above form and discussed with the client and Senior Care Assistant.

Where non-prescribed medication is to be administered, this should be recorded on a "Temporary MAR" sheet (appendix 7) following the guidance in section 2.8.6.

3.4.11 Preparing medication in advance/leaving out medication

To enable independence, it is acceptable, following a documented assessment of the risks, for care staff to leave out medication in a suitable container for clients to take at a later time.

A care plan must be in place to support this practice.

No more than one dose should be left out for the client to take at a later time.

As the care assistant will not witness the client taking the medication, they cannot sign the MAR. However, a code should be used to denote the practice of leaving out medication to be taken at a later time. This code should be recorded on the MAR (if not already available on the MAR) and in the client's care record.

Where there is a need for medication to be sent with the client on a planned outing e.g. day trip, ideally this should be done by sending it in its original packaging. Where this is not practical, the pharmacy should be asked to dispense the medication in a smaller quantity.

If a member of Home Care staff is accompanying the client, the MAR should be taken along with the medicines so administration can be recorded at the time the medication is taken.

Where there is a need for medication to be sent with the client on an un-planned outing, ideally this should be done by sending it in its original packaging.

Where this is not practical and it is also impractical to obtain a separate smaller supply from the pharmacy, sufficient medication for the duration of the outing may be decanted into a suitable container.

Wherever possible, two care assistants should be present when this is done; one should decant and carefully label the container by transcribing all information from the pharmacy label and this should be checked by the second care assistant.

One of these care assistants should be the person administering the medication when the client is out. The MAR should be taken along with the medicines so administration can be recorded at the time the medication is taken.

3.4.12 Hiding or disguising medication ('covert medication')

Medicines are administered covertly only to people who actively refuse their medication and who are considered to lack capacity in accordance with an agreed management plan.

The practice of 'covert medication' should only be undertaken if it is in the best interests of the patient. When consideration is being given to the possibility of administering medication covertly, this must be discussed at a 'best interests' meeting.

The Capacity and Self Determination (Jersey) Law 2016 Code of Practice Chapter 5 contains further guidance CSDL Jersey (2016) Code of Practice.

A document for recording the decision to administer medication covertly is available in appendix 4 of the Safeguarding Partnership Board Multi-Agency Capacity Policy and Procedures (Jersey) 2018.

3.4.13 Emergency situations/'rescue medication'

Clients may have conditions where they need medication in an emergency but are unable to independently self-medicate e.g. during angina or asthma attacks.

Where it is known that a client may require 'rescue medication', written authorisation from a Registered Prescriber should be sought and be available in the care records.

A care plan must be in place to support the administration of the required medication and the appropriate management of the situation.

Rescue medication may be administered by care assistants following training. This medication includes:

- adrenaline via an auto-injector device e.g. 'Epipen', as per FNHC Anaphylaxis Guidelines
- buccal midazolam FNHC Buccal Midazolam Adults Guidance (currently under review)
- rectal diazepam
- medicines via a nebuliser
- Glyceryl Trinitrate (GTN)

If this training is undertaken by a Registered Nurse, the Registered Nurse will not be responsible for monitoring the ongoing competence of the care assistant i.e. it will not be seen as a delegated task.

Where other 'rescue medicines', not identified above, are required, this must be discussed with the Home Care Manager, Operational Lead Adult District Nursing and the head of Quality Governance and Care and the decision regarding its administration recorded in the client's care records.

3.5 Disposal of Medication

It is not acceptable to dispose of any medication down the sink or toilet or to place it in the waste bin. It should always be returned to a pharmacy for destruction.

Clients and/or their families/carers should be encouraged to dispose of all medication that is no longer required by returning it to the pharmacy (ideally the dispensing Pharmacy) for destruction. Only in exceptional circumstances and following a documented assessment of the risks, should staff be involved in the disposing of a patient's medication. Where return of unwanted medication is required, the 'Return of Unwanted Medicines' document (appendix 8) should be completed and recorded in the client's daily care record.

N.B. pharmacies will receipt bags/large quantities of returned medicines as 'unchecked' (unless they are controlled drugs) therefore care assistants should ensure that only small quantities of medication are returned at any one time.

