Family Nursing & Home Care

Medicines Policy

August 2023

Document Profile

Document Registration	Added following ratification
Type	Policy
Title	Medicines Policy
Author	Updated by Mo de Gruchy, Governance Team
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Description	A policy that provides an up to date operational framework to include all activities associated with the routine use of medicines, including prescribing, dispensing and supply, storage and security, administration and disposal.
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Version control / changes made

Date	Version	Summary of changes made	Author
January 2020	3	Complete change in layout and review of all contents. Additional content included regarding administration of medicines, topical preparations and therapeutic monitoring. Medicines Management Standard Operating Procedures available separately to download. Redefined offer of annual staff 'flu immunization Reference to the Safeguarding Partnership Board's Capacity Policy and Procedures has been replaced by the Capacity and Self Determination (Jersey) Law 2016 Code of Practice where relevant 3.6.23 staff filling dosset boxes – removed	Ann Morgan

Date	Version	Summary of changes made	Author
		3.7 tasking of GPs via EMIS – removed 3.8 the need to report transcribing as an incident – removed Procedure for the checking of transcribed medication updated 6.10.1 training requirements for vaccine administration updated	
September 2022	3.1	1.3.5: The statement “Student Nurses cannot administer intravenous medications including intravenous fluids” has been deleted, to encompass revised scope of practice for pre-registration student nurses, as per the Nursing and Midwifery Council “Future Nurse: Standard of proficiency for registered nurses” (2018).	Mo de Gruchy
June 2023	4	Whole document review. Minor revision of role titles and responsibilities. Hyperlink function removed from referred-to policies/Standard Operating Procedures (SOPs). Reference list checked and updated as necessary	Mo de Gruchy

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1 INTRODUCTION

1.1 Rationale

The Jersey Care Commission (JCC) 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 (JCC 2019).

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 qualified nurses, nursing students, senior health care assistants and health care assistants working within the community 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 applies to all clinical staff and any nursing students undertaking part of their training with FNHC. This includes Health Care Assistants working in the nursing teams.
Home Care Assistants working in the Homecare Service must follow the Home Care Medicines Policy.

This policy should be read in conjunction with the following:

- NMC Code (2018)
- NMC Future Nurse: Standards for proficiency for registered nurses (2018)
- British National Formulary (current)
- Jersey Care Commission Standards for Homecare 2019
- Capacity and Self Determination (Jersey) Law 2018
- FNHC Consent Policy
- Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society 2018)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society 2019)
- FNHC Standard Operating Procedures relevant to Medicines Management

1.3 Role and Responsibilities

Chief Executive Officer (CEO)

The CEO 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
- any system in place is the subject of periodic review by management

Director of Governance and Care

The Director of Governance and Care has overall responsibility for:

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

Line Managers/Team Leaders

Those in charge of clinical areas / Line Managers / Team Leaders have 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.

All staff

All staff involved in medicines management have a responsibility to adhere to this policy and its related protocols, guidelines and procedures and to identify and address any learning needs they may have in relation to it.

They should appreciate the importance of involving the patient and/or carer in their treatment as much as possible. This includes ensuring the patient or carer understands and agrees to the proposed treatment and appreciates as far as possible any risks of side effects.

Student nurses

Student nurses who are undertaking part of their training with FNHC must be given every opportunity to become proficient in medicines related activities under appropriate supervision (NMC 2018a).
When supervising a student in the administration of medicines, the same principles regarding delegation and accountability apply. Registrants must clearly countersign the student's signature in the patient's nursing record. Student nurses will remain under the direct and constant supervision of a registered nurse.

Student Nurses cannot supply or administer medicines under a Patient Group Direction (PGD).

2. POLICY

All registered nurses (referred to as 'Registrants') and Student Nurses must apply the NMC Code (2018b) to their practice regarding medicines management and should use this FNHC policy and its appendices for safe and effective local practice.

Guidance from the Royal Pharmaceutical Society (2018; 2019) should also be followed.

3. PROCEDURES

3.1 Assessment of medication management needs

On admission to the caseload the patient's current medicines that are being prescribed should be identified. In addition to prescribed medicines, any 'over the counter' (OTC) medicines, including herbal remedies and 'as required' medicines being, taken should also be identified. Staff are able to access a patient's medicines information (with their consent) through EMIS using the shared care functionality.

When undertaking an initial assessment of adult patient need, the patient's ability to manage all aspects of their own medication, including the administration of medication, should be assessed (appendix 1 FNHC 'Medication Assessment/Risk Assessment Form). Patients may require more than one level of support. The Children's Community Nursing Team should follow their own internally agreed process for assessing the medication needs of children.

Assessment of medication management needs should not be a one-off process and ongoing review is required.

The following levels of support should be determined:

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

Support Levels for the Administration and Management of Medication

Level	Description	Examples
Level 1: General Support or Assistance	General support or assistance is the tasks that staff carry out to help a patient/service user self-medicate. The important principle for general support is that ***the patient/service user is able to instruct the staff member what to do***. The patient/service user must therefore have the mental 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 patient/service user which tablets to pop out). For care to remain at level 1 the patient/service user (not the staff member) takes responsibility for confirming that they are taking the right medicine at the right time (Norfolk County Council 2017). **Occasional infrequent prompts:** these may sometimes be required for the patient/service user 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 patient/service user • 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 patient/service user receives their medication at the correct time and in doing so confirming the '6 Rs' (see section 3.6.1).	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 • Applying transdermal patches (including controlled drugs) • Applying medication to the eye, nose or ear (adapted from Norfolk County Council 2017) After receiving further training from a healthcare professional, non-registered staff may undertake administration of the following 'rescue' (urgent care) medications: • buccal midazolam • rectal diazepam • glyceryl trinitrate (GTN) • adrenaline for anaphylaxis via auto-injector device • medicines via a nebuliser

Level	Description	Examples
		For the above routes, the registrant who delivers this training will not remain responsible for the competency of the care assistant.
Level 3: Administration by specialist technique	Medicines administered by 'specialist techniques' would usually be administered by a registrant. These may be administered by non-registrants as a delegated task. . Where appropriate, a registrant can delegate these tasks to named care workers providing: • the employing organisation / individual is registered with the Jersey Care Commission • they seek agreement from the 'Registered Manager' of the service where relevant • the non-registrant receives appropriate training by a registrant and is deemed competent in the task • the non-registrant has ongoing support from the registrant • the registrant ultimately remains responsible for the delegated task Non registrants should refuse to administer medication by specialist technique "if they do not feel confident in their own competence" (Norfolk County Council 2017, p.7)	'Specialist techniques' include (but are not limited to): • Rectal administration (e.g. suppository) • Vaginal administration (e.g. pessary) • Gastrostomy • Injections e.g. insulin • Administering oxygen • Medications via a 'pump' device (staff should be aware of the FNHC Personal Care and Clinical Tasks in Adult Social Care Policy and Procedures re acceptable and unacceptable delegation)

3.2 Sourcing medicines

Usually medicines for administration by FNHC are provided by the patient/ parent / carer. Vaccines administered under a Patient Group Direction (PGD) are sourced following the guidance in the FNHC Cold Chain Policy.

3.3 Prescribing medicines

3.3.1 Prescribing

The prescriber will be a registered doctor, dentist or registered independent/supplementary or community prescriber.

