Cambian

Policy No: 60.00

Policy and Procedure on

Administration of Medication

Purbeck View School

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1. Monitoring and Review

1.1. The Proprietor will undertake a formal review of this policy for the purpose of monitoring and of the efficiency with which the related duties have been discharged, by no later than two years from the date shown below, or earlier if significant changes to the systems and arrangements take place, or if legislation, regulatory requirements or best practice guidelines so require.

1.2. This local content of this policy and supporting documentation will be subject to continuous monitoring, refinement and audit by the Head of Service.

Signed:

Paul Kniveton
Head of School
January , 2022

2. Responsibility

2.1. Head of Service is responsible for ensuring that:

- This policy and procedure is in place and rigorously followed,
- Staff are trained appropriately and any failure to carry out their duties will be followed up through supervision and disciplinary action if necessary,
- All aspects of medication administration are rigorously followed and documentation completed,
- Notification to regulatory bodies is completed as required under their governing regulations,
- Internal notification procedures are followed including Medication Errors and Serious Incident reporting and escalation.

2.2. Where a location has a full time or part time nurses the nurse will:

- Follow all other relevant policies and procedures and keep up with date with current guidelines and policy.
- Fulfil their responsibility in line with Nurse and Midwifery Council including the NMC Code for Nurses and Midwives and maintaining their registration.

3. Terminology

'Establishment' or 'Location'	A generic term which means the Children's Home/school/college. Purbeck View School is a School and Home.
Individual	Any child or young person under the age of 18 or young adult between the ages of 18 and 25. At Purbeck View School we have children and young people attending and/or residing between the ages of 7 – 19.
Head of Service	A senior person with overall responsibility for the School and Home. At Purbeck View School this is the Head of School and the Registered Manager who are Paul Kniveton and Isabel Clark. Head of Service has overall responsibility for ensuring all aspects of this policy and procedure are followed.
Key Worker	A members of staff that have special responsibility for Individuals residing at or attending the Establishment.
Parent	A parent or person with Parental Responsibility (PR)
Regulatory Authority	Regulatory Authority is the generic term used in this policy to describe the independent regulatory body responsible for inspecting and regulating services. At Purbeck View School this is Ofsted.
Social Worker	A worker allocated to the Individual/family. If there is no allocated worker, the Duty Social Worker or Team Manager is responsible.
Placing Authority	Placing Authority means the local authority/agency responsible for placing the Individual or commissioning the service.
Medication Lead	A person who has day to day responsibility for managing and delivery of medication procedures. At Purbeck View School this is the Registered Manager.
Medication administrator	Any person who has received medication training and has been deemed competent. Medication administrator may administer, order, store, and dispose of medication.
Prescribing Practitioner	A GP, psychiatrist, nurse prescriber or consultant will prescribe medication. These may be Cambian or external professionals. Those able to prescribe medication are termed "Prescribing Practitioner" in this policy and supporting documents.

4. Policy

4.1. This policy and procedure deals with the **Administration of medication.** All aspects of competency, consent, prescribing, administration, medication errors and are explained in relevant sections.

4.2. This document sets out how safely and effectively various processes related to administration of medication MUST be carried out at Purbeck View School.

4.3. Medication should not be used to control Individual's behaviour by excessive or inappropriate use of medicines. The following NICE recommendations must be followed by all prescribers, commissioners,

managers and staff. This part must also be read in conjunction with our **046. Physical Intervention policy and procedure.**

https://www.nice.org.uk/guidance/qs51/chapter/Quality-statement-8-Interventions-for-behaviour-that-challenges

https://www.nice.org.uk/guidance/cg170/chapter/recommendations#interventions-for-behaviour-that-challenges

4.4. For the purpose of this policy, staff undergoing medication training will be referred to as a 'trainee medication administrators'. Those leading competency assessments will be referred to as 'competency assessors'.

4.1. Only those staff who have completed the training identified below are assessed as competent and will be able to administer medication. Those able to administer medication are referred to as 'medication administrators':

- Face to face medication administration training with the competency assessment at the end **[Please note that due to Covid-19 pandemic, it will be acceptable for staff to only complete their medication training via MYRUS E-Learning portal followed by a competency assessment at the end, which covers both practical and knowledge, including 4 observations. Please refer to Becoming a medication administrator – Checklist and learning record as below. All templates related to assessment are available on Cambian Point.**
- The process has been described in detail in **60.00.11 Becoming a medication administrator – checklist and learning record.** Other competency assessment related documents are listed in the **Appendix 1. Relevant policies, procedures and associated documents** and can also be downloaded directly from Cambian Point.

4.2. In addition to medication competency assessment, there may be times when Nurses and Doctors would require additional training in specific areas relating to medication such as training on clozapine, lithium therapy, role of Accountable Officers for Controlled Drugs etc. and it is the responsibility of the Head of Service to ensure that such training is facilitated to ensure staff are kept up to date.

4.3. All staff involved in medication administration must be familiar with the detail of this policy and associated documentation and know what is expected of them under the policy and procedure.

4.4. All individuals in our care must receive the appropriately prescribed medications safely and at the stated times prescribed.

4.5. Any treatment will be administered sensitively, taking the young person's wishes and feelings into account.

4.6. **It is acknowledged that some sites within Education and Specialist Residential Children Services, will be introducing a new electronic Medication Management System called ACCESS from November 2020. This is in essence an E-MAR recording system with the primary aims of improving medication safety and compliance. Staff using ACCESS will be expected to complete a series of Elearning training associated with the system. The**

site or home will have identified superusers who will undergo specific training via ACCESS group in order to enable them to implement the E-MAR effectively.

5. Pharmacy

5.1. At Purbeck View School. our pharmacy service is provided by:

Boots Uk Ltd, FC 009 Poole Boots Pharmacy

Out of hours Telephone Number: 111

5.2. Pharmacy contact details and name of Lead Person/Pharmacist:

- Nicola Avery Telephone Number: 01202 681377 Ext 560
- Dolphin Centre, Poole
- Email: pharmacy.fc009@nhs.net

5.3. If the pharmacy provide an information poster this must be clearly displayed where medication is stored.

6. Safeguarding

6.1. For any incident involving a medication error which leads to or is deemed a Child Protection or Safeguarding Concern, the Designated Safeguarding Lead will follow **025. Cambian Child Protection and Safeguarding policy and procedures.**

6.2. All staff must also read 25.15 **Guide to Child Protection and Safeguarding at Cambian,** which localised version of must be available within each service.

6.3. For any incident resulting from the administration of medication which results in a Serious Incident, the Head of Service will follow the correct reporting and **35.03 Serious Untoward Incident escalation procedure.**

7. Procedure

Competency

7.1. All medication administrators must complete training in administration of medication and must be assessed as a competent administrator before they can be involved in any medication related processes.

7.2. Competency assessors and trainee medication administrators undergoing training via **MYRUS E-Learning portal** must follow **60.00.11 Becoming a medication administrator – checklist and learning record.**, which illustrates all the stages a staff member undergoing medication training will be going through before the final assessment is completed.