In the following circumstances medication should be placed in an envelope and returned to the Pharmacy:

- Where the medication has been taken from the original container and then refused
- Where medication is spat out
- Where medication is found e.g. a tablet on the floor

When disposing of medication packaging, staff should be mindful that client identifiable information will be present. Therefore any labelling with client information should be removed, torn up and put in the bin separately.

3.6 Record Keeping

Care assistants should consult the medication care plan prior to administering medication.

They should also access their CarePlanner® mobile app which will give them the most up to date information relating to client's medication and any changes to be aware of.

Detailed records must be kept of all medication administered using the Medication Administration Record (MAR) charts provided. "PRN" medication administration should also be recorded in the daily care record.

3.6.1 Medication Administration Record (MAR)

The MAR provides a record of the medication:

- to be administered
- given/taken/refused/not given

The MAR chart is not the legal direction to administer; that comes from the prescription signed by the prescriber (or other order to prescribe); the details of which are on the pharmacy label attached to the medication.

The instructions on the MAR and on the pharmacy label should be the same however, if a difference is noted, the care assistant should check to see if a reason for this is detailed on the MAR or care plan.

Should no explanation be recorded or the explanation is unclear, clarification must be sought from the Senior Care Assistant before the medication is administered.

Different MAR charts exist depending upon the chosen supplying pharmacy, therefore care assistants must exercise a high degree of vigilance regarding the use of the codes as these can vary.

A signature on the MAR denotes that the care assistant has observed that the medication has been taken. If administration has not taken place the appropriate code should be entered to record why.

Recording on a MAR chart is not necessary for Level 1 tasks however, a record of these tasks should be in the medication care plan.

All Level 2 and 3 administration must be recorded on the MAR chart.

3.6.2 Recording changes in medication

Only in exceptional circumstances i.e. where the safety of the client could be at risk, should a verbal order to change a medication be accepted.

Verbal orders must be accepted through a Senior Care Assistant and not directly by care assistants.

Changes to medication can only be confirmed with a prescriber and not by the client/family etc.

A record must be made of the prescriber's name, the date and time of the conversation and the instructions. This instruction must be repeated back to the prescriber to confirm that it has been recorded correctly. Wherever possible a second member of staff should witness this.

Written confirmation of changes must be obtained from the prescriber within 24 hours; this can be by letter or email.

The GP should be requested to send a new prescription to the client's named pharmacy so an updated MAR chart can be generated.

Where dose changes or an increase in the frequency of administration have been made, a new supply of the medication or additional medication may need to be obtained.

When the instructions for taking a medicine are to be changed, a diagonal line should be scored through the section on the MAR sheet containing the original instructions for the drug in question and a line drawn through the any remaining recording boxes.

The new instructions for the medicine should then be recorded on a "Temporary Medication Administration Record form (appendix 7).

A clear explanation that this medication has been changed and that the new instruction is on a Temporary MAR sheet must be documented on the MAR along with the date and name of the prescriber who authorised the change.
The name of the care assistant recording the amendment (including designation) and the date and time must also be recorded in the client's care record.

3.6.3 Transcribing medication

The Royal Pharmaceutical Society (2019) identifies transcribing as:

- The copying of previously prescribed medicines details to enable their administration in line with legislation (i.e. the instructions of the prescriber)
- Being used only in the patients' best interests to ensure safe and continuous care: ensuring the medication is accurately administered, without undue delay.

Transcribing cannot be used in place of prescribing to issue or add new medicines or alter / change original prescriptions.

Care assistants may transcribe medication from one "direction to administer" e.g. pharmacy label on the prescribed medication to another form of "direction to administer" e.g. temporary MAR sheet.

This should only be done in exceptional circumstances. Staff are accountable for what they transcribe.

The "direction to administer" should ideally be checked at the time by another care assistant. Where this is not possible/practicable, the next care assistant attending to administer the medication should check the details and sign to verify its accuracy.

3.6.4 Discontinuing medication

Only in exceptional circumstances i.e. where the safety of the client could be at risk, should a verbal order from the prescriber to discontinue a medication be accepted.