The recognised exceptions to this are:

- In areas where there are no resident prescribers and in cases of clinical urgency a remote instruction may be acceptable (see section 3.6.10).
- Certain medicines may be administered against an agreed PGD, as per the FNHC PGD Policy.

In each instance, a record of the administration must be recorded on the appropriate documentation and held in the patient/child's care record.

3.3.2 Titration/use of dose ranges

Some medication may be prescribed within a dose range. This is usually in relation to patient response and symptom control. Registrants must only titrate dosages if they have the required knowledge and skills to do so. Additional support and training must be sought where a learning need is identified.

3.3.3 Anticipatory Prescribing

FNHC supports the practice of anticipatory prescribing for those nearing their end of life. Having ready access to relevant medication prevents delay in patients receiving treatment thus improving symptom control and enhancing quality of life.

Relevant policies/guidance:
Adult Care - Palliative Care: Anticipatory Prescribing Policy June 2022
Paediatric Care - Together for Short Lives: Children's Charities - Children Hospices

3.3.4 Non-Medical Prescribing

FNHC recognises the value that non-medical prescribing brings to the safe, efficient and effective management of medicines and improved patient care.

The organisation must ensure that appropriate governance frameworks are in place and that all legal, professional and practice standards are met to provide optimal standards of prescribing practice by Non-Medical Prescribers (NMPs).

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The benefits of extending prescribing responsibilities to NMPs are:

- improved patient care without compromising safety
- easier for patient's to get the medicines they need because of increased availability of prescribing roles
- increased patient choice in accessing medicines through more contacts with a range of professionals able to prescribe at a time and place more able to suit the patient
- improved use of the skills of health care professionals
- more flexible team working opportunities
- improved communication between all prescribers
- better access to medicines for symptom control improving quality of life for patients

Also refer to FNHC Non-Medical Prescribing Policy.

3.4 Storage of medicines

3.4.1 Safety

Medicines must be stored in a safe place accessible only to those supporting the safe administration of the medicine.

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.

3.4.2 Patient's home

In the patient's home, staff must leave medication in a safe place which is known and accessible to the patient (if appropriate). Residential and nursing homes will follow their own agreed procedures for storage of patient's medicines.

If, following risk assessment (appendix 1), it is not appropriate for the patient and/or their relatives/carers to have access to the medicines, a plan for its safe storage should be made in consultation with the patient, their family (where appropriate), the patient's GP and any other relevant health professionals and care providers.

3.4.3 Schools or Nurseries

Medicines managed by FNHC in these settings are kept in a locked cupboard or fridge as appropriate.

3.4.4 Adrenaline

Staff who carry Adrenaline must always keep this safe and secure, whilst accessible during patient contact. Also refer to the FNHC Anaphylaxis SOP.

3.4.5 Vaccines

The FNHC Vaccine Cold Chain Policy contains information regarding the storage of vaccines.

3.5 Transportation of medicines

3.5.1 Ordering and collecting medicines

Patients or their relatives should be encouraged to organise the ordering of their medicines and only in exceptional circumstances should staff take prescriptions to the pharmacy as part of the patient's care.

Patients or their relatives should be encouraged to organise the collection of their medicines. Only in exceptional circumstances and following a documented assessment of the risks, should staff be involved in collecting a patient's medication. However, FNHC recognises that for the Rapid Response and Re-ablement Team the need to transport medication may be necessary to expedite hospital discharge.

When transporting drugs, they should be out of sight and away from direct sunlight. Medication must be taken straight from the pharmacy to the patient's home i.e. other visits/stops must not be made when carrying medication.

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

3.5.2 Losses and discrepancies

All staff handling medicines should be security conscious at all times. Anyone discovering an apparent loss of drugs, unauthorised access to medicine storage or suspecting the misuse, misappropriation or abuse of drugs must report the matter immediately to their line manager.

3.6 Administration of medicines

3.6.1 General

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

Nurses on all parts of the NMC register are authorised to administer medicines. Student nurses on placement will be supported to be involved in administration of medicines, under the direct and constant supervision of a registered nurse. Other professional groups of registered healthcare professionals may also administer medicines to patients as part of their professional and service role.

All registered nurses (referred to as 'Registrants') must apply the NMC Code (2018b) to their practice regarding medicines management and should use this FNHC policy and its appendices for safe and effective local practice. Guidance from the Royal Pharmaceutical Society (2018; 2019) should also be followed.

The principles of the ‘six rights’ of medicines administration must always be followed to ensure patient safety

- right patient
- right medicine
- right dose
- right route
- right time
- right documentation

Consent must be obtained every time medication is administered as per FNHC Consent Policy. Staff should refer to the Capacity and Self Determination (Jersey) Law 2016 Code of Practice where there is concern about the patient/young person’s ability to give consent.

Medication remains the property of the patient who will normally be responsible for it. In the case of children, this responsibility will usually fall to the parents/guardian.

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

The administration of medicines is not solely a mechanical task. In administering any medication, assisting, or overseeing any self-administration of medication, registered nurses must exercise their professional judgment and apply their knowledge and skill in the given situation.

The responsibility for the administration of medicines rests with the registered nurse. Each registered nurse is accountable for their actions and omissions when administering medicines.

Each administration of a medicine must be recorded on the appropriate medication administration chart which will be scanned into the patient/child’s electronic care record.

It is the nurse’s responsibility to ensure that he / she is able to give their full concentration to the administration of medicines and if this is not possible then the administration should be withheld until the correct environment is resumed.

The date of first opening of liquid medicines, topical medicines and other medicines with a limited shelf-life after opening must be recorded on the product at time of first opening.

Single health professional administration of medication is normal practice in community-based care including the administration of controlled drugs (see section 5 re the administration of controlled drugs). However, all registered health professionals should use their professional judgement when administering medication and consider utilising a two person check for the following instances:

- where there is a complex calculation
- administration of an unfamiliar drug
- administration of drugs to a child (under the age of 18)
- administration of controlled drugs

Where a two person check has taken place - the name and role of the second checker should be clearly recorded in the progress notes. It is of paramount importance that the person undertaking the second check works independently and unprompted by the person requesting the check. The second checker is jointly accountable for all parts of the process.

Before administration of a medicine the nurse must:

- Read the prescription carefully. The medicine must not be administered if the nurse has any concerns or if there is any doubt about the legibility of the prescription or other particulars of dosage, route, time or frequency. If there are any doubts then the prescriber must be contacted.
- Check that the prescribed dose has not already been given. For 'when required' medicines the dose and timing of the previous dose should be checked before administering. A check must also be made that there has been no duplication of prescribed drugs in any other section of the prescription or through the patient self-medicating with an over the counter medicine, e.g. more than one product containing Paracetamol.
- Select the medicine required, checking the label against the prescription.

The registrant responsible for administration of medication must also ensure that:

- They know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.
- Any associated therapeutic blood monitoring for dose ranges and / or blood chemistry is up to date and the dose to be administered is not contra indicated.
- They can clearly identify the patient/client to whom the medicine is to be administered.
- They have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient, the patient's care plan and co-existing therapies.
- They have checked the expiry date of the medicine to be administered.
- There is no previous history of sensitivities or allergies in association with the drug to be given.
- They have checked that the entries in every section of the Medication Record and Authorisation Sheet (Appendix 2) has been completed, and that the prescription is in date, with a valid start date. Any prescription using a "stop date" is valid on the stop date stated but not thereafter.
- They have recorded the patient's weight on the medication administration authorisation record for all children and where the dosage of medication is related to weight or where the clinical condition dictates a recorded patient weight.
- Any contra-indications (check the monograph or Summary of Product Characteristics (SPC) for the drug, usually found on line on sites such as BNF online and medusa) or change in the patient's clinical condition which may require a drug to be withheld are noted, and medical advice sought should the unplanned withholding of a drug be indicated.
- Where combining the medication in a syringe driver confirm drug compatibility.
- The patient and/or carer are aware of the importance and implications of the prescribed treatment. The patient and/or carer have the information needed, including information leaflets where requested by the patient/carer, to understand and consent to the treatment. Patient concordance with their treatment should be encouraged at all times.
- If there are any special instructions e.g. with respect to food, swallow whole.