7.3. The final assessment will be completed by the competency assessor: Registered Manager (RM) or people delegated by the RM e.g. Nurse, Care Manager, Home or Deputy Manager, providing all completed relevant training and are competent administrators themselves.

7.4. Following this, each medication administrator should be subject to **3 observation of practise per year** by competency assessor – see **60.00.11 - Becoming a medication administrator – checklist and learning record** for more details.

7.5. In addition to this, each medication administrators will also receive a **Knowledge - annual refresher** completed by competency assessor – see **60.00.11 - Becoming a medication administrator – checklist and learning record** for more details.

7.6. All medication administrators and assessors are expected to know medication administration procedures by being actively involved in medication administration, as a minimum - **10 administrations per year.**

7.7. Any medication administrators who for some reason (e.g. change of a role/duties/responsibilities) are NOT involved in a regular administration of medication, must complete **Annual Summary Record of 10 Administration** which can be printed from Local Drive, AnnualspaceSummaryspaceRecordspaceofspaceTenspaceAdministrations.pdf. The form must be completed in each 12 month period in order to keep their skills and knowledge updated. Once completed it must be

passed on to their line manager to check during supervision/appraisal. This is in addition to 3 observations per year and the knowledge – annual refresher.

7.8. If a staff member is not assessed as competent, then their line manager is to document this together with the actions they are going to take e.g. additional learning, additional observations, other. This must be recorded in the **Outcome** section of the **60.00.13 Medication competency assessment – knowledge (final assessment)**.

7.9. All competency assessors should complete a 3 yearly refresher to ensure their knowledge and practice is up to date.

7.10. Specific training from the pharmacy can be requested by the Registered Manager as a result of legislation change, audit, supervision etc.

7.11. Any concerns regarding a doctor's competence are to be raised with the service's Designated Safeguarding Lead and Clinical Director.

Making decisions

7.12. This section must be read in conjunction with **0.13 Consent and Mental Capacity policy and procedure.**

7.13. For children under the age of 16 a parental/carer and where appropriate - placing authority consent must be sought, signed and held in the Individuals Health file.

7.14. There is a section within the LAC Placement Plan provided when a child is admitted to the home and this is sufficient if there are unforeseen difficulties experienced with getting the form signed immediately by the social worker (i.e. for night time admissions and out of hours). This should be signed at the 72 hour review and this should then be included in the young person's Health File.

7.15. For young people over the age of 16 Cambian will follow guidance and procedures for **0.13 Consent and Mental Capacity policy and procedure** to obtain the relevant consent, this will be either the consent from the individual or a best interest decision following a best interests meeting.

7.16. Young people have the right to choose to manage their own medicines, however Head of Service must consider a young person's choice and whether there is a risk to them or others if they do so. For CAMHS Hospital, the Responsible Clinician together with other members of the multi-disciplinary team will be responsible for completing the risk assessment before decision is made.

7.17. Unless a risk assessment indicates otherwise, all individuals of the age of 16 and over who have the capacity to safely self – administer medication, will be entrusted with the retention and administration of their own medication. To support safe self – administration process Individuals will undertake self-administration preparation programme stages (0-3) and after completion, the appropriate arrangements for them to self-administer will be made. This part must be read in conjunction with **self - administration** section of this policy.

7.18. Documentation relating to consent to administration of medication (consent forms, best interest meetings templates, MCA1 and MCA2 – capacity assessment templates) will be completed during the admission process and then reviewed annually or as and when required e.g. in the case of fluctuating capacity.

Sharing information about Individual's medicines (young adults)

7.19. To support high quality care, it is important that information about medicines is shared with the Individual and their family members or carers and between health and social care practitioners. Services must have an agreed clear protocol about communication and sharing information about an Individual's medicines that take account of the person's expectations for confidentiality. This includes communication with:

- the Individual and their family members or carers
- social care practitioners
- health professionals, for example, the person's GP or supplying pharmacist
- other agencies, for example, when care is shared or the person moves between care settings.

Medicines Optimisation – Young Adults

7.20. Medicines optimisation is the safe and effective use of medicines to enable the best possible outcomes for Individuals. It also looks at the value that medicines deliver, making sure that they are both clinically and cost

effective, and that Individuals get the right choice of medicines, at the right time, with clinicians engaging them in the process.

7.21. Medicines optimisation applies to Individuals who may or may not take their medicines effectively. Shared decision-making is an essential part of evidence-based medicine, seeking to use the best available evidence to guide decisions about the care of the individual, taking into account their needs, preferences and values' (Greenhalgh et al. 2014; Sackett et al. 1996[i]).

7.22. For guidance on medicines related communication and medicines reconciliation when a person is transferred from one care setting to another, read in full the NICE guideline on Medicines Optimisation.

7.23. Where an Individual lacks capacity to make decision in relation to their medication, services must ensure that the individual and (where appropriate) their family members or carers are actively involved in discussions and decision making. Record the Individual's views and preferences to help make decisions in the Individual's best interest.

Ensuring records are accurate and up to date

7.24. Head of Service must ensure that records about medication are accurate and up-to-date by following the process set below:

- recording information in the Individual care plan,
- recording information in the Individual's medicines administration record (MAR),
- recording information from correspondence and messages about medication, such as emails, letters, text messages and transcribed phone messages,
- follow Cambian **60.01 Ordering, storage and disposal of medication procedure.**

7.25. All staff must follow the relevant legislation to ensure that appropriate records about medication are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

Identifying, reporting and reviewing medication-related problems

7.26. All services must ensure that a robust local process is in place for identifying, reporting, reviewing and learning from medication errors involving Individuals where possible. Weekly Cambian KPI's must be used for analysis and 'lessons learnt' purposes and shared with SLT/SMT and staff.

7.27. In order to evidence competence, prevent medication errors and develop the staff, Registered Managers/Medication Lead must complete **60.00.09 Monthly Medication Audit.** In addition to that **10.00.10 Full Medication Audit** must also be completed 3 times per year (April, August and December). Any actions

identified through medication audits must be shared with STL, medication administrators and staff. Actions must be completed within the timescale identified and lessons learnt discussed with everyone involved.

7.28. An annual audit should also be completed by each site to review the stock management procedures, medication documentation, administration and handling processes. This should be arranged by the Head of Service/Registered Manager and ideally completed by the pharmacy supplying medication.

7.29. Each school/college/home should consider working with all relevant stakeholders to develop an action plan, in line with other local and national strategies and governance arrangements, for improving the safety of Individuals and reducing medication errors.

7.30. All staff should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional as soon as possible, this would usually be the GP or out-of-hours service. Staff should record the details in the Individual's care plan and tell the supplying pharmacy.