Verbal orders must be accepted through the Senior Care Assistant and not directly by the care assistant.

A record must be made of the prescriber's name, the date and time of the conversation and the instructions. This instruction must be repeated back to the prescriber to confirm that it has been recorded correctly. Wherever possible a second member of staff should witness this.

Written confirmation must be obtained from the prescriber within 24 hours. This can be by letter or email.

When a medication is to be discontinued, a diagonal line should be scored through the section on the MAR sheet containing the original instructions for the drug in question and a line drawn through the any remaining recording boxes.

A clear explanation that this medication has been discontinued must be documented on the MAR along with the date and name of the clinician who authorised the change.

The name of the care worker (including designation) recording this discontinuation and the date and time must also be recorded in the client's care record.

3.6.5 Use of Temporary Medication Administration Record (MAR)

A temporary MAR may be used when it is not practicable to immediately obtain a pharmacy-generated MAR. It can also be used to record changes to medication that have been authorised by a prescriber ahead of obtaining an updated MAR from the pharmacy.

Temporary MAR charts should be completed using indelible black ink. All text should be written in capital letters.

Where instructions are being copied from e.g. the pharmacy label on the medication, care must be taken to ensure that this is done accurately (as per section 3.6.3).

The Senior Care Assistant completing the temporary MAR should sign the entry and the next care assistant to administer the medication must check the accuracy of the details and countersign to confirm that all is correct.

The Senior Care Assistant must then make the necessary arrangements to obtain a pharmacy-generated MAR within 48 hours.

3.6.6 Errors in medication administration

All medication errors should be recorded in the client's care record and be reported immediately to the Senior Care Assistant or Home Care Manager (Home Care Service Medicines Management SOP1).

Any errors in medication administration must be reported via the 'Assure' system, including a delay or omission of a 'critical medicine' as defined in section 3.4.5.

FNHC supports the principle that the reporting of drug errors serve as an opportunity for shared learning to prevent recurrence and promote patient/client safety.

3.6.7 Reporting Adverse Reactions

Action must be taken to remedy any adverse drug reactions i.e. contact manager, call for emergency help.

A record of the incident and actions taken must be clearly documented in the client's care record ensuring that all 'allergy and alerts' sections are completed as appropriate. Incidents must also be reported via the 'Assure' system,

The client's GP and the prescriber (if different) must be notified and the adverse reaction reported via the 'Yellow Card Scheme' which can be accessed online at https://yellowcard.mhra.gov.uk/ .

4. CONSULTATION PROCESS

Identify who has been involved and when including clients and partner agencies

Name	Title	Date
Judy Foglia	Director of Governance, Regulation and Care	27/07/2021
Teri O'Connor	Home Care Manager	27/05/2021 27/07/2021
Tia Hall	Operational Lead Adult District Nursing Services	27/07/2021
Justine Bell	Education and Practice Development Nurse	27/07/2021
Elspeth Snowie	Clinical Effectiveness Facilitator	27/07/2021

5. IMPLEMENTATION PLAN

A summary of how the document will be implemented with time frame

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	
Forms/templates to be uploaded to Central Filing	Head of Information Governance and Systems	

6. MONITORING COMPLIANCE

Compliance with this policy will be identified through audits.
Incident and near miss reporting will inform learning and potential reviews associated with medicines management.

7. EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity
- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times.

8. GLOSSARY OF TERMS

None

9. REFERENCES

Family Nursing & Home Care (2020) *Medicines Policy*. Available at: medicines-policy-2020-final.pdf (fnhc.org.je). Last accessed 25th May 2021

Government of Jersey (2019) *The Code of Practice: Professional standards of practice and behaviour for Health and Social Care Support Workers in Jersey.* Available: https://carecommission.je/wp-content/uploads/2020/01/Code-of-Practice-Sept-2019-Final.pdf Last accessed 25th May 2021

Jersey Care Commission (2019a) *Care Standards: Home Care.* Available at; https://carecommission.je/wp-content/uploads/2019/02/JCC-Care-Standards-Home-Care-2019-v1..pdf Last accessed 25th May 2021