- For oral / enteral liquid medicines, if the dose cannot be measured accurately with a medicine spoon or pot, an oral / enteral syringe must be used. Intravenous syringes must not be used when measuring oral liquids.

Tablets must not be crushed routinely for patients with swallowing difficulties or for administration via a tube feed. Before crushing any tablet the registered nurse should ensure:

- they have confirmed the safety of crushing the tablet, having taken appropriate advice
- The appropriate prescriber has given approval, following consideration of alternative formulations.

Crushing tablets is an unlicensed use of a medicine.

All regular and single insulin bolus doses must be measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used to administer insulin. Higher concentration insulins (U200; U300; U500) must be administered using the device they are presented in, not with a U100 insulin syringe.

For all injections, the FNHC Injectable Medicines Policy should be followed.

3.6.2 Delegation of drug administration

When delegating drug administration to others who are non-registrants, the delegating registrant remains accountable for the appropriateness of the delegation and remains responsible for the patient's care.

FNHC-delegating staff must ensure that, recorded in the patient's nursing record is an up to date assessment of the patient's ability regarding medication management and an appropriate care plan supporting the safe administration of medication.

The administration of medication by a specialist technique may be delegated to non-registrants. Specialist techniques include (but are not limited to):

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

The registrant must ensure the non-registrant has completed an Accredited Level 3 Medication Administration Module (Vocational Qualification) (JCC 2019) and be satisfied that they are competent to carry out the task.

Non-registrants must refuse to administer medication, including by specialist technique, if they do not feel competent to do so.

Delegating the administration of medication will be client specific when this task is delegated to a non-registrant who is not part of FNHC nursing team. However, for FNHC non-registrants who are part of a FNHC nursing team and have been deemed competent to administer medication, including by specialist technique, the delegation does not need to be client specific.

Where the administration of medication is delegated to others, a clear plan of care must be recorded in the nursing and care records to reduce the risk of the medication being given twice or not given at all (see the standard operating procedure for 'Shared Administration of Medication (adult care only).

The administration of medication via a PGD must not be delegated.

3.6.3 Written authorisation to administer medication

Where registrants are required to administer medication prescribed by a registered prescriber, written authorisation to administer must first be obtained. Ideally this should be on the approved FNHC authorisation to medicate documentation (see appendix 2) unless the medicine is being administered under a PGD (see 3.6.7 below).

FNHC acknowledges that other forms of written authorisation may be used e.g. hospital medication chart; written instruction in the patient's care records.

Whilst, ideally the original copy of the 'Medication Record and Authorisation Sheet' (or any other acceptable form of written authorisation) signed by the Registered Prescriber should be available, FNHC acknowledges the difficulties of obtaining the original documentation and accepts that staff may work from a facsimile of the original document providing this copy is clear and legible. However, wherever possible, original documentation should be sought.

When requesting written authorisation to administer medication, staff must request that the prescriber completes all the required details of the medication.

3.6.4 Refusal by a registered prescriber to complete written authorisation

Where written authorisation for the administration of medicines on the appropriate FNHC documentation is not possible because the registered prescriber refuses the request for written authorisation, a registrant can check any available written medication instruction e.g. on the hospital discharge medication ('TTO') sheet and transcribe the instruction onto the appropriate FNHC medication record. This should be done in accordance with The Royal Pharmaceutical Society (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings (p6 Transcribing) and section 3.8 below.

It should be noted however that providing there is a written instruction for a named patient from a registered prescriber for a medicine including the dose, route and frequency then the medicine can be administered.

Where no written authorisation of any form exists and the registered prescriber refuses to provide it, then they must be advised that FNHC staff cannot administer the medication and they will need to make alternative arrangements to ensure that their patient receives the appropriate treatment. This must be documented fully in the patient's nursing records and reported to the relevant Operational Lead for the service. An incident report should also be completed

3.6.5 Medicines Reviews

Where medication is being administered by FNHC staff, the prescriber should be asked, at appropriate intervals, to review the medication and confirm that it is still appropriate. Consider the type of medication, recommended duration of treatment and presentation of the patient in determining when to request a medicines review. The frequency of the review should be clearly recorded in the care plan that relates to the medication administration.

The General Medical Council (2013) advise the following, “Reviewing medicines will be particularly important where:

1. patients may be at risk, for example, patients who are frail or have multiple illnesses
2. medicines have potentially serious or common side effects
3. the patient is prescribed a controlled or other medicine that is commonly abused or misused
4. the BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals”

Where patients require the administration long-term/life-long medication, the review should take place at least annually.

The outcome of medication reviews must be clearly documented in the patient’s records and changes reflected in the relevant care plan.

3.6.6 Therapeutic Monitoring

Therapeutic drug monitoring is the measurement of specific drugs and/or their breakdown products (metabolites) at timed intervals to maintain a relatively constant concentration of the medication in the blood. Some of the monitored drugs tend to have a narrow "therapeutic index," which is a ratio between the toxic and therapeutic (effective) dose of medication.

Many of the drugs that require therapeutic monitoring are taken for a lifetime. They must be maintained at steady concentrations year after year while the person ages and goes through life events that may alter that individual's therapeutic level. Examples of these conditions include cardiovascular disease, kidney disease, thyroid disease, liver disease and HIV.

It is important therefore, that staff are aware of patient medications that require therapeutic monitoring and that this is up to date and the current dose of medication is not contraindicated. They should liaise with the prescriber as appropriate.

3.6.7 Insulin

When staff are required to administer/prompt insulin a specific ‘Insulin Authorisation’ form (see appendix 3) is to be completed by a prescriber.

3.6.8 Non-registrants and administration of medicines

For FNHC non-registrants working in a nursing team medication administration will only be undertaken as a task delegated by a registrant.

3.6.9 Patient Group Directions (PGDs)

PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription (NICE 2013, updated 2017). Registered nurses may administer medicines using a PGD, as per the FNHC PGD Policy.

The master copy of all PGDs available in the organisation is held by the Head of Quality and Safety. PGDs will also be available electronically on the Procedural Document Library.

Staff are only eligible to work under a specific PGD if they fulfil the following criteria:

- have signed the relevant 'Agreement by Authorised Practitioner' document and had the use of the PGD authorised by their Line Manager or another appropriate manager
- have their name recorded on the centrally held database

3.6.10 Administering medication from a remote prescription/direction to administer including 'verbal direction'

Where changes are required to current medication (not including controlled drugs) and it is not practicable to get written authorisation, then verbal authorisation is permissible (RPS 2019 p.5). However, it must be confirmed by text, fax or email before the medication is administered. Ideally the verbal instruction from a registered prescriber should be received by two registrants. Where this is not practicable, the second person hearing the new instructions can be:

- another healthcare worker
- the patient
- a family member
- another carer

The required medication change must be fully documented in the patient's nursing records, dated, timed and signed by both the nurse and the second person.