7.31. There are six most common areas of risk with medicines across health and care:

- prescribing, monitoring and reviewing
- administration
- transfer of care
- reporting, learning from incidents
- supply, storage and disposal
- staff competence and workforce capacity

7.32. More information about each of the categories can be found in Medicines_in_health_and_adult_social_care_CQC report.pdf

Medication Administration Record sheet (MARs)

7.33. Purbeck View School has now come away from paper MARR charts and now utilises an e-meds online systems. All staff are trained to use this and have their own login (only applicable where ACCESS/EMARS has been implemented).

7.34. No medication prescribed individually for one individual can be given to another individual.

7.35. In majority of cases medication administration record sheet (MAR's) will be provided by the pharmacy, however Cambian MARs template can be used instead - depending on the location.

7.36. Should change/s to the MARs need to be made and pharmacy providing MARs is not available, then only medication administrator may amend/alter the MAR. If an alteration/amendment is required:

- A copy of the new prescription is to be taken,
- The copy is to be faxed to the pharmacy to check for interactions,
- Any alteration/amendments made by medication administrator are to be scanned and emailed/faxed/or handed in to a doctor/pharmacy so that the amendments/alterations can be signed off. Where original prescriptions are handed in, copies of each are made before this takes place,
- Any handwritten entries on the MARs must be written legibly using a black ink pen.
- The amendment/alteration is to be countersigned by another medication administrator (2 signatures required).

7.37. MARs (which may be supplied/completed by pharmacy) are to contain:

- Name of Individuals, date of birth and GP name,
- Medication name labelled clearly,
- Dose form e.g. tablet, capsule, liquid (if a drug is prescribed as two different forms e.g. PRN lorazepam tablet and IM, then the MARs will record these separately),
- Strength where appropriate,

- Where the dose is indicated by number of tablets, puffs or topical applications use the full wording rather than symbols. For example it should be written as 'two tablets' 'two puffs',
- Avoid the unnecessary use of decimal points e.g. 3 mg not 3.0 mg,
- Quantities of 1 gram or more should be written as 1g etc. Quantities less than 1 gram should be written a milligram's, e.g. 500 mg not 0.5g. Quantities less than 1 mg should be written as micrograms, e.g. 500 mcg not 0.5 mg,
- Frequency,
- Any additional directions,
- Photo of Individual should be included in the medication folder. Ensure the individual personal details e.g. name, date of birth, allergies and GP are recorded accurately and fully on the MARs.

7.38. Ensure Individuals personal details such as name, date on birth or allergies are recorded accurately on MARs.

Safe and effective administration process

7.39. Individual's own schedule and activities must be taken into consideration, however only with liaison with medical professional, so appropriate steps are taken to ensure individual received their medication within appropriate time.

7.40. Under no circumstances should medication be given to individual in envelope or temporary containers.

7.41. The **Registered Manager/Medication Lead** must also ensure that:

- Only medication administrators are authorised to administer medication,
- There is a current **60.00.14 Specimen signature List** and initials of those involved in the administration of medication held in the medication file to check authorisation to administer. This is to include the internal prescribing practitioner's signature where applicable. The list is to be dated to ensure it is kept current and must include signatures of agency nurses too.
- Where a medication administrator is unable to answer any question asked by an individual about their medication they should obtain advice from the pharmacist or refer to the individual information leaflets available. Advice taken is to be documented in the individual's notes.
- It is part of the core role of all staff that each individual's mental and physical condition in relation to the medication that has been administered is monitored, recorded and reported upon. If any changes are noted or any causes for concern, the staff on duty should ensure that advice from the prescribing practitioner or other medical professional is obtained and recorded.

7.42. As part of the Admission Procedures, the Head of Service should check that the individual or the person with parental responsibility has been asked if the Individual has any known allergies or sensitivities or potential adverse reactions to any medicine. This is to be recorded on the MAR.

7.43. The NMC supports the use of a thorough, open and multi-disciplinary approach to investigating adverse events, where improvements to local practice in the administration of medicinal products can be discussed, identified and disseminated.

7.44. All errors and incidents require a thorough and careful investigation at a local level, taking full account of the context and circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed. Although Cambian recognises that in

locations where there is an on-site nurse and medication is not usually administered by the nurse it advocates their input when dealing with adverse events.

Administration – 'BEFORE'

7.45. Meeko House now uses an e-meds online system to store, administer and monitor medication administration. Stadd are trained to use this system with their own login (only applicable where ACCESS/EMARS has been implementaed).

7.46. All medication administrators must take responsibility for maintaining their knowledge regarding medication and any contra-indications/ side effects that the medication is known to have.

7.47. The medication administrator MUST follow 7 rights of medication administration, commonly referred to as '7R's' :

- **Right medication**. This means that the medication that is given in the right medication. Check the label and MARs is clear and unambiguous, check if the medication hasn't already been given, and check any drug sensitivity/allergy information on the MARs.
- **Right Individual.** Giving the medication to the Individual for whom it was intended – check the MARs (is it current MAR?), check the photo of the Individual in the medication file.
- **Right dose**, also check the expiry date/ discard, opening date.
- **Right route**
- **Right time**
- **Right reason**
- **Right documentation**

Administration – 'DURING'

7.48. The medication administrator must ensure that:

- Medication is administered and taken promptly
- They observe individuals taking their medication and also check with them if they had e.g. swallowed the tablet/s/applied cream etc.
- If medication is administered more than 1 hour outside of the recorded administration time the actual time of administration is to be recorded. Patient's information leaflet can be checked for guidance.
- Where medication are not given at the right time medication administrator is to inform the senior member of staff on duty and follow the relevant **Medication error procedures.**

Administration – 'AFTER'

7.49. The medication administrator must ensure that:

- MARs is signed immediately following administration, when satisfied that medication has been taken appropriately.
- Where medication has not been taken (or has partially been taken) an appropriate coded entry must be made on the MAR (see letter coding on MAR). For locations that do not use coding an appropriate, agreed comment e.g. refused must be entered.
- Under no circumstances must the administration section be left blank.
- Where PRN medication is administered, the time of administration is to be recorded on the MAR, the time PRN medication has been offered (even if refused) should also be recorded on the MAR.
- Individuals who are on a self-medication programme the applicable code for self-administration is to be entered onto the MARs.

Off premises

7.50. When offsite, medication must be stored in a suitable lockable container and held where possible in another lockable space e.g. boot of car (taking into account the temperature) or if the Individual is to be away from the vehicle for a length of time, such as at an event, then medication administrator may carry the medication in a lockable container. The exceptions are:

- Emergency medications will be kept in medical-bags/ cool bags depending on medication. The temperature of medication stored is not to exceed 25 degrees C.
- Medication carried by the individual for self-administration; the individual must keep the medication as safe as practical whilst ensuring they can access in an emergency.

Short Trips (less than 8 hours)

7.51. Medication taken off site will be held in a secure bag (normally a 'bum bag') and medication administrator should carry this at all times. Controlled drugs must be held securely and easily accessible e.g. in an emergency bum bag.

7.52. Medication administrators are to follow the instructions with the leave medication to ensure medication is administered correctly.