Jersey Care Commission (2019b) *Personal Care and Clinical Tasks Guidance for Adult Social Care.* Available at: https://carecommission.je/wp-content/uploads/2019/03/JCC-Guidance-personal-care-and-clinical-tasks-adult-social-care-ratified-20190314.pdf. Last accessed 25th Mayb2021

Medicines Healthcare Products Regulatory Agency (2018) *Drug Safety Update, Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients.* Available at: Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients - GOV.UK (www.gov.uk) Last accessed 26th May 2021

NICE (2017) Managing medicines for adults receiving social care in the community. Available at: Managing medicines for adults receiving social care in the community (nice.org.uk). Last accessed 28th May 2021

10. APPENDICES

Appendix 1 Home Care Service Medication Assessment/Risk Assessment

Family Nursing & Home Care

Part 1

Client's Name			
URN		**Date of Birth**	
Address			
		Name of GP	
		GP Tel. Number	
		Name of Pharmacy	
		Pharmacy Tel. Number	

Section A – Initial Medication Assessment		
Any known allergies?	Yes / No	If 'yes' please specify
Is the client self-medicating all medicines? (including non-prescribed medicines)	Yes / No	If 'yes' – ***complete section B only***
Is support with all medication provided by family/others?	Yes / No	If 'yes' – ***complete section B only***

Section B – obtaining supplies of medication		Tick as appropriate
Who orders medicines from the GP?	Client	
	Family/friend/other	
	Care worker	
	Pharmacy	
How will medicines be obtained from the pharmacy	Client collects	
	Family/friend/other	
	Care worker	
	Pharmacy delivery service	
Comments/actions required		

Only complete Part 2 if FNHC needs to be involved with the client's medication.
(If completing Part 2 there is no need to sign this page – sign at the end of the document)

Name of Assessor (please print): …….. **Job Title:** ……

Signature of Assessor: …….. **Date:** ……..

Date reassessment due: ……

Part 2

Client's name: ……**URN:** ….....

Only complete Part 2 if involvement in the client's medication management is required

Section C - Level of assistance required with the following types of medication:	
Key:	
S	Self-medicating (includes family/others support)
1	Level 1 general support or assistance* (clarify assistance required below) – client in control of ensuring that they get their medicines and for the "6 Rs"
2	Level 2 – Administration (FNHC staff take responsibility for ensuring that the client gets their medication and the principles of the "6Rs")

	Morning	**Lunchtime**	**Teatime**	**Evening**
Tablets/capsules etc.				
Oral liquids				
Creams/ointments etc.				
Transdermal patches				
Eye drops				
Ear drops				
Nose drops/sprays				
Inhalers				
Other - specify				

*Describe assistance required for level 1 medication:

Is there any level 3 administration (specialist techniques)? *N.B level 3 administration can only be carried out following training and assessment of competence by a Registered Nurse and as a delegated task from the District Nursing Service* ***(CARE PLAN TO BE COMPLETED BY DELEGATING DN TEAM)***	Yes / No

Specialist Technique	**Self - Medicating**	**Registered Nurse Administering**	**Care Assistant Administering**
	Tick as appropriate		
Injections			
Suppositories/enemas			
Pessaries			
Medication via PEG			
Oxygen			
Pump devices			
Other (specify)			

Comments/Actions Required:

Client's name: ……**URN:** ….....

Section D – Administration Systems and Recording Documents			
In what type of administration system is oral medication presented?	Family/other filled dossett box	Yes / No	***N.B.*** *Care Assistants cannot administer medicines (level 2) from this type of device*
	Pharmacy filled compliance aid	Yes / No	
	Original containers	Yes / No	
Is a MAR chart required?			Yes / No
Has a MAR chart been ordered from the pharmacy			Yes / No
Is a temporary MAR in place whilst awaiting the pharmacy generated MAR?			Yes / No
Is any additional equipment required for medication administration?			Yes / No
If 'yes' is it available in the client's home?			Yes / No
Are there any circumstances in the client's home that would preclude staff checking off new medication and MAR charts?			Yes / No
If Yes, please give details and alternative arrangements in place:			
Comments/actions required:			

Section E - Warfarin			
Is the client prescribed warfarin?	Yes / No	If Yes, is level 2 administration required?	Yes / No
If Yes – has the GP surgery been asked to send dose updates to the team?			Yes / No
Comments/action required			

Client's name: ……**URN:** ….....