Written authorisation from the registered prescriber should be obtained as soon as possible thereafter; normally within 24 hours or 72 hours if a bank holiday or weekend.

New medication cannot be prescribed remotely by non-medical prescribers.

Medical prescribers can provide a remote direction to administer a new medication but this should only be in exceptional circumstances e.g. palliative care and the prescription/direction to administer must be confirmed by fax, email or text before it can be administered. Again written authorisation should be obtained thereafter from the registered prescriber, ideally on the relevant FNHC medication documentation, within 24 hours or 72 hours if a bank holiday or weekend.

The use of text messaging to convey an order to administer medication is an option for community care.

3.6.11 Administration of medications via an enteral feeding device

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

Please refer to:

- FNHC Policy and Procedures for the care of an infant, child or young person who requires enteral feeding (section 2.6)

- Medicines administration via a gastrostomy or percutaneous endoscopic gastrostomy (PEG) tube www.clinicalskills.net

Registrants should ensure that patients/parents/carers are also aware of the risks.

Before any medication is administered via an enteral feeding device the patient must have had a medication review. Ideally this should be undertaken by the patient's General Practitioner and a Community Pharmacist in collaboration with the Dietician responsible for 'prescribing' the feeds.

Only a few medicines are actually licensed for enteral administration therefore most medication will be administered outside of its product license (also see section 6.4).

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.

The number of medicines administered via the enteral route should be kept to a minimum and wherever possible, alternative licensed routes used.

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.

3.6.12 Administration of medications via a syringe driver

Please refer to the Palliative Care (Adult): Ambulatory Syringe Pump Policy.

3.6.13 Administration of Topical Preparations

Topical medications introduce medication through the skin, by absorption. The administration of topical preparations must be authorised for administration by a prescriber and administration recorded on the appropriate documentation.

Topical medications include:

- Transdermal systems.
- Pastes
- Aerosol sprays
- Ointments
- Lotions
- Creams

They are primarily used for localised effect, some medications have a systemic effect.

They can be difficult to deliver in precise doses. It is not necessary to administer large amounts of topical medications to the skin as it may be irritating to the skin, stain clothes and expensive.

Ensure gloves are worn when applying topical preparations. Staff involved in topical administration should ensure good hygiene, washing hands before and after the administration.

Creams and ointments should be applied to clean skin and only to the area it has been prescribed for.

Key points:

- Check expiry date before use
- Highlight any short expiry date as a reminder to all personnel involved in patient care
- Record the date opened and the calculated expiry on the medicine package / label. Some packaging does not allow for the pharmacy label to be placed over the product e.g. eye drops. In these circumstances the outer packaging will have to be endorsed with the date of opening. It is essential that the product remains in the outer packaging throughout the duration of treatment.
- Products whose appearance would suggest it may be unfit for use should be given to the patient to dispose and the patient asked to obtain new products.

The following information should be written clearly on the authorisation to administer chart:

- Indication
- Name of topical preparation
- Site, frequency and directions for application
- Length of treatment – a clear start date and end date

3.6.14 Emollients

Emollients soothe, smooth and hydrate the skin and are indicated for dry or scaling disorders. There are many different emollients available and patients may access these either ‘over the counter’ or on prescription from their General Practitioner (GP) or other Registered Prescriber. Emollient preparations sometimes contain urea or antimicrobials.

This medicines policy enables staff to apply emollients without written authorisation from a Registered Prescriber providing clear and documented benefit from their use is attained.

Staff should be aware of the potential fire-hazard from paraffin-based skin emollients particularly where these are used in large amounts.

"*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.*" (MHRA 2016)

Patient clothing and bedding should be changed regularly (ideally daily) *"because emollients soak into fabric and can become a fire hazard"* (MHRA 2016).

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

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

3.6.15 Preparing medication in advance

To enable independence, it is acceptable, following a documented assessment of the risks, for staff to leave out oral medication in a suitable container for clients to take at a later time. A care plan must be in place to support this practice.

3.6.16 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) guidance should be sought from a pharmacist and documented in the patient's nursing records.

3.6.17 Covert Administration of Medication (Hiding or disguising medication)

Medicines are administered covertly only to people who actively refuse their medication and who are considered to lack mental capacity in accordance with an agreed management plan (RPS 2019).

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, assessment of capacity should be undertaken. Staff should refer to the Capacity and Self Determination (Jersey) Law 2016 Code of Practice for guidance in this matter (GofJ 2016).

A document for recording the decision to administer medication covertly is available in appendix 5 of The Safeguarding Partnership Board's Multi-Agency Capacity Policy & Procedures 2018.

3.6.18 Refusing medication

If a patient refuses medication, this must be recorded in their nursing/care records and reported to the FNHC staff member responsible for the patient's care. The right to refuse medical treatment is universally recognised as a fundamental principle of liberty. Where there are concerns about capacity to make that decision, seek advice and refer to the Capacity and Self Determination (Jersey) Law 2016 Code of Practice.

Medication should be placed in a suitably marked container (an envelope is sufficient) and returned to the Pharmacy in the following circumstances:

- 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

Wherever possible, returning medications to pharmacy should be by a family member/informal carer or by the pharmacy delivery service.

Where it is established that the client is not taking their medication as prescribed, this must be reported to the patient's GP and/or the appropriate non-medical prescriber.

3.6.19 Errors in medication administration

All medication errors should be recorded in the patient's nursing/care record and be reported immediately to the Line Manager.

Errors and near misses in medication administration must be reported/recorded via the 'Assure' system.

Refer to the FNHC Medicines Management SOP.

3.6.20 Critical Medicines

In 2010 the National Patient Safety Agency 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"* (NPC 2010). Whilst this recommendation did not extend to community care providers, it seems reasonable that FNHC should develop such a list in order to reduce harm from omitted or delayed medicines.

The list developed by FNHC is in Appendix 4 and includes:

- anti-infective medication
- anticoagulants
- insulin
- resuscitation medicines
- medicines for Parkinson's disease
- other locally identified medicines

This list reflects the drugs most commonly encountered by FNHC Community staff and is therefore not exhaustive as patients may present at any time with a medicine that requires timely administration.

'Critical medicines' that have been omitted or their administration delayed must be reported via the Assure System and treated as a patient safety incident.

3.6.21 Mixing Medicines

In 2009, the Medicines Healthcare Products Regulatory Agency (MHRA) stated that"…mixing drugs together, where one is not a vehicle for the administration of the other, creates an unlicensed medicine." (MHRA 2009). However it has been acknowledged that in palliative care the mixing of medicines for administration by single injection or via a syringe driver is a longstanding practice and necessary for effective symptom control.

Following recommendations from the Commission on Human Medicines, medicines regulations were amended (DofH 2010) to enable doctors and other prescribers to mix medicines themselves and to direct others to mix medicines.

These changes apply not only to palliative care, but to all clinical areas where the mixing of medicines prior to administration is accepted practice and supported by the employer's policies for delivery of healthcare.

3.6.22 Shared care arrangements

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 patient and where appropriate their family/carers) to prevent medication being missed or overdosing. Systems of work must enable the safe administration of all medication. See SOP Medicines Management (Shared administration of medication).