7.53. If regularly prescribed medication is taken on a trip and it is to be administered whilst on the trip, the copy of the MARs is to also be taken with the medication and signed when the medication is administered. On return the original MAR is to be updated to ensure all administrations are recorded. Following that the copy of MARs is destroyed. Where emergency medication is taken out on trips e.g. as a precautionary measure and is administered, then the emergency medication administered is to be documented on the MARs as soon as practicable.

7.54. If controlled drugs are taken on a trip out, it is required that 2 staff sign it out - one of the people involved must be supporting the person on the trip out, however the controlled drug register must remain on site. On return the controlled drug registered must be completed and signed by 2 staff (including the same person who was one of the two signing it out) as soon as it is possible.

7.55. If emergency PRN has been used the medi-bag/cool bags must be replenished.

7.56. If a young person who has been assessed as able to self-administer and who regularly takes medicine with them away from the school/college/home then this must be added onto the young person's Individual Risk Assessment/Risk Management Plan in response to the agreed strategies/support for the young person and family where applicable.

7.57. Health care plan/EHCP MUST also reflect young person's needs in this area.

Overnight or Home Leave

7.58. When an individual has home leave/holiday away from the establishment any medication being sent home will be booked out and back in on their return using the **60.01.01 Leave medication form.** This form must be completed and signed by the medication administrator and the parents/carer concerned both on leaving and return to the establishment.

7.59. Any individual who has capacity and has been assessed as fully independent to travel and self-administer medication may sign instead of the parent/carer, however If a young person regularly takes medicine with them away from the home then this must be added onto the young person's Individual Risk Assessment in response to the agreed strategies/support for the young person and family where applicable.

7.60. Health care plan/EHCP MUST also reflect young person's needs in this area.

7.61. Any extra medication is to be sent to the company pharmacy for disposal. If the section of the form to document administrations is not completed by parents, where possible staff to ask parents on return to site if

all medication have been administered and document this conversation in the students medical file and on back on the MARs.

7.62. Medication returned from home visit should be checked and where advisable discrepancies discussed with the family and also reported to the Social Worker to look into.

Intramuscular Injection

7.63. For guidance on intramuscular injections please refer to the **033. Intimate and Invasive Care policy**.

Adverse reactions and side effects

7.64. Each individual should have the possible side effects explained to them at the time of prescribing and / or before the first occasion that the medicine is administered in a format appropriate to the level of functioning and understanding of the individual. Some examples of sites containing this information are:

LD Medication Guideline - University of Birmingham

https://www.birmingham.ac.uk/research/activity/ld-medication-guide/index.aspx

7.65. The Registered Manager on site is responsible for ensuring that any adverse reaction is fully documented in the individual records, the staff handover and, if necessary, as part of an incident report/accident book.

7.66. Where the adverse reaction is as a result of an error in administration of medicine, the procedure detailed in this policy for drug errors is to be followed.

7.67. Should an individual be experiencing a side effect of medication, the Medication Lead or staff are to check the MARs to ascertain whether any PRN medication has been prescribed for this. If it has then the Individual's PRN Protocol must be followed and administered as prescribed. If the side effect is causing undue distress/pain do not give any further doses until the prescribing practitioner has been contacted for advice.

7.68. If there is a serious risk to health from side effects/adverse reactions from medication then emergency services are to be contacted immediately. Staff are to follow the **59. Health Policy** for management of emergency health situations.

7.69. The staff member is to seek advice from the individuals GP or NHS 111 and follow the advice. Any advice give must be recorded.

7.70. Evident side effects are to be discussed in the individuals review/ GP appointment and a plan of managing the side effects to be discussed.

7.71. Any sign of side effects or adverse reactions are to be documented fully in the medical notes, including actions taken.

7.72. If a young person is suspected to be under the influence of alcohol or an illicit substance after returning back from leave or upon admission, staff should seek medical advice immediately before the administration of any regular prescribed medication. For the CAMHS hospital, the nurse in charge will be able to consult with the doctor for advice and the young person urine can be tested for any illicit substances. For non CAMHS site, staff should seek medical advice by dialling NHS 111 Emergency Services.

PRN medication

7.73. Medicines that are taken 'as needed' are known as "PRN" [Pro – re nata] and is usually prescribed to treat short term or intermittent medical conditions and not to be taken regularly.

7.74. Analgesics (pain killers), night time sedatives and laxatives are some common examples of medicines prescribed in this way. This can also include medication offered by the pharmacy i.e. homely remedy for

coughs or hay fever etc. The Individual should be offered the medication at the times they are experiencing the symptoms or at the times specified by the prescriber.

7.75. The reason why PRN medication has been prescribed/indicated, how it should be administered and also the intended effect must be clarified in the **60.00.08 PRN Protocol** completed and shared with the Individual and staff working with them.

7.76. The PRN protocol should be used as a tool to support good practice, providing information and highlighting the working protocol to encourage the appropriate use of PRN medication.

7.77. PRN medication is to be given as directed by Individual's PRN Protocol and is recorded on the MAR sheet.

7.78. Individualised PRN Protocol must be kept together with MARs allowing staff immediate access without delaying the process of administration.

7.79. PRN medication should be offered to Individuals at the times they are experiencing the symptoms, this can be done by telling a member of staff or by staff identifying the Individual's needs.

7.80. Individuals should be monitored for PRN medication side effects, any observations should be recorded (Monitoring form) and reported to relevant people e.g. GP/Nurse, pharmacy, RM/Principal, Family and recorded on MAR.

7.81. Consideration should be given to the Individual's capacity to refuse the medication. Staff must record on MARs when the Individual has been offered PRN medication and why. That record will then help to identify times when PRN medication has been refused and the reasons why.

7.82. The interval between dosages and the maximum dosage within a 24 hour period must be recorded on the MAR sheet.

7.83. Any changes in the 'PRN' requirements need to be discussed with the prescriber when reviewing the Individual's medication. The prescriber will authorise any change in writing which should then be documented in the Individual's notes.

7.84. If written authorisation has been given by the prescriber/pharmacy to stop the 'PRN' then it needs to be crossed out on the MAR and countersigned by another member of staff. The Individual's notes must be updated to reflect this change.

7.85. The location must contact the practice and local pharmacy to confirm that the 'PRN' medication is removed from the Individual's computer record and therefore it does not appear on next MAR or prescription.

7.86. Any remaining medication should be disposed of following the service policy and procedure.

7.87. The Individual should be monitored in case symptoms re-occur and require further review from prescriber.

7.88. All PRN medication must be kept in original packaging and stored safely according to storage requirements and policy.

7.89. All PRN medication must be administered in accordance with the service policy and procedure; any errors should be reported and **60.02.02 Medication Error Interview** form used to record details of the incident and identify actions. Cambian believes that it is important to learn from errors so that work can be improved and the likelihood of future errors reduced.