Section F - Storage of medication	
Are there any excess or date expired medicines in the home which may cause confusion or mistakes in administration?	Yes / No
If Yes– can family/other return medication to the pharmacy?	Yes / No
If No – "Return of Medication" form to be completed	Yes / No
Storage location of medication	
Does any medication require special storage e.g. refrigeration?	Yes / No
Comments/action required:	

Section G – Access to medication	
Can the client access their medication?	Yes / No
Is there an identified risk of tampering with the medication and/or overdose risk?	Yes / No
Does additional secure storage need to be considered for medication?	Yes / No
If Yes – please state action taken to minimise risk	
Is there a need for medicines to be left out to be taken when the Care Assistants are not present?	Yes / No
Are there any other identified risks e.g. children, pets, remembering to take medication?	Yes / No

If Yes state risk/s identified and how it/they will be minimised/managed:

Name of Assessor (please print): ……**Job Title:** ……

Signature of Assessor: ……...**Date:** ……..

Date reassessment due: ……

Appendix 2 Home Care Service GP liaison letter re medication

Date

Dear Click here to enter text.

Re: Click here to enter text.

The above client is in receipt of Home Care Services from Family Nursing & Home Care and the care package delivered includes administration of medication. They have identified that they will obtain all their medication from Click here to enter text..

Please can prescribed medication be requested in its original packaging and, where appropriate, as a 28 day supply.

To ensure our care assistants are able to administer the client's medication safely and in accordance with best practice, **please inform us, as soon as possible, of any changes to their current list of prescribed medication** by calling 443651. Out of hours a message can be left on the voicemail.

Thank-you for your support in this matter.

Yours sincerely,

(Click here to enter text. - Family Nursing & Home Care)

Appendix 3 Home Care Service Pharmacy liaison letter re medication

Family Nursing & Home Care

Date

Dear Click here to enter text.

Re: Click here to enter text.

The above client is in receipt of Home Care Services from Family Nursing & Home Care that includes medicine administration. They have identified you as the named pharmacy from which they will obtain their medication.

To ensure our care assistants are able to administer the client's medication safely and in accordance with our local policy, all medicines should be supplied in their original packaging. In addition, **please send a pre-printed MAR sheet with all dispensed medication.**

Should you have any concerns please contact the Home Care office on telephone number 443651. Out of hours a message can be left on the voicemail.

Thank-you for your assistance.

Yours sincerely,

(Click here to enter text. – Family Nursing & Home Care)

Appendix 4 Home Care Service Critical Medicines List

Whilst all medicines should be administered in a timely manner, there are some that must not be omitted or their administration delayed as this has the potential to cause harm. These are referred to as *'critical medicines'*. The list below is **not exhaustive** but serves as a reminder of the medicines that need timely administration.
Any omission or delay in the administration of the medications on this list must be discussed with the Prescriber or relevant Physician and recorded on ASSURE as a patient safety incident.

Drug Group / Class	Rationale for Inclusion / Risk if Drug Delayed or Omitted
STAT (urgent) doses of **any drug**	Any drug that is deemed urgent enough to be prescribed as a "STAT" on the medication chart
Emergency treatment of a life threatening allergic reaction (anaphylaxis)	When used for the treatment of a severe allergic reaction an urgent response is required as this is a life-threatening event.
Anticoagulants (blood thinning medication)	Risk that the service user could develop 'a blood clot' which could lead to a life-threatening event such as a stroke or a heart attack
Antiepileptic Agents (drugs people take to control their epilepsy or treat a 'fit')	• Loss of the ability to control 'fits' • When used for the management of prolonged 'fitting', urgent treatment is required
Anti-Parkinsonian Agents (drugs used to control the symptoms of Parkinson's disease)	Loss of symptom control
Bronchodilators and Respiratory Stimulants (drugs that help people to breath more easily)	• The service user's breathing problem may worsen • Breathing emergencies need an urgent response
Corticosteroids ("steroids")	• Treatment failure in acute conditions • Health problems can occur with abrupt withdrawal after a prolonged period of corticosteroid use. Symptoms can include weakness, fatigue and low blood pressure.
Oral Hypoglycaemic Agents (drugs to lower glucose levels in the blood)	Poor control of the service user's blood sugar levels with the risk of blood sugar levels becoming too high