3.6.23 Compliance Aids

Where registrants are required to administer medication, this should be done from original packaging and registrants should have access to the manufacturers' information about the medicines e.g. summary of product characteristics or the patient information leaflet.

Monitored dosage systems (MDS) are patient compliance aids and are not an appropriate method of medication supply when the administration is being undertaken by registrants. Only in exceptional circumstances should registrants administer medicines from a MDS and only if it is the type of compliance aid filled by a pharmacist. A rationale for those exceptional circumstances needs to be documented. If administration of medication by Registrants is to be ongoing, a supply of medication in original packaging should be requested.

Before the use of a compliance aid (e.g. monitored dosage system) is considered, other solutions should be explored e.g. reminder charts, large print labels. If a compliance aid is thought to be necessary, the patient'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. Patient information leaflets for all dispensed medicines should be available with every MDS supplied.

3.6.24 Role of relatives / carers in medicines administration

Relatives, often a partner or immediate family / parents can be an integral part of medicines management for patients who require support or do not have capacity to manage their medicines safely.

This is a role that should be supported and in the patient's best interests. The following must occur:

- Risk assessment (see appendix 1), which will identify when this is appropriate.
- Consent (where appropriate) must have been received from the patient Relevant agencies informed of family or carer involvement.
- Training, support and the capability of the family member/carer regarding the administration of medication and recording of administration has been completed and documented in the patient's care record.
- Monitoring and follow-up arrangements must be agreed between the patient, relatives or carer and supervising healthcare professionals
- A record of all discussions, agreements, consent, training and family member/carer's capability are detailed in the patient's care record.

Monitoring and follow-up will be according to individual need and circumstances.

3.7 Record keeping

The NMC Code and Royal Pharmaceutical Society guidance should always be followed when recording information relating to medicines management. (NMC 2018b; RPS 2019)

On admission to the caseload, staff should seek the patient's consent to access their GP records. Where consent is given, using the facility within EMIS, staff can access the whole patient record including the GP's record of their medication. It should be noted, however, that this list may not be a complete record of current medication taken or the most up to date e.g. patient taking over the counter medicines, recent change in medication by another healthcare professional such as a hospital clinician.

A record should be accessible of all medication currently being taken including 'over the counter', herbal and 'as required' medication. This record should be updated in line with section 3.6.5 and after any significant change in the patient's condition or following admission to hospital. If aware that the patient is taking other medicines or that there has been a change to the regime or dose/dosage recorded on their electronic GP records (e.g. post hospital discharge), the GP should be informed.

Where access to the GP records is not available, the approved medication documentation for the service should, ideally, be used to record this information, however, other documentation may be acceptable/appropriate e.g. a pharmacy generated Medication Administration Record (MAR) or a hard copy record generated by a Doctor's surgery.

Where levels 2 & 3 medication management are required, a care plan should be available in the patient's nursing records. If the administration of the medication is to be delegated to a non-registrant, a care plan should also be available in the care records that the non-registrant can access. Where relevant, care plans should include a statement that the medication administration can be delegated. It should also include when the patient's care needs should be reassessed along with a decision about the appropriateness of the delegation continuing.

To minimise risk, the care plan must not include details of the medicines for administration unless there is a documented rationale why this has been necessary.

Detailed records must be kept of all medication administered. This information must be documented in the patient's nursing/care record using the appropriate medication administration documentation (available in 'Central Filing').

3.8 Transcribing

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)
- 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 to alter/change original prescriptions.

Registrants may transcribe medication from one "direction to administer" to another form of "direction to administer" however, this should only be done in exceptional circumstances. Staff are accountable for what they transcribe.

Where transcribing is unavoidable, the "direction to administer" should be checked, ideally by another Registrant. Where this is not possible, it should be checked by another competent healthcare worker or by another Registrant the next time the medication is administered.

3.9 Reporting Adverse Reactions

Action must be taken to remedy any adverse drug reactions. A record of the incident must be clearly documented in the patient's nursing/care records ensuring that all 'allergy and alerts' sections are completed as appropriate.

The patient's GP and the prescriber (if different) must be notified and the adverse reaction reported via the 'Yellow Card Scheme' Yellow Card | Making medicines and medical devices safer (mhra.gov.uk).

For reporting issues identified with medicines and medical devices used to treat COVID-19 go to Official MHRA side effect and adverse incident reporting site for coronavirus treatments and vaccines | Coronavirus (COVID-19)

3.10 Destruction of medicines

3.10.1 Disposal of medication

It is never appropriate 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. Patients 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 5) should be completed (see section 3.5 re the transportation of patients' medicines) and scanned into the EMIS record when completed.

Any medication left in a syringe (e.g. when a syringe driver has been discontinued before all the medication has been delivered) should be discharged onto a suitable absorbent material which has been placed in a sharps bin. In the event of this medication being a controlled drug, its disposal must be documented following the appropriate Standard Operating Procedure (SOP).

3.10.2 Disposal of medication packaging

When disposing of medication packaging, staff should be mindful that patient identifiable information will be present. Disposal by FNHC staff should not compromise patient confidentiality.

3.11 Emergency Situations

3.11.1 Emergencies

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

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

Where written authorisation to administer the medication is not available, staff can still assist the client to take the necessary 'rescue medication' or, where necessary, administer the 'rescue medication' if the patient/client is unable to do this themselves. This action must be documented in the patient's nursing/care records and the staff member's Line Manager informed.

3.11.2 Emergency Treatment for Anaphylaxis

“Intramuscular adrenaline is the first-line treatment for anaphylaxis (even if intravenous access is available)” (RCUK 2021 p.28).

Adrenaline for the treatment of anaphylaxis should be easily accessible to all registrants authorised to carry this medication. This cohort of staff is required to carry:

- two ampoules of adrenaline as part of their standard medical supplies
- instructions on the dosages that are to be administered (dosages differ according to adults and children)
- 1ml syringes and a selection of different sizes of hypodermic needles

Adrenaline must be available at all clinics where immunisation takes place and at all District Nursing clinics.

Adrenaline should only be administered if anaphylaxis is suspected. If adrenaline is administered, full details should be recorded in the patient’s/child’s nursing/health record, consistent with this policy.

In the case of children, when adrenaline is administered, full details should also be recorded in the parent held record book (red book) if available.

In both cases, the incident should be recorded/reported on the Assure system and the patient/child’s GP informed in writing.

If the cause of anaphylaxis is thought to have been drug induced the health care professional involved must report this via the ‘Yellow Card ‘scheme Yellow Card | Making medicines and medical devices safer (mhra.gov.uk)

Training in the administration of adrenaline is detailed in section 3.23.

3.11.3 Adrenaline Auto-injector Devices (e.g. Epipen)

The Resuscitation Council (UK) states that “if the only available adrenaline preparation is an auto-injector, this can be used in the first instance” (RCUK 2023 p.31)

3.12 Controlled Drugs

The Director of Governance and Care is responsible for overseeing the management and use of controlled drugs by all services provided by the Organisation.
Staff must comply with the legal requirements for controlled drugs and FNHC Standard Operating Procedures. These include the following aspects of controlled drug management:

- Transportation
- Storage
- Administration
- Recording
- Destruction
- Theft or Loss

3.12.1 Stock Checks

FNHC recognises that there may not always be two registrants available to witness the administration and checking of the stock balance of controlled drugs. In this situation, it is reasonable that, where possible, another competent person acts as the witness e.g. a carer.