7.90. If the medication involves the administration of emergency medication e.g. Epipen then the **033. Intimate and Invasive Care policy** to be followed. [delete/amend as appropriate to your location]

7.91. Medication administrators are to look at the time medication has been given when establishing whether PRN medication can be given. For example: individual is prescribed drug a max 3 doses of a PRN medication in 24 hours. Doses are given on 21.8.11 @ 01.20hrs, 21.8.11 @ 11.00hrs, 21.8.11 @ 19.25hrs and 22.8.11 @ 00.10hrs. This would constitute a drug error as 4 doses have been given within a 24 hour period.

Confirmation of change and verbal order

7.92. The medical practitioner may in an emergency verbally inform of a change to existing medication e.g. stop a dose. **A written confirmation** via email or fax confirming agreed change must be sought first. In case written

confirmation is not going to be readily available the medication administrator should make use of the **60.01.10 Verbal Order Form** to record:

- Who took the telephone call?
- The time of the call
- The name of the person who called
- The change(s) made
- Read back the information that has been written down to reduce the chance of misunderstandings
- Spell out the name(s) of the medicine(s)
- Ask the GP to repeat the message to another member of staff
- **Request written confirmation as soon as possible by fax, letter, and email or by issue of a new prescription.**
- Fax/email the completed **Verbal Order Form** informing the GP – 'as per telephone conversation the verbal order was administered following their advice'.

7.93. The medication administrator should inform staff including Medication Lead, nurse (if applicable), and parents, individual and update paperwork.

7.94. This should not be routine practice.

7.95. An order to change the dose, time or frequency of existing medication is received. Two medication administrators can amend the MARs by scoring through the original entry and write a complete new entry on MAR, following the written confirmation from a prescriber. The copy of the written confirmation should be attached to the MARs.

7.96. It is good practice that the MARs and label match, however if a medication change occurs, temporarily the label will not match the MARs (e.g. dose, frequency, timing etc.). This is acceptable on a temporary basis, however request to the pharmacy for amended prescribed label should be made as soon as it possible. [Staff can use the company pharmacy red alert labels to indicate that the dose has changed and will be different to the original label – delete if not applicable.]

Homely Remedies

7.97. The use of homely remedies is for rapid intervention of common, uncomplicated minor physical ailments.

7.98. As part of the admission process each individual must have a **06.01.16 Parental consent form for medical and personal care** signed by parent/guardian/ placing authority detailing what that individual may receive. This is to be renewed annually. Where an Individual is 16+ and has the capacity to provide consent to administration of medication, they will be asked to do so. See section on Capacity.

7.99. The only homely remedies allowed to be given are those **60.02.05 Homely Remedies Guidance,** any other forms of medication are to be prescribed.

7.100. Individuals should be monitored for side effects, any observations recorded (Monitoring form) and reported to relevant people e.g. GP/Nurse, pharmacy, RM/Principal, Family/carers/Placing Authority.

7.101. The Head of Service must be satisfied via weekly stock check, that the homely remedies can be reconciled.

7.102. When homely remedies are used this is to be recorded on the individual's MARS and also on **60.02.06 Homely Remedies Administration record.**

Controlled Drugs (CD's)

7.103. All residential and education locations do not require the appointment of an accountable officer. CAMHS Hospital is required to have a nominated person taking on the responsibility of Control Drugs Accountable Officer (CDAO). The CDAO must also confirmed the name of individuals who can act as witnesses for the destruction of controlled drugs. The information regarding the CDAO and named witnesses should be made available to clinical staff team members and a poster displayed in the clinic room. The CDAO must ensure that the CQC is notified by completing the CDAO application which will then appear on the CQC CDAO register.

CDAO is expected to be a member of the Local Intelligence Network (LIN) group for controlled drugs and to attend the quarterly meetings on a regular basis.

7.104. The Head of Service is accountable for the safe management of the controlled drugs.

7.105. Controlled drugs must be prescribed in accordance with the British National Formulary (BNF), the Medicines Act 1968 and the Misuse of Drugs Regulations 2001.

7.106. Controlled drug prescribing must be carried out by a registered medical prescriber. They must be registered with a primary care organisation as a private controlled drugs prescriber in order to prescribe controlled drugs privately The primary care organisation will supply prescription pads (FP10PCD/ WP10PCD and a unique

private CD prescriber code.) Cambian Speciality doctors and consultant psychiatrists are required to apply for this registration.

7.107. Controlled drugs must be added to the individuals medicine administration sheet (MARs).

7.108. For Cambian doctors that are registered medical prescribers: Private prescriptions for controlled drugs must state:

- Name and address of individual.
- The address of the prescriber.
- Dose form e.g. tablet, capsule.
- The strength of the preparation where appropriate.
- Dose (please note the wording as directed is not to be used).
- Frequency.
- Total quantity or number of dose units in both words and figures.
- Signature of the prescriber.
- The date.
- It is good practice to include an individual student identifier (e.g. NHS number).
- The private prescriber's identification number for any private prescriptions.

7.109. Prescriptions for controlled drugs are valid for 28 days from the date of prescribing or valid from the "start date" specified by the prescribers.

7.110. The administration of controlled drugs should comply with Cambian policies and procedures for the administration of medication.

Controlled Drugs - schedule 2

7.111. The witness to a schedule 2 controlled drug needs to be trained, through undertaking the first and second stage of the Cambian medication Achieve modules. **The medication administrator is required to be a fully trained (Cambian Achieve level 1- 3 or face to face) and signed off as competent to administer medication.**

7.112. For administration both members of staff should be present to witness :

- The preparation of the controlled drug to be administered,
- The controlled drug being administered to the individual,
- The destruction of any surplus drug.

7.113. The medication administrator administering the controlled drug must ensure that the following information is recorded on the appropriate page of the controlled drugs record book:

- Date of administration,
- Name of individual,
- Dose form administered and if any wasted,
- The remaining stock balance (which must be checked),
- Signature of authorised person who administered the controlled drug,
- Signature of witness who witnessed administration of the controlled drug.

7.114. An accurate record of administration should be made for all controlled drugs on the individual's MAR.

7.115. Controlled drugs must not be administered if the MAR or label is unclear, illegible or ambiguous or if there is any reason for doubt.

7.116. Administration of schedule 3 and 4 part 1 controlled drug is not legally required to be entered into a controlled drugs register. They can however be recorded in the controlled drugs register if this is at the request of the registered manager /responsible manager/lead nurse or the CQC/ OFSTED/Estyn/CIW.

Controlled Drugs - stationery

7.117. Controlled drugs registers (CD Register) can be obtained from the company pharmacy. Private prescription forms may only be written on official private controlled drugs forms.

7.118. Orders and records must be made in indelible, black ink.

7.119. Should an error be made in a controlled drugs register there must be no cancellation, obliteration or alteration made in the CD register. The authorised person must:

- Make an entry either in the margin or as a footnote,
- Date the entry,
- Record the error,
- Sign the correction,
- The witness should also sign and date the correction.

7.120. Any drug error involving controlled drugs is to follow the drug error process.

7.121. Controlled drugs registers and copy of private prescriptions for controlled drugs must be retained at the location for 7 years after the date of the last entry.