Emergency treatment of hypoglycaemia (emergency treatment when blood sugar levels become dangerously low)	Dangerously low blood sugar levels can be life-threatening
Management of Symptoms at End of Life	Poor symptom control
Opiates (strong pain-killers)	Poor pain control
A drug called 'Desmopressin' used in the treatment of cranial diabetes insipidus (this is a condition where there is an inability to regulate kidney function)	Risk of life threatening dehydration

Appendix 5 Home Care Service When Required (PRN) Protocol

The Senior Care Assistant should obtain information from the supplying pharmacy or other healthcare professional involved in the treatment of the person on why the medication has been prescribed and how to give it. This information should be recorded below.

<table>
<tr><td>Client name:</td><td colspan="2"></td><td>URN</td><td></td></tr>
<tr><td colspan="2">Medication:</td><td>Strength:</td><td colspan="2">Form:</td></tr>
<tr><td colspan="5">Directions (dose and frequency):</td></tr>
<tr><td colspan="5">When should this medication be given?</td></tr>
<tr><td colspan="5">What should the medication do?</td></tr>
<tr><td colspan="5">What time gap should be left between doses?</td></tr>
<tr><td colspan="5">What’s the maximum dosage in 24 hours?</td></tr>
<tr><td colspan="5">How long should the medication work for?</td></tr>
<tr><td colspan="5">When should GP or other medical advice be sought?</td></tr>
<tr><td colspan="2">Signed (person completing form):</td><td colspan="3">Name of person information obtained from (healthcare professional):</td></tr>
<tr><td colspan="5">Date:</td></tr>
<tr><td colspan="5">Date protocol to be reviewed:</td></tr>
</table>

This chart should be kept with the MAR chart for care assistants to refer to as necessary

Appendix 6 Home Care Service Administration of non-prescribed medication

Complete this form with advice from the GP or pharmacist who supplies the client's regular medication. This form may be completed with advice over the telephone or via a face to face visit. If the client is self-medicating, there is no requirement to complete this form.

Client's Name		**URN**	
Name of Pharmacist (or GP)			
Name of Pharmacy/GP Surgery			
Date of conversation			
Name of person completing form			

Complete Section A OR B, then ALL of Section C

Section A: Request for specific medicine by client:	
Record the name of the medicine being requested:	
If the Pharmacist/GP recommends a different treatment, record this here:	

Now complete Section C

Section B: Clients who have not requested a specific medicine:	
Record the symptoms that the client has and wants treatment for:	
Record the name of the treatment that the Pharmacist/GP recommends here:	

Now complete Section C

Section C: Information about the non-prescribed medication	
Inform the Pharmacist/GP of all medicines currently taken by the client (you may obtain this information from their medicine chart or repeat prescription list) - Initial the box to indicate this has been done	Initial:
Ask the Pharmacist/GP how long should the client take this treatment for before seeking further medication advice (record this here):	
Record the dosage directions here – the Pharmacist/GP may tell you to follow the directions on the container	

Client's name: ……**URN:** ….....

Section C: Information about the non-prescribed medication (continued)	
Ask the pharmacist/GP if there are any symptoms that would need you to seek further attention, should the client develop these. Record these symptoms here:	
Record any other advice given by the Pharmacist/GP	

'Over the Counter' medicines should be purchased, wherever possible, from the client's named pharmacy.

Once obtained, if the client requires administration of the purchased medication, it should be written onto a temporary MAR.

The name and form (tablets, capsules etc) and the dose to be given should be recorded on the temporary MAR, in addition to the other information required on the form.

Purchased medication should generally be for short-term use only. If required long-term, the GP's advice should be sought.

Signature of person who completed form: ……..