When recording on the controlled drug stock sheet receipt of medication from the pharmacy or use of the controlled drug, the quantities should be recorded in words not figures (for example, ten not 10) to reduce the chance of entries being altered.

Stock balances of liquid medicines may be checked by visual inspection but the balance must be confirmed to be correct on completion of a bottle.

3.12.2 Morphine Oral Solutions

If the proportion of morphine hydrochloride 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).

3.13 Specialist Uses

3.13.1 Cytotoxic Medication

3.13.2 Anti-cancer Cytotoxic Medication

At the present time, FNHC do not administer cytotoxic medication, including oral medication, for the treatment of cancer. Staff should be aware that the administration of oral anticancer medication requires the same level of precaution as administration by the parenteral route.

This is to protect both the professional administering the medication and the patient. “Oral anti-cancer medication have the same potential for risk as parenteral systemic anti-cancer treatment (SACT) in terms of treatment-related toxicities and potential for serious medication errors leading to patient harm” (Health Service Executive 2018).

If a patient is self-medicating with oral anticancer medication there must be an alert in their nursing/care records and all staff made aware of this and the current Jersey Health and Community Services guidelines relating to SACT.

Any requests to administer cytotoxic medication should not automatically be accepted at this time however, staff should first discuss the detail of any such request with the Operational Lead for their service. Referrals for the administration of anticancer cytotoxic medication will be monitored and this information will be used to drive any change to current policy.

3.13.3 Spillage involving anti-cancer cytotoxic medication

In the event of FNHC staff being required to deal with a spillage involving anti-cancer cytotoxic medication (including oral anti-cancer cytotoxic medication) the Oncology Department at JGH must be contacted for advice. Out of hours the person ‘on call’ for Oncology can be contacted via the hospital switchboard.
See also the FNHC Waste Management Policy and, where appropriate, the SOP for the Administration of Subcutaneous Methotrexate for Inflammatory Arthritis in Adults.

3.13.4 Cytotoxic medication for Rheumatoid Arthritis

Refer to the SOP for the Administration of Subcutaneous Methotrexate for Inflammatory Arthritis in Adults.

See also RCN (2021) guidance RCN Administering Subcutaneous Methotrexate for Inflammatory Arthritis.

3.14 Medication acquired over the internet

Registrants should never administer a medication that has not been prescribed, nor one that has been acquired over the internet without a valid prescription.

3.15 Patient's own medication that has been purchased abroad

The registrant must seek to confirm the authenticity of the original prescription and whether it has a UK license. Where this is not possible the patient should be asked if they would be willing to have a drug with similar properties prescribed for them that has a UK license. If in agreement, arrangements should be made for this to happen.

In a life-threatening situation and the patient is unable to self-administer the "unlicensed" medication, the registrant may administer the medication. Clear and accurate records of this event must be made in the patient's nursing records and the patient's GP informed. An incident form should also be completed and the relevant Operational Lead informed. If appropriate, discussion can also take place with the organisation's Pharmacy Advisor. A documented plan for ongoing care regarding medication management should be put in place.

Where a patient is unable to self-medicate and refuses to take anything but the "unlicensed" product, a documented risk assessment should be undertaken in conjunction with other relevant parties e.g. the patient, their GP, the Operational Lead for the service, the organisation's Pharmacy Advisor.

3.16 Intravenous medication

Intravenous (IV) medication cannot be administered by non-registered staff.

Pre-registration student nurses who have undergone theory and have had the opportunity to practice in a simulated environment can administer IV medication under the direct and constant supervision of a registered nurse.

Refer to the FNHC Standard Operating Procedures:

- Preparation of injectable medicines
- Use of intravenous medicines in the Rapid Response and Reablement Team

3.17 Unlicensed medicines & medicines used 'off-label'

Unlicensed medicinal products may not be administered against a PGD.

Licensed medication used outside its licensed indications ('off-label') may be administered against a patient group direction but only where such use is exceptional, justified by best practice and the status of the product is clearly described. An incident report should be completed.

"Before administration, the person administering the medicine must have an overall understanding of the medicine being administered and seeks advice from a prescriber or a pharmacy professional" (RPS 2019).

3.18 Complementary and alternative therapies

Registrants must give consideration to both the patient's condition and any co-existing treatments before commencing any complementary or alternative therapies. Informed consent must be obtained from the patient.

Any registrant planning to use complementary and alternative therapies must first discuss this with their Operational Lead to ensure that FNHC are prepared to accept vicarious liability for this practice and that indemnity insurance is in place.

All complementary and alternative medicines must be recorded in the patient's medication record alongside any other medicinal products that may be taken.

Registrants can only administer complementary and alternative medicines that patients have bought 'over the counter' (OTC) and 'self-prescribed' if there is written authorisation by a Registered Prescriber.

Non-Registrants must not offer advice on treatment options for complimentary and/or alternative therapies. Patients/clients should be advised to seek advice from their GP.

3.19 'Over the Counter' (OTC) medication

Registrants should not administer any medicinal product without written authorisation from a Registered Prescriber unless the medicinal product involved is covered by a PGD or is an emollient (see section 3.6.14).

Any co-administration of 'over the counter' medications and those prescribed should be discussed with the patient's GP or relevant Registered Prescriber.

3.20 Buccal Midazolam

Midazolam is classified as a schedule 3 controlled drug and its use is governed by the Misuse of Drugs (Jersey) Law 1978 and the Customs and Excise (Jersey) Law 1999. It is exempt from storage and recording regulations.

Buccal midazolam can currently only be prescribed by a hospital doctor when its use is for the treatment of prolonged seizures. It is not available on the GP prescribing list except for use in palliative care.

To support and standardise the use of buccal midazolam for both adults and children who have prolonged epilepsy seizures, refer to the following FNHC policies and standard operating procedures:

- Administration of Buccal Midazolam to Children who have prolonged epilepsy seizures
- Administration of Buccal Midazolam to Adults who have prolonged epilepsy seizures

3.21 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. 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 healthcare workers therefore staff must exercise an awareness of these drugs and the risks. NIOSH have developed a list of drugs considered to be hazardous (NIOSH 2014). Not all drugs on the list will be harmful to healthcare workers and for those that do pose a risk, the actual harm will depend on what is done with the drugs.

Where staff are required to administer a hazardous drug that poses an actual risk to them, a Control of Substances Hazardous to Health (COSHH) risk assessment must first be carried out and discussed with the Operational Lead for the service.

Sources of information regarding medicines safety include, Pharmaceutical companies, online resources and the Medicines Information Unit at Jersey General Hospital. Safety precautions must be clearly documented in the patient's nursing records and communicated to all relevant personnel involved in the patient's care.

3.22 Immunisation

3.22.1 General

It is advocated that "all healthcare professionals advising on immunisation or administering vaccines must have had specific training in immunisation including the recognition and treatment of anaphylaxis" (DofH 2013 p.25).

PGDs are available for the administration of most types of vaccines. Staff using PGDs must do so in accordance with local policy.

Following the administration of vaccines, patients should be observed for immediate signs of adverse drug reactions; *'there is no evidence to support the practice of keeping patients under longer observation…'* (DofH 2013 p.32).

3.22.2 Influenza and Pneumococcal Immunisation

Registered Nurses working for FNHC may be requested to administer seasonal 'flu and/or pneumococcal vaccinations to patients. In this situation, a PGD should not be used; instead written authorisation from the patient's GP must be obtained.

Consent forms are available in appendix 6.

3.22.3 Seasonal Staff Influenza Immunisation

In line with local and national policy, FNHC will offer staff free annual influenza immunisation.

A consent form for seasonal influenza immunisation for staff is available. As this is subject to change annually the correct form should be confirmed with the HCS staff immunisation nurse (Infection Prevention and Control Team) prior to the commencement of staff influenza immunisation clinics.

The original consent form should be filed in the staff member's personnel file and a copy sent to the HCS Infection Prevention and Control Team so local immunisation rates can be collated.

3.22.4 Childhood Immunisations

Nurses working in the Child and Family Service should promote the uptake of routine childhood immunisations in line with the Healthy Child Programme and the current Department of Health recommended childhood immunisation schedule.

Staff must work in partnership with Public Health to identify children and young people most at risk and requiring further protection such as BCG and Hepatitis B vaccinations. This does not include travel vaccines to which clients would be signposted to their GP.

Routine surveillance should be used to identify children and young people with an incomplete immunisation schedule. Where this is identified, arrangements should be made for immunisations to be brought up to date.

3.22.5 Maintaining the 'Cold Chain'

All vaccines must be stored and handled maintaining the 'cold chain' at all times, in order to protect the vaccine's potency.
All staff involved in any aspect of vaccine management from transportation and storage through to administration must be aware of how to maintain the 'cold chain' and be familiar with FNHC's Vaccine Cold Chain Policy and Procedures.

3.23 Training

Staff administering medication will be appropriately trained and are responsible for maintaining their knowledge and skills in this area.

3.23.1 Anaphylaxis Training

Staff who may be required to administer adrenaline must undertake annual updates on the recognition and treatment of anaphylaxis and in basic life support. An eLearning training package for anaphylaxis/adrenaline administration is offered as part of the mandatory training programme.

3.23.2 Training/updating for non-medical prescribers

For local requirements, please refer to the current Jersey Health & Community Services (HCS) Non-Medical Prescribing Policy on the HSS Intranet site.

3.23.3 Immunisation training

All staff who undertake vaccine administration should complete the current training stipulated by the organisation as detailed in the annual training prospectus.

All staff undertaking vaccine administration must undertake annual anaphylaxis and Basic Life Support training, be familiar with FNHC's Vaccine Cold Chain Policy and Procedures and keep themselves updated regarding immunisation and the vaccine/s for administration e.g. via chapter 4 of The Green Book (DofH 2013).

3.23.4 Training in medication administration for non-registrants

Level of Medication Administration	Training Required
1 - support	Completion of the service area's induction training in medication
2 - administration	Successful completion of an Accredited Level 3 Medication Administration Module (Vocational Qualification) (JCC 2019) before they can undertake this task. Clinical areas must provide non-registrants with on-going updating, supervision and assessment of their practice. The frequency of reassessment will be determined by their line manager
3 - administration by specialist technique	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.

4 CONSULTATION PROCESS

Name	Title	Date
Gill John	Team Lead CCNT	27.06.2023
Justine Le Bon Bell	Head of Education and Development	27.06.2023
Michelle Cumming	Ope0rational Lead CFS	27.06.2023
Jo Davies	Deputy Operational Lead CFS	27.06.2023
Clare Stewart	Operational Lead RRRT	27.06.2023
Louise Hamilton	Team Lead RRRT	27.06.2023
Tia Hall	Operational Lead Adult Services	27.06.2023
Jo Champion	Team Lead DN Services	27.06.2023

5 IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Upload onto Procedural Document Library (PDL)	Secretary / Administration Assistant (Quality and Governance Team)	Within two weeks of ratification
Upload to Virtual College (VC)	Head of Education and Development	Within two weeks of ratification
Communication regarding updated policy on PDL and VC	Secretary / Administration Assistant (Quality and Governance Team)	Once uploaded onto PDL and VC

6 MONITORING COMPLIANCE

Compliance with policy will be identified through audits and clinical supervision.

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

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10 APPENDICES

Appendix 1 Medication Assessment / Risk Assessment Form

Medication Assessment/Risk Assessment (Nursing)

Family Nursing & Home Care

Patient'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 patient self-medicating all medicines? (including non-prescribed medicines)	Yes / No	If 'yes' - **move to section B**
Is support with all medication provided by family/others?	Yes / No	

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

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Adapted with permission from Norfolk County Council's 'Medication Risk Management and Agreement Plan' – updated January2020

Medication Assessment/Risk Assessment (Nursing)

Family Nursing & Home Care

Patient's name:…… **URN:**……

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) - patient in control of ensuring that they get their medicines and for the "6 Rs"
2	Level 2 – Administration

	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 by a Healthcare Assistant following training and assessment of competence by a Registered Nurse and as a delegated task from the Nursing Service. See section 2.10 of Medicines Policy* ***(CARE PLAN TO BE COMPLETED BY DELEGATING NURSING 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:

Medication Assessment/Risk Assessment (Nursing)

Family Nursing & Home Care

Patient's name:……**URN:**…….....

Section D – Administration Systems			
In what type of administration system is oral medication presented?	Family/other filled dossett box	Yes / No	***N.B.*** *Nurses & HCAs* ***must not*** *administer medicines (level 2) from this types of device*
	Pharmacy filled compliance aid	Yes / No	***N.B.*** *Nurses & HCAs should not administer medicines (level 2) from this type of device.*
	Original containers	Yes / No	
Is any additional equipment required for medication administration?			Yes / No
If 'yes' is it available in the patient's home?			Yes / No
Comments/actions required:			

Section E – Controlled Drugs (SOPs for controlled drug should be followed where required)		
Are Schedule 2 controlled drugs prescribed?	Yes / No	If 'yes', detail arrangements to reduce risk:

Section F – Anticipatory Medication		
Is anticipatory medication in place or being considered?	Yes / No	If 'yes', follow Anticipatory Prescribing Policy and related procedures.

Section G – Cytotoxic Medication		
Is cytotoxic medication prescribed?	Yes / No	If 'yes', detail arrangements to reduce risk:

Section H - Warfarin			
Is patient prescribed warfarin?	Yes / No (If 'no' move to section I)	Is level 2 administration required?	Yes / No
Is the patient aware of when their next INR blood test is due?			Yes / No
Does the patient need advice about taking warfarin?			Yes / No
Comments/action required			

Medication Assessment/Risk Assessment (Nursing)

Family Nursing & Home Care

Patient's name:……**URN:**……

Section I - 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' – has the "Return of Medication" form been completed?	Yes / No
Storage location of medication	
Does any medication require special storage e.g. refrigeration?	Yes / No
Comments/action required:	

Section J – Access to medication	
Can the patient 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 Healthcare Workers are not present?	Yes / No
Are there any other identified risks e.g. children, pets, remembering to take medication, to FNHC staff?	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:** ……

Medication Reassessment Needed YES / NO **If 'YES', Date Due:** ……

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Adapted with permission from Norfolk County Council's 'Medication Risk Management and Agreement Plan' – updated January2020

Appendix 2 Authorisation to Administer Medicines Form

Medication Record & Authorisation Sheet

Family Nursing & Home Care

Name:.....

D.O.B:.....

URN:.....

Or Affix Patient Label

Allergies & Alerts:

Caution: *Before administration, please be aware of medication prescribed on other medication sheets*

Date	Name of Medication	Dose	Route	Frequency (please tick)							Who will administer?	Signature of Prescriber	Date Stopped
				Breakfast	Lunch	Dinner	Bedtime	As Required	Stat	Other (specify)			

PO	oral	PV	vaginal	S/C	subcutaneous
TOP	topical	PR	rectal	IM	intramuscular
TD	transdermal	SL	sublingual	IV	intravenous

Sheet Number: ❑

Version March 2020

Appendix 3 Authorisation to Administer Insulin

Family Nursing & Home Care

Insulin Authorisation Sheet

Guidance for Prescriber: When a dose change is made, please discontinue the previous dose and complete the details of the new dose to be administered. Entries must be signed by a Registered Prescriber. Please scan document and email to adult.referrals@fnhc.org.ie

Name: .....

D.O.B: .....

URN/EMIS No.: .....

Or Affix Patient Label

Allergies & Alerts:

Caution: ***Before administration, please be aware of medication prescribed on other medication sheets***

Date Started	Type of Insulin	Dose	Route	Tick as appropriate				Signature of Prescriber	Date stopped
				Breakfast	Lunch	Dinner	Bedtime		
			s/c						
			s/c						
			s/c						
			s/c						
			s/c						
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			s/c						
			s/c						

s/c = subcutaneous

Sheet Number:

Version December 2019

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Appendix 4 Critical Medicines

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 doses of **any drug**	Any drug that is deemed urgent enough to be prescribed as a "STAT" on the medication chart
Emergency treatment of anaphylaxis / allergy	When used for the treatment of acute anaphylaxis an urgent response is required as anaphylaxis is a life-threatening event.
Systemic **Antimicrobials**	Potential worsening of systemic infection and deterioration of condition
Anticoagulants **(**Deep vein thrombosis/pulmonary embolus treatment or thromboprophylaxis)	Risk of thrombus and serious embolic episode
Antiepileptic Agents (including the management of prolonged seizures/status epilepticus)	Loss of seizure control When used for the management of prolonged seizures/status epilepticus an urgent response is required
Anti-Parkinsonian Agents	Loss of symptom control
Bronchodilators and Respiratory stimulants	Deterioration in clinical condition When used for the management of an acute Chronic Obstructive Pulmonary Disease exacerbation or in the management of respiratory emergencies an urgent response is required.
Corticosteroids	Treatment failure in acute conditions Risk of acute adrenal insufficiency with abrupt withdrawal after a prolonged period of corticosteroid use
Disease-Modifying AntiRheumatic Drugs	Treatment failure e.g. when used in the management of inflammatory disorders such as rheumatoid arthritis
Immunomodulating drugs	Disruption of regimen scheduling
Immunosuppressant drugs for transplant	Risk of rejection due to sub-therapeutic levels

Drug Group / Class	Rationale for Inclusion / Risk if Drug Delayed or Omitted
Insulin	Poor glycaemic control with the risk of hyperglycaemia
Oral Hypoglycaemic Agents	Poor glycaemic control with the risk of hyperglycaemia
Emergency treatment of hypoglycaemia	Risk of life-threatening hypoglycaemia
Management of Symptoms at End of Life	Poor symptom control
Opiates	Poor pain control
Posterior Pituitary Hormones	Desmopressin (when used in cranial diabetes insipidus) – risk of life threatening dehydration and hypernatraemia

Appendix 5 Return of Unwanted Medicines Form

Return of Unwanted Medicines

Family Nursing & Home Care

Service User 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

Service User 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 service user's care record

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Appendix 6 Immunisation consent forms

Family Nursing & Home Care

Pneumoccal Immunisation Consent Form (patient)

Name: .....

D.O.B: .....

URN: .....

Or Affix Patient Label

N.B. This consent for is for use with adult patients only

Checklist	Yes	No
1. Have you an acute illness e.g. fever?	☐	☐
2. Have you any allergies?	☐	☐
3. Have you had the pneumoccocal vaccine before?	☐	☐
4. Are you pregnant or breastfeeding?	☐	☐
5. Has the GP signed the medication authorisation record	☐	☐

Action Plan

Question Number	If Patient Answered:	Action
1	Yes	do not give drug; discuss with GP first
2	Yes	do not give drug if allergic to any of the components of the vaccine; inform GP
3	Yes	do not give drug; discuss with GP
4	Yes	do not give drug; discuss with GP first
5	No	do not give drug until written authorisation obtained

Continued Overleaf

document updated December 2019

Family Nursing & Home Care

Pneumoccal Immunisation Consent Form (patient)

Patient's Name: ..... **URN:** .....

Patient information leaflet given and explanation about adverse drug reactions and who to contact if any concerns:	Yes ☐ No ☐

Consent Form

My doctor has requested that I receive the pneumoccocal vaccine and I am happy for the nurse to give it to me. I understand why I am having it, what possible side effects there may be and who I should contact if I have any concerns.

Patient's Signature ..... Date: .....

Administration:

Product Name .....

Batch Number .....

Expiry Date .....

Dose .....

Route .....

Site .....

Date & Time Given .....

Nurse's Signature .....

Reiterate advice about adverse drug reactions and who to contact if any concerns.

Assess patient to be feeling well before leaving the house/clinic.

This should be completed and scanned into the patient's electronic nursing record

document updated December 2019

Family Nursing & Home Care

Influenza Immunisation Consent Form (patient)

Name:.....

D.O.B:.....

URN:..... .....

Or Affix Patient Label

N.B. This consent form is for use with adult patients only

Checklist	Yes	No
1. Have you an acute illness e.g. fever?	☐	☐
2. Have you any allergies?	☐	☐
3. Have you ever had a 'flu vaccination?	☐	☐
4. Did you had a severe reaction after the vaccination?	☐	☐
5. Are you allergic to eggs?	☐	☐
6. Are you pregnant or breastfeeding?	☐	☐
7. Has the GP signed the medication authorisation record	☐	☐

Action Plan

Question Number	If Patient Answered:	Action
1	Yes	do not give drug; discuss with GP
2	Yes	do not give drug if allergic to any of the components of the vaccine; inform GP
3	No	move on to question 5
	Yes	Check when and if given recently do not give drug; inform GP
4	Yes	do not give drug; discuss with GP
5	Yes	do not give drug; inform GP
6	Yes	do not give drug; inform GP
7	No	do not give drug until written authorisation obtained

Continued Overleaf

document updated December 2019

Family Nursing & Home Care

Influenza Immunisation Consent Form (patient)

Patient's Name: ..... **URN:**.....

Patient information leaflet given and explanation about adverse drug reactions and who to contact if any concerns:	Yes ☐ No ☐

Consent Form

My doctor has requested that I receive the influenza vaccine and I am happy for the nurse to give it to me. I understand why I am having it, what possible side effects there may be and who I should contact if I have any concerns.

Patient's Signature ..... Date: .....

Administration:

Product Name .....

Batch Number .....

Expiry Date .....

Dose .....

Route .....Intramuscular.....

Site .....

Date & Time Given .....

Nurse's Signature .....

Reiterate advice about adverse drug reactions and who to contact if any concerns.

Assess patient to be feeling well before leaving the house/clinic.

This should be completed and scanned into the patient's electronic nursing records

document updated December 2019

Appendix 7 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: Medicines Policy			
Date of Assessment	July 2023	Responsible Department	Governance
Name of person completing assessment	Mo de Gruchy	Job Title	Quality and Performance 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 gypsies and travellers)	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