Supported self - administration

[Self-administration can vary from person to person and for different medicines. Medication administrator should assess the risk for each of the individuals. They need to find out how much support an individual needs to carry on taking and looking after their own medicines – see (0-3) stages of self administration procedure.

7.122. Self-admiinistration can vary from person to person and for different medicines. Medication administrator should assess the risk for each of the individuals. They need to find out how much support an individual needs to carry on taking and looking after their own medicines-see (0-3) stages of self administration procedure.

7.123. Self-administering medicines should not be treated as 'all or nothing' situation. For example, some individuals might keep and use their own inhalers but not their other medicines. Support may include practical help such as providing a glass of water. Other support could include:

- reminder charts
- large print labels
- easy to open containers
- help measuring liquids
- using compliance aids
- devices to help with inhalers or eye drops
- colour-coded labels
- Support may also be providing the person with suitable information about their medicine. This includes explaining how to take it and any potential side effects.

7.124. In residential settings, the risk of someone else accidentally (or intentionally) taking medicines intended for another person is greater. A robust system of risk assessment is essential. The assessment must explore whether the person:

- Wants to take responsibility for looking after and taking medicines,
- Knows the medicines they take, what they are for, how and when to take them and what is likely to happen if they omit taking them,
- Understands how important it is not to leave the medicines lying around where someone else may unintentionally take them and be harmed as a result.

Independent self – administration and Preparation Programme

7.125. In line with the aim to become independent the individual will be assessed, consulted and supported in order that they may be able to self-administer medicines.

7.126. Individuals are to receive only the medication **prescribed** for them and do not receive any medication prescribed for any other person.

7.127. Each individual should have a medication administration record (MAR) which clearly identifies each medication that has been prescribed for use for that individual.

7.128. When an individual is self- administering the relevant code is to be entered onto the MAR. For those individual on stage 1 the medication administrator is signing to confirm that the individual has self-medicated and has also been observed to take/use their medication. If an individual on any stage of self-medication goes on leave then also relevant code is to be entered onto the MAR.

7.129. All self-administration packs for stages 2-3 kept by the individual are to be kept in the individual's room in a locked cupboard (e.g. bedside cabinet). The exception to this, in accordance with an individual's risk assessment is inhalers and creams.

7.130. All individuals self –medicating are to be given a self-medication ticklist to complete to aid self-medication.

7.131. Any individual, who discloses that they have been prescribed medication by the external professional and who is planning to commence self-medication whilst remaining in care of Cambian should complete self-administration preparation programme stages (0-3) successfully. Until this process is completed, medication should be stored and administered by medication administrator.

7.132. Any individual who self-administer and has access to their own medication should be assessed for risk of self-harm e.g. suicidal ideation via overdose. When any risk factors are indicated, this should be recorded in the Individual Risk Assessment/Risk Management Plan and access to medication reconsidered, including medication removal if appropriate. This should be undertaken in line with the Head of Service/ RM, Responsible clinician and re - assessed by earliest point.

7.133. Any individual who self – administer medication is placed on 15 minute monitoring for safety should be assessed around safety of continuing self –administration and their access to medication should also be considered. The outcome of such assessment will determine whether medications should be removed from the individual. Once the 15 minute monitoring is removed, a further risk reassessment to reinstate self-medication should be completed.

The Stages of self - administration

Stage 0 – Education and preparation

The individual has either requested/incited to start self-medication or the MDT feel they are potentially suitable for self-medication

Medication administrator/nurse will spend time with the individual explaining what each of the medication is for, potential side effects and why medication is to be taken at the correct time and at the correct dosage, in order that the individual has a full understanding of their medicines. A medicine reminder chart will be issued to the individual
↓
A **Self-medication Risk Assessment** is to be completed by either medication administrator/nurse or doctor and the outcome discussed at MDT
↓
Where the risks have been assessed and it is deemed that the individual poses minimal risk of endangering themselves or others, the individual will progress to Stage 1.

Stage 1– The Individual comes to room where medications are stored

This stage is for a four week period

The individual will come to the clinic/medical room/storage at agreed times without prompts and request their medication
↓
The individual will be asked to identify their medication
↓
They will be asked to dispense the appropriate dosage from its packaging and take it appropriately
The **Self-Medication Record** is to be completed and the code "o" entered onto the medicine card/MARs.
↓
Should the individual refuse their medication or are unable to complete the steps of Stage 1, then the self-medication programme is to be discussed with Medication Lead / nurse/ Doctor involved at the earliest opportunity. For the doctor this can be by phone, for a nurse this will occur on next on shift
↓
Once the individual has successfully completed Stage 1, they can progress to Stage 2

Stage 2– Medication is given for a 3 and 4 day period

This stage is for a four week period

The individual will come to the medical room/storage on a Monday and Thursday morning without prompt and request their medication
The individual is given their medication for the 3 and 4 day period
↓
The staff are to enter SA onto the Mars to indicate the individual is self-medicating for that 3, 4 day period of time and the appropriate section of the **Self-Medication Record** is to be completed.
↓
Under no circumstances should medication be given to individuals in envelopes or temporary containers. The pharmacy MUST provide appropriate and fully labelled containers.
↓
The individual will be expected to take the container to their room and place it in a locked drawer or medication safe
↓
Staff are to carry out one random check each day during the 3 and 4 day period to check medication compliance. The appropriate section of the **Self-medication Record** is to be completed and an entry made in the individual's medical notes.
↓
Should the individual refuse their medication or are unable to complete the steps of Stage 2, then the self-medication programme is to be discussed with Medication Lead / nurse/Doctor at the earliest opportunity. For the doctor this can be by phone, for a nurse this will occur on next on shift
↓

Once the individual has successfully completed Stage 2, they can progress to Stage 3

Stage 3– Medication is given for a 7 day period

This stage is for a four week period

The individual will come to the medical room once a week in the morning without prompt and request their medication.

↓

The individual is given their medication for the 7 day period

↓

Under no circumstances should medication be given to individuals in envelopes or temporary containers. The pharmacy will provide appropriate and fully labelled containers.

↓

The nurse/ authorised person is to enter code SA onto the MARs to indicate the individual is self-medicating for that 7 day period of time, and the appropriate section of the **Self-medication Record** is to be completed.

↓

The individual will be expected to take the container to their room and place it in a locked drawer or medication safe

↓

Staff are to carry two random checks during the 7 day period to check medication compliance. The appropriate section of the **Self-medication Record** is to be completed and an entry made in the individuals medical notes.

↓

Should the individual refuse their medication or are unable to complete the steps of Stage 1, then the self-medication programme is to be discussed with Medication Lead / nurse/Doctor at the earliest opportunity. For the doctor this can be by phone, for a nurse this will occur on next on shift

↓

Once the individual has successfully completed Stage 3 the self-medication programme has been completed. The individual will now self-medicate.