Job Title: ……

Date: ……

Appendix 7 Home Care Service Temporary Medication Administration Record (MAR)

Full Name:	URN:	Address:	GP/Surgery:	MAR Start Date:	Sheet No:

Date of Birth:	Date:																													
1.	Morning																													Form completed by:
	Lunch																													
	Tea																													
	Bedtime																													
2.	Morning																													Form checked by:
	Lunch																													
	Tea																													
	Bedtime																													
3.	Morning																													MAR requested from pharmacy by:
	Lunch																													
	Tea																													
	Bedtime																													
4.	Morning																													Date requested from pharmacy:
	Lunch																													
	Tea																													
	Bedtime																													
5.	Morning																													***FILL IN CARE WORKER IDENTIFICATION ON REVERSE***
	Lunch																													
	Tea																													
	Bedtime																													

Care Assistant Identification	
When you use the chart for the first time, print name and initials below	
Name:	**Initials:**

Instruction to Care Assistant to complete Temporary MAR:

Complete all details for the client

Copy the information exactly from the pharmacy label attached to the medication – this should include: medication name, strength, form and dose.

The care assistant completing the form must sign and date the form on the right hand side.

The next care assistant to use the temporary MAR must check the information written and countersign the form on the right hand side.

The remainder of the form is completed in the same way as the standard MAR chart.

Care assistant must ensure that a standard MAR chart has been ordered from the client's named pharmacy, as soon as is practically possible.

Appendix 8 Home Care Service Return of Unwanted Medication

Client Name:		**URN:**	

I authorise that the following medications may be removed and returned to the pharmacy or dispensing surgery for destruction:

Name of medicine	Quantity

Client Signature:	**Date:**

If you are unable to sign this form, a representative may sign for you

Signature of representative:	
Relationship to the person named above:	
Print name:	**Date:**

For Pharmacy/Surgery use only

I confirm the medicines listed above have been handed over for safe destruction

Signed on behalf of pharmacy:	**Date:**
Pharmacy stamp:	

File this document in the client's care record

Appendix 9 Home Care Service Collection of Controlled Drugs

Client Name:		**Date of Birth:**	

The following controlled drugs have been given to the Family Nursing & Home Care staff member named below for this client.

Name of medicine ***(to be completed by Pharmacist)***	**Quantity** ***(written in words please)***

Name of Care Assistant :	

I have checked and confirmed the care assistant's identification (ID) against their Family Nursing & Home Care photographic ID badge. ***Yes / No***
Delete as applicable

Signature of Pharmacist:			
Print name:		**Date:**	
Pharmacy stamp:			

To be completed by the client/other on receipt of the above medication			
I confirm that the type and amount of medication detailed above has been received			
Signature of Client/Other:		**Date:**	
Print Name:			
Relationship to Client ***(if applicable):***			

Please file this document in the client's care record

Appendix 10 Home Care Service Controlled Drugs Stock Sheet

Controlled Drug Stock Sheet

Family Nursing & Home Care

Name:.....

D.O.B:.....

URN: .....

Or Affix Patient Label

Allergies & Alerts:

N.B. Please do not use this document for recording the stock in the 'Just in Case' box. Separate documentation is available for this purpose.

Stock levels and the number of units received and/or used must be written in words not numerical figures (e.g. twenty not 20).

Drug Name: ..... **Strength:** .....

Actual Stock	Date & Time	Name of Supplying Pharmacy and Number / Amount Added to Stock	Amount/ Number Used	Batch Number	Expiry Date	Total Stock Remaining	Signature

Version 2 – updated September 2015

Appendix 11 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: Home Care Service Medicines Policy			
Date of Assessment	July 2021	Responsible Department	Governance/Home Care
Name of person completing assessment	Mo de Gruchy	Job Title	Quality Performance and Development Nurse

Does the policy/function affect one group less or more favourably than another on the basis of :	**Yes/No**	**Comments**
• Age	No	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	No	
• Ethnic Origin (including hard to reach groups)	No	
• Gender reassignment	No	
• Pregnancy or Maternity	No	
• Race	No	
• Sex	No	
• Religion and Belief	No	
• Sexual Orientation	No	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions** (what needs to be done to minimise / remove the impact)	**Responsible Officer**

Monitoring of Actions
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level