↓

Random checks during the 28 day period will be conducted by the staff in order to ensure medication compliance. This is to be documented in the individual's medical records. Should the individual refuse to take their medication or is unable to take medication as prescribed at any time, then this is to be discussed with the Medication Lead at the earliest opportunity.

Refusals

7.134. If a young person who has the capacity to understand the potential consequences of risk around not taking prescribed medication refuses medicine, spits it out, or it is omitted for any reason, this must be recorded on

the MAR and GP/111 or pharmacy issuing medicine contacted for advice. This pertains to any medication that is self-administered as well.

7.135. Parents/carers/Placing authority should also be made aware of refusal and what steps have been taken. All discussions with GP, pharmacy and parents/carers/Placing Authority recorded.

7.136. Good practice recommends a key working session should also support this situation especially if a young person has a profile of refusing medication.

Covert Administration

7.137. In Cambian covert administration of medication will **ONLY** takes place in accordance with the requirements of the Mental Capacity Act 2005 and good practice frameworks (Mental Capacity Act 2005: Code of Practice) to protect both the person and support workers.

7.138. Covert administration of medication will only be done in exceptional circumstances and only where there is no other alternative. This type of administration should only to be used for an individual who lacks capacity. Under no circumstances should this form of medication administration be used unless the procedure listed below has been completed and a lack of capacity for this situation has been proved, documented, and that covert administration is in the individual's best interests. Please refer to **013. Consent and Mental Capacity Policy.**

7.139. The NMC statement on the Covert Administration of Medicines 2007 states that 'the NMC recognises that there may be certain exceptional circumstances in which covert administration may be considered to prevent an individual from missing out on essential treatment'.

7.140. In such circumstances and in the absence of informed consent, the following considerations must apply:

- The best interests of the individual must be considered at all times.
- The medication must be considered essential for the individual's health and well-being, or for the safety of others.
- The decision to administer a medication covertly should not be considered routine, and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the individual. It should be individual specific, in order to avoid the ritualised administration of medication in this way. A **60.00.07 Covert medication protocol** must be completed and signed by medical practitioner before administration takes place.
- The method of administration of the medicines should be agreed with the pharmacist and this includes the type of food or/and drink that can be used in the process of administration.
- There should be broad and open discussion among the MDT and the supporters of the individual, and agreement that this approach is required in the circumstances. Those involved should include carers, relatives, advocates, the care co-ordinator and the multidisciplinary team (pharmacist is to be consulted). Family involvement in the care process should be positively encouraged and is obligatory for those under 16. The decision and the action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals.

7.141. All medication administrators involved should be fully aware of the purpose and implications of such treatment, and should have the opportunity to contribute to the multidisciplinary discussion.

7.142. A medication administrator may refuse to administer medication covertly. In such circumstances this issue is to be raised with their line manager without delay.

7.143. In the case of an incapable individual, covert means should never be used to administer medication to him/her unless both the medication and the means are lawful within the MCA.

7.144. The multidisciplinary team must first make every effort to obtain the persons consent (which is to be clearly recorded in the individuals file), and to administer medicines openly; such efforts must continue. The individual's known wishes, values, religious belief and views must be taken into consideration. The purpose and intention of covert medication must be recorded. Any decision to administer covert medication must only be made after full discussion with the MDT and a comprehensive record made of the decision, (please see

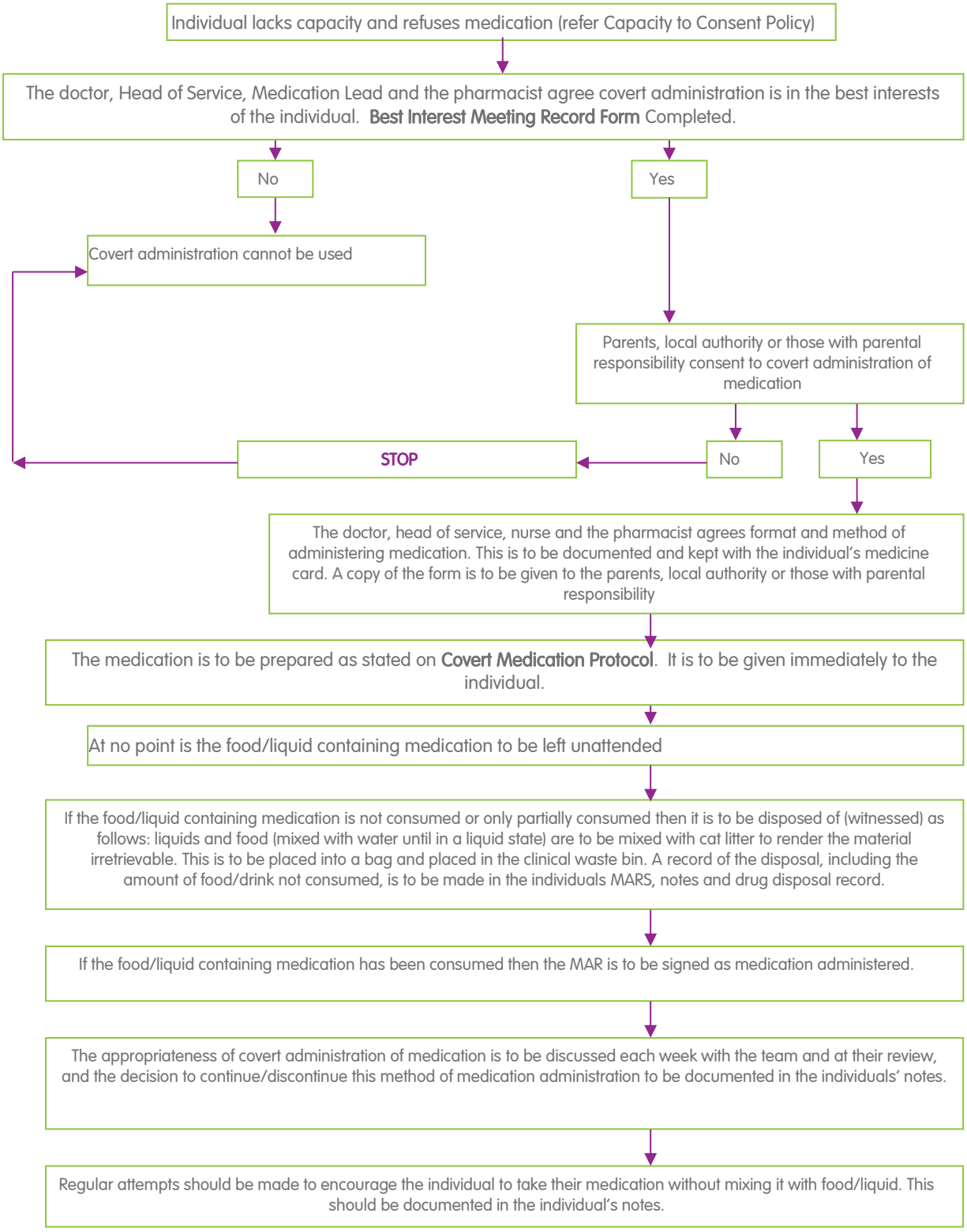
flowchart). It is important to remember that capacity may fluctuate, sometimes over short periods of time, and for this reason must be reviewed weekly at a review meeting.

7.145. Medication must be administered by the least restrictive means.

7.146. To attempt the best medication consumption, medication should be mixed with the smallest amount of food/drink possible, e.g. a spoon of yoghurt or other agreed type of food/drink agreed by medical practitioner.

7.147. Regular attempts should be made to encourage the individual to take their medication. This is best achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

Flow chart for Covert Medication Decision Making



Unlicensed and 'off – label' medicines

7.148. There might be clinical situations when the use of unlicensed medicines or use of medicines outside the terms of the license (e.g. 'off-label') may be judged by the prescriber to be in the best interest of the individual on the basis of available evidence, e.g. when the treatment of an individual requires a drug which has a marketing authorisation but for a condition, at a dose, via a route or for an age that is not listed in the summary of product characteristics for that drug (off-label use).

7.149. The General Medical Council - Good practice in prescribing medicines - guidance for doctors September 2008 states: *'You may prescribe medicines for purposes for which they are not licensed. Although there are a number of circumstances in which this may arise, it is likely to occur most frequently in prescribing for children. Currently pharmaceutical companies do not usually test their medicines on children and as a consequence, cannot apply to license their medicines for use in the treatment of children. The use of medicines that have been licensed for adults, but not for children, is often necessary in paediatric practice'.*

7.150. It is Cambian policy to follow strictest evidenced based best practice in prescribing medication. Cambian follows guidance outlined by the GMC as well as the Maudsley guidelines. Cambian will always ensure the

prescribing is in keeping with the law as well as guidance outlined by regulatory bodies and evidenced based practice.

7.151. In a school a GP, psychiatrist or consultant physician will prescribe medication. These may be external professionals from the education location. Those able to prescribe medication are termed 'prescribing practitioner' in this policy.

7.152. The term 'school' is used in this policy to refer to school/college locations.

7.153. It is the prescribing practitioners' responsibility to provide information to individuals on the nature and associated risk of any treatment, including off-label medicines.

7.154. It is at the prescribing practitioner's discretion to utilise a medication off-label.

7.155. The prescribing practitioner must:

- Be satisfied that it would better serve the individual's needs than an appropriately licensed alternative.
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy.
- Take responsibility for prescribing the medicine and for overseeing the individuals care, monitoring and any follow up treatment, or arrange for another doctor to do so.

7.156. A discussion regarding the use of off label medication including the potential benefits and side effects is to take place prior to prescribing (unless in emergency circumstances) with the multi- disciplinary team, individual, parent/ person with parental responsibility/advocate (if applicable) .

7.157. The discussion with the individual, parent/person with parental responsibility/advocate (if applicable) is to be recorded in the individual's notes.

7.158. A record of the off label medication is to be recorded in the individuals notes including the reasons for prescribing the medicine.

7.159. For medication above BNF limits please refer to the BNF for guidance.

Medication Errors and Near Misses

7.160. Refer to separate **Medication Errors procedure**.

7.161. A Medication Error occurs when an individual does not receive their medication exactly as it has been prescribed to them such as:

- Wrong person
- Wrong medication
- Wrong date/time
- Wrong/missed dose or quantity
- Wrong strength of medication
- Administered after medication no longer prescribed
- Wrong storage e.g. incorrect temperature
- Administration of out of date medication
- Clerical errors e.g. not signing MAR sheet after administration
- Improper administration techniques/wrong route
- Medication spoiled

7.162. The medication error may or may not cause potential or actual harm to an individual.

7.163. A Near Miss is defined as an incident which could have led to harm but did not, and are subsequently regarded as potential errors that are spotted before reaching the individual and have caused no harm.

7.164. All medication errors and near misses must be recorded and reported as soon as they are identified. The Head of Service, Medication Lead must be made aware immediately and they will oversee the investigating and reporting including any notifications to the Regulators and to Cambian senior directorate.

7.165. In line with all regulatory requirements, our Regulators [enter Ofsted/Estyn/CQC/CIW etc.] will be informed of any drug error that has occurred due to misconduct and that has resulted in actual or potential harm.

Archiving

7.166. The current and previous month's MAR and the current sample signature lists are to be kept in the medical room/storage. Any records, sheets or lists older than this are to be archived. MAR's must be retained for a period of 20 years following either the death or discharge of an individual

Appendix 1: Policy documents, procedures and associated documents

60.00.00a - Administration of medication – Children's Homes Guidance (Children's Residential Care Division)

Policy documents

60.00.01 - Prescribed Medication Administration Record Sheet

60.00.02 - Non- Prescribed Medication Administration Record Sheet

60.00.03 - Controlled Drugs Medication Administration Record sheet

60.00.04 - Homely Remedies Guidance

60.00.05 - Homely Remedies Administrated Record

60.00.06 - Self Medication Record

60.00.07 - Covert Medication Protocol

60.00.08 - PRN Protocol

60.00.09 - Monthly medication audit

60.00.10 - Full medication audit

60.00.11 - Becoming a medication administrator – checklist and learning record

60.00.12 - Medication competency assessment – practical (stage 3)

60.00.13 - Medication competency assessment – (final assessment) held with the competency assessor after 4th observed administration in stage 3)

60.00.14 - Specimen signature list

Procedures

60.01.00 - Ordering, Storage and Disposal of Medication procedure

60.01.00a - PROCEDURE – Prescribed Medication Administration Record Sheet

60.02.00 - Medication Error procedure

60.03.00 - Transcribing – Locations with a nurse ONLY

Other relevant policies and procedures

0.25. Child Protection & Safeguarding policy and Procedure

0.33. Intimate and Invasive Care policy and procedure

0.35. Serious Incidents escalation Process and Threshold

0.13. Mental Capacity and Consent policy and procedure

0.50. Deprivation of Liberty policy and procedure

Appendix 2: References for further guidance

- General Medical Council - Good practice in prescribing and managing medicines and devices (2013)
- Handling of Medicines in Social Care
- The Human Medicines Regulation 2012
- The Mental Capacity Act 2005 and MCA Code of Practice
- The Health and Social Care Act 2008, Regulations 2014, reg. 13 (7).
- The Health Act 2006
- The Children's Homes Regulations 2015
- Quality Standards 2015 Social Care
- Guidelines from the Royal Pharmaceutical Society of Great Britain
- Nursing and Midwifery Council (NMC) Standards for Medicine Management
- NICE Guidelines on Management of Medicines in Care homes 2014 as amended 2018
- The Misuse of Drugs Regulations Act 2001
- Hyperlink to legislation that may be relevant to health and social care:
- https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers-relevant
- Medicines in Health and social care - Learning from risks and sharing good practice for better outcomes CQC report
- Handling medicines in social care-guidance
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes