Southlands School

Policy name: Medication Management



Policy Author	Laura Dickie, Head of Policy
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Policy Approver	Jo Dunn, Compliance, Regulation and Quality Director
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Version No.	002
Policy Level	Homes, Supported Accommodation and Education
Staff groups affected	All Homes, Supported Accommodation and Education Staff

Policy - Medication Management Children Universal

Monitoring and Review

This policy will be monitored on an ongoing basis through the organisation's governance and quality assurance systems. Responsibility for ensuring that the policy remains compliant with legislation and regulatory frameworks sits with the Regional Manager and Divisional Director**.** A formal review of this policy will be undertaken no later than two years from the date of approval**,** or sooner if changes in legislation, regulatory guidance, or operational requirements necessitate it.

The Head of Policy will support this process by identifying relevant changes in legislation, regulation, national standards and emerging best practice. The Head of Policy will also incorporate learning from inspections, audits and practice developments into future revisions whilst overseeing all proposed amendments to this policy to ensure accuracy, consistency and compliance.

This policy must not be altered at a local or service level within homes and supported accommodation services. Services may develop local procedures to support implementation, where these align with this policy and do not alter its intent.

Site Lead approver	**Alison Priddle** ***Alison.Priddle@Cambiangroup.com*** **Jack Murphy** **Jack.Murphy2@cambiangroup.com**
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Version Number	**001**





Alison Priddle
Principal / Responsible Individual

Jack Murphy
Head of Care/Registered Manager

Term	Definition
Children	Under 18's we support
Learners	Any learner/learner
Adults we support	Over 18's we support
Staff	Employees, contractors
Volunteers	Volunteers/work experiences
External professionals	Social workers, medical professionals, advocates, therapists, teachers etc
Stakeholders	Parents, families, neighbours etc
Internal partner services	HR, L&D, CQR, Finance etc
Regulator(s)	OFSTED, CIW, CIS, Estyn, ES
Divisional Director	MDs/Directors
Regional Manager	Refers to the senior leader with regional or multi service oversight - including roles such as Regional Manager, Responsible Individual (RI), Nominated Individual (NI), Service Directors, or Exec Lead etc. ** The job title varies across the business ** Where statutory/regulatory duties apply to a specific role, these duties remain unchanged and must be fulfilled by the appropriate role in line with legislation and regulation.
Service Manager	Refers to the senior operational leader responsible for the day-to-day running of a service, including roles such as Home Manager, Registered Manager, Head Teacher, Principal, or Exec Head depending on service type and regulatory context. ** The job title varies across the business ** Where statutory or regulatory duties apply to a specific role, these duties remain unchanged and must be fulfilled by the appropriate role in line with legislation and regulation.

Service	Home/supported accommodation/school/college/fostering
Organisation	Children's services brands that are part of the CareTech organisation
Group	Children's services
Division	Directors portfolio
Region	Regionals portfolio

Glossary – Use of Terms

The organisation uses standard umbrella terms across its policies to support consistency and clarity across different service types, structures and nations.

These terms describe levels of responsibility, not job titles, and are intended to help staff understand accountability without requiring policies to list every role used across the organisation.

Where a policy applies to a specific nation, regulated service or statutory framework, any statutory roles and legal duties named within that policy take precedence over glossary terms and must be fulfilled by the appropriately appointed individual in line with legislation and regulation.

1. Purpose & Scope

This Medication Management Policy sets out the organisational standards for safe, ethical, person-centred and trauma-responsive medicines management across every service, including children's homes, day schools, colleges and residential schools operating in England, Wales and Scotland. It applies equally to children and adults, ensuring continuity of safety and legal compliance across all age groups and placement types.

The policy provides a unified organisational framework and must be read in conjunction with Appendices A–H, which provide detailed operational procedures on:

- Homely remedies
- Transcribing
- Storage and disposal
- Controlled drugs
- Covert medication
- "As required" medicines
- Training and competence
- Incident management

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2. Trauma Responsive & Ethical Principles

Medication administration involves inherent power imbalance, particularly in settings caring for children and adults with histories of trauma, adversity or distress. It is essential that trauma-responsive, rights-based practice informs every interaction.

Therefore, every service must ensure that:

2.1 Promote Psychological Safety

- Staff (employees, contractors) use predictable routines, avoid surprise interventions, and explain medicines clearly before each administration.
- Children and adults are offered choice wherever possible (timing, seating, water, explanation).
- Staff (employees, contractors) acknowledge feelings, fear or uncertainty and avoid rushed or authoritative communication.

2.2 Protect Dignity & Privacy

- Medicines must be administered discreetly, in a calm, safe setting, respecting bodily and emotional privacy.
- No administration should occur publicly unless in an emergency.

2.3 Support Autonomy and Capacity Development

- Encourage self-management where safely assessed, in line with national school healthcare guidance in each nation.
- Children and adults should be supported to understand their healthcare, ask questions, and meaningfully participate in decisions.

2.4 Ethical Use of Medicines

- Medicines must never be used as punishment, for staff convenience, or as a behavioural control tool.
- Non-pharmacological alternatives (comfort, sensory regulation, de-escalation, hydration, quiet space) must always be considered first.

2.5 Rights-Based Consent

- Children and adults must be supported to understand their medicines, the purpose and benefits, and their right to refuse, unless overridden lawfully under capacity legislation.

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3. Governance & Responsibilities

3.1 Board / Executive

- Ensure organisation-wide compliance with nation-specific regulatory frameworks.
- Allocate adequate resources for training, pharmacy involvement, audit systems and medicines equipment.
- Review annual governance reports and trends.

3.2 Service Managers

- Ensure daily compliance with this policy.
- Appoint a competent Designated Medicines Lead who has line management responsibility and reports to Senior Leadership Team members.
- Be responsible for overall medication compliance within the service and reporting of medication errors against Key Performance Indicators.
- Ensure all staff are trained in accordance with relevant nation-specific standards.

- Ensure data accuracy, secure storage and complete incident reporting.
- Ensure school and college compliance with national healthcare needs guidance.

3.3 Designated Medicines Lead (per service service)

- Oversee medicines administration record accuracy, reconciliation, storage temperatures, expiry checks, controlled drugs register accuracy, cyclical audits, and staff competency evidence, including signed-off assessment records stored securely (paper or electronic) with access for the Senior Leadership Team.
- Act as liaison with pharmacists to ensure compliance with national expectations.

3.4 Pharmacist Involvement

Pharmacists must be involved in:

- Reviewing the homely remedies list, ensuring safety and avoiding interactions.
- Providing advice on formulation changes (crushing, liquid alternatives, enteral tubes).
- Supporting reconciliation of complex regimens.
- Supporting incident review and learning where a Service Level Agreement is in place.

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4. Safe Medicines System

4.1 Prescribing & Directions

- Only accept clear, written prescriptions — no “as directed” instructions.
- Follow clinician prescribing directions as set out in the agreed individualised care plan.
- Verbal orders should be accepted only in emergencies, with immediate written follow-up.
- **Prescribers –** Psychiatrist employed within specialist Mental Health Residentials Services are the only clinicians who are recognised as being competent to prescribe medications. External to the organisation, children and young people may be prescribed medications by their GP or hospital clinician as appropriate.
- **Unlicenced Medication** – Unlicenced medication may be prescribed in circumstances when following the prescriber`s assessment, it is deemed appropriate to prescribe such medication in order to meet the specific medical needs of the person. Best practice guidance issued by the professional registering body, such as GMC should to be followed.

4.2 Medicines Reconciliation

- Required on admission, following leave, post-hospital discharge, and after any medication change.
- Compare medicines administration records, pharmacy labels and discharge summaries.

4.3 Medicines Administration Record Documentation

- Administer medicines and immediately record the outcome (for example administered or refused).
- Never pre-record or alter entries except by correct cross-referencing.
- Record refusals, omissions and reasons.

4.4 Transcribing (See Appendix B)

- To be avoided and used only as a last resort.
- If unavoidable, strict controls in Appendix B must be followed (two-person process, audit trail, original source attached).
- Controlled drugs must never be transcribed by one person. Transcribing must be undertaken by two people, checked twice, and verified by the Registered Manager, with accurate recording in the controlled drugs register.

4.5 “As Required” Medicines (See Appendix F)

- Require individual protocols detailing symptoms, alternatives, dose, monitoring, expected effect and escalation.

4.6 Homely Remedies (See Appendix A)

- Administered only from the approved service list and in line with Appendix A procedures, with pharmacist review.

4.7 Controlled Drugs

- Must be managed in line with the Misuse of Drugs Regulations 2001 and local requirements.
- Require controlled drugs cabinet storage, bound registers, witness procedures, denatured disposal for hospital settings, or robust procedures for non-nurse-led services, and clear escalation of discrepancies.
- Controlled drugs incidents may require escalation or police reporting.
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4.8 Covert Administration (See Appendix E)

- Only lawful where the individual lacks capacity, refusal places them at risk, and a full best-interests meeting is held with pharmacist guidance and prescriber authorisation.
- Scottish services must follow Mental Welfare Commission covert medication pathways.

4.9 Storage, Security & Disposal (See Appendix C)

- Locked cupboards, separation of internal and external medicines, rigorous key control, and temperature monitoring (2–8°C fridge, 15–25°C room).

4.10 Self-Administration

- Permitted following structured risk assessment.
- Must support independence, confidence and safety.
- Aligned with national guidance on promoting self-care in education and residential settings.

5. Consent, Capacity & Rights

5.1 Under 16s

- Assess Gillick competence — the child must demonstrate understanding of purpose, risks and alternatives.
- Parental, social worker or legal guardian consent must be obtained and evidenced where the child is unable to give consent themselves.

5.2 Ages 16–17 (England and Wales)

- Governed by the Mental Capacity Act 2005; capacity is presumed unless proven otherwise.
- Where capacity is lacking, best-interests decision-making must be undertaken.

5.3 Scotland

- Governed by the Age of Legal Capacity (Scotland) Act; where capacity is lacking, the Adults with Incapacity (Scotland) Act 2000 applies.

5.4 Best-Interests Decision-Making

- Consider emotional wellbeing, trauma history and least-restrictive alternatives.
- Document rationale thoroughly.
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5.5 Refusal of Medication

- Explore distress triggers, avoid coercion and provide explanation.
- Respect competent refusal unless serious harm is likely and legal frameworks permit intervention.
- Document and report to the prescriber.

6. Education Settings

Medication management within education-based services (schools and colleges) must comply fully with statutory guidance, regulatory requirements and best practice expectations in each nation.

Each service must clearly demonstrate compliance during inspection and ensure that systems are safe, consistent and centred around the needs of children and adults.

The organisation adopts the following nation-specific standards:

6.1 England

In England, all school and college-based services must follow the Department for Education statutory guidance *Supporting Learners with Medical Conditions*. This guidance places legal duties on governing bodies and proprietors to ensure that learners with ongoing or short-term medical needs receive safe and effective support.

It requires services to:

A. Publish a Medication Policy

Services must have a publicly available medication policy describing how medicines are managed, stored, administered, recorded and reviewed. This policy must be easily accessible to parents, carers, learners and professionals.

B. Develop Individual Healthcare Plans for learner with Health Needs

Individual Healthcare Plans must be co-produced with parents and carers, learners, healthcare professionals and education staff. Plans must include:

- emergency responses
- medicines required
- administration instructions
- triggers and risks
- how medicines are stored and accessed

Individual Healthcare Plan creation and review are mandatory under Department for Education guidance.

C. Ensure Suitable and Sufficient Staff Training

Department for Education guidance requires services to ensure that enough staff are appropriately trained and competent to administer medication safely. Training must be specific to the needs of learners — for example asthma, anaphylaxis, epilepsy, diabetes or complex gastrointestinal conditions.

Staff must feel fully confident and be assessed as competent by appropriate staff before supporting medical needs.

D. Plan for Emergency Medication Access and Response

Services must have robust systems for emergency medicines such as inhalers, adrenaline auto-injectors, seizure rescue medication and emergency pain relief.

Staff must know precisely:

- where emergency medicines are kept
- who can access them
- how to respond in an emergency
- backup arrangements on trips or off-service visits

Inspection frameworks require schools to evidence this planning.

England-based services must therefore demonstrate clear implementation of this policy, fully integrated Individual Healthcare Plans, trained staff and evidence of annual review in preparation for inspection.

6.2 Wales

All Welsh education-based services must comply with the Welsh Government statutory guidance *Supporting Learners with Healthcare Needs (2017)*. This guidance places duties on governing bodies to ensure learners have safe and equitable access to education regardless of their medical needs.

The guidance requires:

A. A Local Healthcare Needs Policy

Each service must publish and regularly update a healthcare needs policy detailing medicines governance, staffing, Individual Healthcare Plans, processes, communication expectations and emergency response procedures.

B. Development and Maintenance of Individual Healthcare Plans

Individual Healthcare Plans must be created for all learners who require medicines or have health needs. These must include detailed administration instructions, monitoring requirements, emergency actions and cross-agency responsibilities, including collaboration with specialist nurses and health boards.

C. Secure Storage and Safe Administration Systems

Medication must be stored securely, often in locked cupboards or refrigerators, separate from general service items, with rigorous temperature checks.

Administration must follow safe recording practices and adhere to policy, including double-checking where required. These expectations mirror the requirements set out in the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 for care settings.

D. Robust Planning for Trips, Off-Service Learning and Activities

Welsh guidance explicitly requires services to plan medication management for educational visits, residential trips, sporting activities and alternative provision. This includes risk assessments, staff training, secure transport of medicines and emergency response planning.

6.3 Scotland

School-based services in Scotland must follow the statutory guidance *Supporting Children and Young People with Healthcare Needs in Schools (2017)*. This guidance requires a strong National Health Service–education partnership and clear systems to support learner's health.

A. National Health Service – Education Partnership

Education authorities and health boards must work collaboratively to ensure medication training, care planning and healthcare support are available. The guidance explicitly requires shared responsibility, information sharing and joint planning for complex needs.

B. Individual Care Plans / Individual Healthcare Plans

Care plans must be created for all learners with health needs. These must detail medication dosage, routes, emergency procedures, storage and staff responsibilities.

A multi-agency planning approach is expected in Scotland, especially for chronic or high-risk conditions, including shared care agreements between medical teams.

C. Training of School Staff

Training must be adequate, robust, up to date and specific to the needs of learners. Staff must understand their responsibilities, have confidence in administering medicines safely, be assessed as competent and be able to identify when to escalate for health support.

6.4 Inspection Expectations Across All Nations

Inspectors in England (Ofsted), Wales (Estyn and Care Inspectorate Wales) and Scotland (Education Scotland and Care Inspectorate) expect each education-based service to:

- evidence fully implemented Individual Healthcare Plans
- demonstrate staff competence
- have clear medication storage, administration, waste and recording systems
- show strong safeguarding links
- evidence emergency planning
- maintain clear policy documentation
- provide accessible and inclusive support to all children and adults

Failure to demonstrate these systems is a common cause of regulatory action.

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7. Staff Training & Competence

High-quality medication practice depends on staff who are trained, competent, confident and supported. Training must align with national competency frameworks.

Competence is not assumed by training alone. Staff must also be observed and assessed regularly by staff who are trained and assessed as competent to assess others.

This policy does not include all methods of medication administration, for example intramuscular, intravenous, subcutaneous or enteral routes.

The organisation uses a three-tier training framework.

7.1 Level 1 — Awareness Training

(Level required for all staff, including teachers, support workers and residential staff.)

Awareness training is a mandatory e-learning course for all staff. This ensures every staff member can participate in trauma-responsive medication culture and understand their safeguarding responsibilities.

A. Medication Practice
Staff learn how trauma may influence children's and adults' responses to medication, including fear, avoidance, dissociation, compliance under stress or refusal. They are taught strategies to reduce anxiety, provide predictability and communicate therapeutically.

B. Legal Frameworks Across Three Nations
Staff gain awareness of:

- Gillick competence (for under 16s)
- Mental Capacity Act 2005 (England and Wales)
- Adults with Incapacity (Scotland) Act 2000
- Department for Education, Welsh Government and Scottish Government school healthcare requirements

C. Medicines Safety Basics
Covers medicines administration record reading, safe handling, refusal pathways and emergency escalation.

7.2 Level 2 — Medicines Administration

Required for any staff who administer medication.

Training includes:

- medicines administration record accuracy and documentation standards
- safe storage, disposal and reconciliation
- knowledge of date-of-opening processes
- recognising discrepancies between electronic medicines administration records and supplied medication
- ordering medication
- use of electronic medicines administration record systems
- managing interim medications
- stock control
- administration of oral, topical and inhaled medicines
- managing "as required" medications safely
- implementing homely remedies protocols
- understanding and responding to side effects
- annual observed practice during live medication rounds

Level 2 staff must demonstrate competence before working unsupervised.

7.3 Level 3 — Advanced / Specialist Medicines Administration

Required for staff administering high-risk or complex medicines, including:

- controlled drugs
- seizure rescue medication such as buccal midazolam
- insulin administration and blood glucose monitoring (in line with the *Diabetes Management Policy*)
- enteral tube medication (percutaneous endoscopic gastrostomy / nasogastric), administered with robust clinical oversight from National Health Service clinicians
- high-risk “as required” medication

Competency includes:

- competency-based assessment
- annual refresher
- post-incident reassessment where required
- compliance with applicable national frameworks, professional standards and medicines optimisation guidance across England, Wales and Scotland

Full requirements are set out in Appendix G.

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8. Incidents, Near Misses & Organisational Learning

Medication errors can have serious consequences. National learning from regulators emphasises the importance of transparent reporting, timely action and organisational learning.

The organisation’s approach is rooted in a no-blame, restorative learning culture unless wilful misconduct or gross negligence is evident.

8.1 Immediate Actions

When an error, near miss or concern is identified:

1. Ensure the safety of the children and adults
    - clinical assessment

    - contact prescriber, National Health Service 111, or emergency services if needed
2. Correct the medicines administration record if the error is not a stock issue
    - do not overwrite
    - cross through errors with a single line
    - clearly document the correction and rationale
3. Inform parents, guardians or the placing local authority where appropriate

8.2 Safeguarding / Child Protection Considerations

Medication errors and near misses are not automatically safeguarding concerns. However, some medication incidents do meet safeguarding or child protection thresholds and must be managed under safeguarding/child protection procedures in addition to health and safety and regulatory reporting processes.

A medication incident must be considered a safeguarding concern where it involves:

- actual or potential significant harm to a child
- failure to administer essential medication, or administration of incorrect medication or dosage
- neglect, unsafe practice, or failure to follow agreed procedures
- repeated or patterned medication errors, including where previous learning has not been implemented
- deliberate acts, concealment, falsification of records, or wilful disregard of risk
- failure to seek appropriate medical advice following an identified error

Where safeguarding thresholds may be met:

- the concern must be **escalated immediately** to the Designated Safeguarding Lead (or equivalent)
- safeguarding decision-making and professional judgement must be **clearly recorded**
- external safeguarding agencies must be notified where required

Safeguarding responses must consider **both individual practice and organisational responsibility**, recognising that system failures and environments can contribute to risk.

8.3 Reporting & Notification

- Complete the Medication Error Form on the same day.
- Determine whether the incident meets regulatory notification thresholds:
    - Ofsted (England children's homes)
    - Care Inspectorate Wales
    - Care Inspectorate (Scotland)
    - Determine whether incident meets Serious Untoward Incident reporting thresholds.

Controlled drugs-related incidents may require escalation and, in serious cases, police involvement. Failure to report controlled drugs discrepancies is taken extremely seriously by regulators.

8.4 Investigation

Investigations must examine:

- human factors (workload, training, fatigue)
- communication issues
- environment and equipment
- system processes
- trauma impacts on children's and adults' decision-making and staff responses

The goal is improvement, not blame.

8.4 Organisational Learning and Improvement

Learning outcomes may include:

- revising standard operating procedures
- policy updates
- enhancing training
- improving communication or storage systems
- strengthening risk assessments
- increasing staffing or supervision during peak periods

Services must track action completion and feed learning into quarterly governance meetings. Full operational detail is set out in Appendix H.

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9. Nation-Specific Compliance

9.1 England

Services in England must comply with:

- Children's Homes (England) Regulations 2015 — Regulation 23
- Department for Education Medical Conditions Guidance
- National Institute for Health and Care Excellence social care guidance SC1 and NG67
- Misuse of Drugs Regulations 2001 for controlled drugs

9.2 Wales

Services in Wales must comply with:

- Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017
- Supporting Learners with Healthcare Needs (2017)
- All Wales Medicines Support Frameworks endorsed by Social Care Wales, All Wales Medicines Strategy Group and Welsh Medicines Information Centre

9.3 Scotland

Services in Scotland must comply with:

- Health and Social Care Standards (2017)
- Healthcare Needs in Schools (2017)
- Care Inspectorate Medication Guidance
- Adults with Incapacity (Scotland) Act 2000 and Mental Welfare Commission covert guidance

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10. Audit & Review

Monthly Audits

Services must complete monthly medication audits, including:

- medicines administration record accuracy checks
- “as required” protocol review
- fridge and room temperature logs
- homely remedies stock and use

Quarterly Audit & Controlled Drugs Review

Quarterly audits review controlled drugs registers, reconciliation processes, controlled drugs balances, training compliance and incident themes, including review of medication errors.

Annual Corporate Medicines Governance Report

Providers must monitor and review the quality of medicines management. The annual report will summarise:

- training levels
- incident analysis
- storage and controlled drugs audit outcomes
- improvement actions

Equality Impact Statement

This policy has been developed to promote equality, safeguard individual's rights, and ensure fair and inclusive practice across all services. The potential impact of the policy on children, young people, young adults, families, and staff with protected characteristics has been considered in line with the Equality Act 2010.

No negative impacts have been identified. Staff must apply this policy with sensitivity to individual need and make reasonable adjustments to ensure equitable access, safety, wellbeing, and participation for every individual. Any emerging risks of differential impact should be reported and addressed through ongoing review and quality assurance.

APPENDIX A — HOMELY REMEDIES

1. Purpose & Scope

Homely remedies are non-prescription medicines used to relieve minor, self-limiting symptoms when **children and adults** or young adults are not prescribed a medicine for that condition. This appendix provides national compliant guidance for children's homes, residential schools, day schools and colleges.

• Care settings may administer non-prescription items when governance, training and documentation systems are in place, and only in line with an agreed list and symptoms-based protocol.
• Any **over the counter** medication not on the Homely Remedies – including homeopathic/herbal/food supplements/vitamins etc MUST be approved by a **General Practitioner** or **Pharmacist** prior to administration
• Only medication supplied in the **United Kingdom** and in the **British National Formulary** can be administered
• Services are also required to have clear procedures for storage, administration and record keeping of all medication including over the counter items.

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2. Governance Requirements

2.1 Approved List & Review

• A corporate level list is authorised by the Clinical Director, Head of Policy and Responsible Individual annually.
• The list must be checked against evidence for safety in children, especially age/weight restrictions.
• Any changes must be documented and cascaded.

2.2 Pharmacist Involvement

• The **Royal Pharmaceutical Society** emphasises pharmacist input in medicines governance within social care.
• A local community pharmacist must review:
o the list,
o contraindications,
o suitable formulations,
o potential interactions with prescribed medicines.

2.3 Consent & Capacity Requirements

• under 16s: parental consent unless Gillick competent; ensure **children and adults'** voice is considered.
• 16–17s in England/Wales: **Mental Capacity Act 2005** presumption of capacity.
• Scotland: Age of Legal Capacity (Scotland) Act principles and **Adults with Incapacity (Scotland) Act 2000** if lacking capacity.
• For looked after children, follow statutory medical decision-making requirements in each nation.

2.4 Situations Where Homely Remedies Must Not Be Used

• Symptoms potentially indicating serious illness (e.g., abdominal pain with fever, chest pain, difficulty breathing).
• Where symptoms persist beyond 48–72 hours without clinical improvement.
• Where **children and adults** are taking interacting prescribed medicines.
• For sedation, behaviour control or sleep induction — strictly prohibited under **Royal Pharmaceutical Society** principles.

3. Storage, Stock Control & Labelling

• Store in locked cupboard separate from prescribed medicines; expiry dates checked monthly and rotated accordingly.
• Record opening date for liquids/creams/tablets; dispose after period recommended by manufacturer.
• Medicines fridge required if any liquid remedy/antibiotics etc requires cold storage.

4. Administration Protocol

4.1 Step by Step Decision Process

1. Assess symptoms using homely remedies assessment tool.
2. Check contraindications (asthma for ibuprofen, paracetamol duplication, allergies).
3. Check temperature logs for fever management.
4. Check recent doses — avoid duplication with prescribed analgesics.
5. Gain consent from **children and adults** accordingly.

6. Administer with explanation using trauma responsive communication (predictability, choice, validation).
7. Record on **medicines administration record** as a homely remedy with reason and response.
8. Escalate if symptoms persist, worsen, or meet “red flag” criteria.

4.2 Monitoring & Review

• Document effect after 30–60 minutes where appropriate.
• Escalate to health professionals if poor response or worsening condition.

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5. Example Corporate Homely Remedies List (Requires Local Pharmacist Endorsement)

• Paracetamol (oral liquid/tablets; age and weight specific dosage)
• Ibuprofen (oral; contraindications checked)
• Simple linctus (age >1)
• Antihistamine (e.g., chlorphenamine)
• Mild topical emollient/antiseptic

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6. Training & Competence

• All staff administering homely remedies must complete medicine management training aligned with regulatory requirements and best practice standards.
• Annual competency assessment required.

APPENDIX B — TRANSCRIBING

1. Purpose

Transcribing is the act of copying medication details from one source to another (e.g., from dispensing label to **medicines administration record**). This is a high-risk process and must be strictly controlled.

• Regulatory medication safety incident analysis highlights fatal errors from incorrect transcription.
• And emphasises accurate and up to date records and robust processes for medicines ordering/record keeping.

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2. Default Position — "Do Not Transcribe"

Medicines administration record charts should be produced by the pharmacy wherever possible. The organisation avoids transcribing except where explicitly unavoidable.

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3. Permissible Transcribing Circumstances

(Understanding transcribing for medicines administration – **National Health Service Specialist Pharmacy Service – the first stop for professional medicines advice**)

1. Emergency admission or discharge when pharmacy medicines administration record not immediately available.
2. Short course hospital medications requiring immediate administration.
3. ALL settings where **General Practitioner** or pharmacy provided medicines administration record is not standard practice, and staff must create an **individual healthcare plan / medicines administration record** entry directly from the dispensing label (per national guidance on supporting learners with medical conditions).

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4. Strict Controls (Mandatory)

4.1 Two Person Process

• One competent medication trained staff member transcribes;
• A second medication trained competent staff member independently checks and signs.

This aligns with safety standards for high-risk medicines governance.

4.2 Acceptable Source Documents

• Original pharmacy dispensing label
• Hospital discharge summary
• Prescriber's signed written instruction

4.3 Requirements for Accuracy

• Copy exact spelling, dose, frequency, route, special instructions (e.g., take with food).
• Check contraindications, interactions and duplications with pharmacist if needed.
• Never convert unclear directions (e.g., "as directed") — must contact prescriber.

4.4 Prohibited Practices

• No transcribing of **controlled drugs** under any circumstance;
• **Controlled drugs register** – entries must come from the original label and be immediately entered into the controlled drugs register
• No transcribing verbal directions.
• No transcribing for covert or **"when required"** administration plans — prescriber must issue explicit direction, with no titrating doses.

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5. Documentation & Record Keeping

• Use official CareTech medicines administration record sheet (MARs) with:
o Date/time
o Names of transcriber and checker
o Source document attached or scanned
o Reason for transcribing
o Duration until pharmacy medicines administration record available

• Keep log for minimum of regulatory retention period.

6. Review & Audit

• Monthly audit of transcription logs by Medicines Lead.
• Annual thematic audit to identify training or policy gaps.
• Any transcription error = medication incident; subject to learning review.

APPENDIX C — STORAGE, SECURITY & DISPOSAL OF MEDICINES

1. Purpose

To ensure medicines are stored, handled and disposed of safely in line with national regulatory requirements.

Medication should be accounted for from receiving on service, to returned to pharmacy / all stock administered.

All stock received onto services MUST have a signed as received log – often provided by the Pharmacist, which should be signed for immediately and medication stored safely locked behind a door until Care/Education medication administrators are able to remove to add to home/school stock – within an hour.

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2. Storage Requirements

2.1 General Storage

• Locked cupboards attached to a solid wall; accessible only to authorised staff.
• Keys to all medication cupboards must be stored in a key safe next to the medication cabinet and ‘code’ restricted to medication administrators only.
• A key sign sheet must be available at all times, for staff to sign out keys prior to medication administration and back in on return to the key safe.
• Storage meets **Royal Pharmaceutical Society Safe and Secure Handling of Medicines** principles.
• External (topical) medicines stored separately from oral medicines.
• Medicines belonging to individual **children and adults** must be stored separately and labelled clearly.
• Each **child or adult** must have their own named shelf for their medication only.
• Medication cupboards must be clean and tidy at all times with monitored weekly cleaning of all areas.
• Only ONE bottle/pack of the same medication should be open at any one time and this must clearly labelled with the date opened.

2.2 Temperature Control

• Room temperature: maintained at 15–25°C; daily log.
• Medicines fridge: 2–8°C with daily minimum–maximum temperature monitoring; quarterly calibration.

• Non-compliant temperature episodes must be escalated and medicines quarantined until pharmacy advice is obtained.

2.3 Controlled Drugs Storage

• **Controlled drugs** cabinet must comply with Misuse of Drugs Safe Custody Regulations; securely fixed.
• Keys code held only by authorised staff; key log maintained.
• Applies differently across schedules (see Appendix D).

2.4 Self Administration Storage

• Following individual risk assessment, **children and adults** may keep their medicines in a locked personal drawer/cabinet.
• Risk assessment must account for agreed reasonable quantity to be stored by **children and adults** at any one time and remaining stock held with staff in accordance with safe storage.
• Must align with national healthcare needs guidance.

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3. Stock Control & Record Keeping

All medication MUST be accounted for when entering the service.

• Count all medicines on arrival, including the amount of individual tablets per pack if tablets do not arrive in a sealed box; record liquids in millilitres; and compare with the amount requested on the repeat prescription.
• Record immediately on **medicines administration record** or **controlled drugs register**.
• Maintain daily audit of running stock balance for **“when required” medicines** and **controlled drugs**.
• Check expiry dates monthly and rotate stock to ensure use by dates used in order.
• Ensure medication used in correct order where there are numerous boxes; e.g. box 1 of 3 / 2 of 3 / 3 of 3.

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4. Storing of Waste Medication on Services

• Wasted medication MUST NOT be stored with current medication.
• A separate locked area in the medication cupboard must be used to store waste medication.

• All wasted medication must be logged in the home/school wasted medication book and accounted for on the audit.
• Wasted medication must be moved to a central store weekly and signed out of the home and into the central store log ready for return to pharmacy immediately. This log must be a duplicate log book.

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4. Disposal & Returns

All medication MUST be accounted for when leaving the service.

On return to pharmacy the log book must be signed for as received by the pharmacy and one copy of the logged entries sent with returned wasted medication and one copy retained in the log book for record keeping.

4.1 Routine Medicines

• Any unused medication must be returned to pharmacy in original packaging if still secure or in sealed envelopes / clear small zip lock bags with the name of person, name of medication and date wasted, clearly written on the packaging. Fluids must be disposed of using a small secure lock medicine bottle with same labelling. Return to pharmacy using tamper evident bags.
• Record in waste disposal log.
• Never dispose of medicines in domestic waste.
• No tablets should be cut in half. This should be actioned by the Pharmacist when dispensing.

4.2 Controlled Drugs

Destruction must occur using denaturing kits in the presence of an authorised witness and documented in the **controlled drugs register**. Controlled drugs must be safely destroyed so they cannot be used again, using an approved disposal method, witnessed by an authorised member of staff (not a child or adult who is cared for) and recorded in the controlled drugs register.

• **Controlled drugs** discrepancies require immediate escalation to manager and potentially the Clinical Director.
• Wasted **controlled drugs** must be accounted for in the waste disposal log as well as the controlled drugs register.
• If the service is nurse led / hospital, they will need to apply for a **T28 waste exemption** and denature before removal by waste disposal company.

4.3 Homely Remedies Disposal

• Dispose when expired, contaminated, or no longer required, and return to the pharmacy using the same process as prescribed medication.
• Topical medicines opened >3 months discarded unless manufacturer states otherwise.

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5. Transport of Medicines

• For trips/outings: sealed container; medicines administration record copy; emergency medicines accessible; temperature protective pouch if needed.
• **Controlled drugs** still require two medication trained staff to administer off service and controlled drugs book MUST be signed on return to service. Where this is not possible due to staff ratio, the Service Manager must undertake a risk assessment as a last resort.
• Schools must follow national medical needs guidance for off-service activities.

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6. Audit & Monitoring

• Weekly checks by Medicines Lead.
• Quarterly corporate audit; actions logged; trends analysed.

APPENDIX D — CONTROLLED DRUGS MANAGEMENT

1. Legal Framework

UK-wide (all settings, including education)

- **Misuse of Drugs Act 1971**
- **Misuse of Drugs Regulations 2001**
- **NICE NG46** – safe prescribing, storage, administration, recording, disposal and incident reporting

England

- **Care Quality Commission (CQC)** – health and social care
- **NHS England Controlled Drugs Accountable Officer (CDAO) framework**
- **Ofsted** – children's homes *and* education settings

Wales

- **Care Inspectorate Wales (CIW)** – care services
- **Estyn** – education settings
- **Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017**

Scotland

- **Care Inspectorate** – care services
- **Education Scotland** – education settings
- **Scottish controlled drugs governance arrangements**

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2. Receipt of Controlled Drugs

• Check packaging full and intact before signing.
• Two authorised staff must sign controlled drugs into stock and controlled drugs register.
• Entry must include: date, time, prescriber, formulation, strength, quantity received, running balance.
• Received medication must be entered onto the **electronic medicines administration record** as well as added to stock in the controlled drugs book.
• Controlled drugs books should have an index page updated to give current page for stock of each medication.
• Each page in the controlled drugs book must be for a separate medication strength and **child or adult**.

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3. Storage

• Schedule 2 controlled drugs (e.g., morphine, oxycodone, methylphenidate): must be stored in controlled drugs cabinet.
• Some Schedule 3 controlled drugs (e.g., buprenorphine, temazepam) also require controlled drugs cabinet storage.
• Key control: restricted to authorised staff; key log maintained.

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4. Administration

• Two authorised staff check identity, dose, time, stock and **medicines administration record**.
• Checks to **electronic medicines administration record** and controlled drugs book for consistency and signature of administration.
• Record dose given immediately in medicines administration record and controlled drugs register.
• Document wastage separately (e.g. refused), witnessed and signed.

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5. Monitoring & Running Balances

• Running balance checked with each entry.
• Daily audits of stock.
• Weekly balance check by Medicines Lead; monthly independent audit.
• Quarterly audits by Medicines Lead in March, June, September and November.
• Discrepancies = critical incident; immediate escalation and possible notification to Clinical Director, Police or regulator.

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6. Disposal

• Controlled drugs destroyed using a denaturing kit or approved disposal system; witnessed by authorised staff or accredited witness as required.
• Document in controlled drugs register and disposal log.
• Must still be stored in the controlled drugs cupboard until removed to pharmacy.

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7. Prescribing & “When Required” Controlled Drugs

• Controlled drugs must have clear prescriber directions; no “as directed” or variable doses.
• For “when required” controlled drugs, individual protocol required with maximum daily dose, review points and non-pharmacological strategies.

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8. Staff Training

• Staff handling controlled drugs must have advanced medication training, competency assessment and annual refresher in line with nation specific requirements.

APPENDIX E — COVERT ADMINISTRATION OF MEDICINES

1. Definition & Ethical Context

Covert administration = giving medication in disguised form (e.g., hidden in food/drink) without the person's knowledge.

• This is a last resort measure only when refusal of essential medicine places the person at significant risk.
• Covert administration must never be used for convenience or behavioural control.
• Must maintain dignity, rights and trauma sensitive practice.
• Planned care planning evident, to show steps to demonstrate a move to taking without need for covert management in the future.

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2. Legal Basis by Nation

England

Adults

• **Mental Capacity Act 2005** – assess capacity, act in best interests, use least restrictive option
• **Care Act 2014** – safeguard adults and promote wellbeing

Children

• **Children Act 1989 and 2004** – welfare paramount, act in best interests, safeguard the child
• **Children and Families Act 2014** – meet Special Educational Needs and Disabilities needs and support inclusion

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Wales

Adults and Children

• **Social Services and Well-being (Wales) Act 2014** – promote wellbeing, safeguard, ensure voice and participation
• **Mental Capacity Act 2005** – (where applicable) best interests and least restrictive decision-making

Children

- **Children Act 1989 and 2004** – welfare paramount, act in best interests, safeguard the child

• **Additional Learning Needs and Education Tribunal (Wales) Act 2018** – identify and meet additional learning needs

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Scotland

Adults

• **Adults with Incapacity (Scotland) Act 2000** – interventions must benefit the person and be least restrictive

Children

• **Children (Scotland) Act 1995** – welfare paramount and child's views considered
• **Education (Additional Support for Learning) (Scotland) Act 2004** – meet additional support needs

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All Nations

• **Human Rights Act 1998** – lawful, necessary, and proportionate restriction of rights
• **United Nations Convention on the Rights of the Child** – uphold children's rights, voice, and best interests

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3. Required Steps (Non-Negotiable)

3.1 Confirm Essential Medical Need

• The medicine must be essential for preventing deterioration or promoting recovery.
• Consider alternatives (different formulation, different medicine, timing adjustments).

3.2 Capacity Assessment

• Conduct decision specific capacity assessment: understanding, retention, weighing, communication.
• Use Gillick test for under 16s where relevant.
• Document clearly.

3.3 Best Interests / Multidisciplinary Meeting

At minimum include:

• Prescriber
• Manager / Medicines Lead
• Key worker
• Parent / carer / welfare attorney / guardian (if appropriate)
• Advocate (where available)

Meeting must consider: will, preferences, emotional impact, trauma history, less restrictive options.

3.4 Pharmacy Formulation Guidance

• Pharmacist must specify:
o Safe method of disguising
o Whether tablet can be crushed or capsule opened
o Stability and food interactions

During covert practice, pharmacy advice is mandatory due to risk of altered absorption or medicine inactivation.

3.5 Prescriber Authorisation

Prescriber must issue a written direction stating:

• Covert administration authorised
• Specific medicine(s)
• Duration / review date
• Situations requiring re evaluation

3.6 Medicines Administration Record and Documentation

• **Medicines administration record** must indicate “covert—per authorised plan”
• Covert Medication Plan kept attached to the **electronic medicines administration record** electronically or with the medicines administration record and in care file and reviewed at least every 4–12 weeks depending on clinical need.

3.7 Review & Revocation

• Covert administration stops immediately if:
o Capacity returns
o Risks reduce
o **children and adults** express clear wish to refuse with capacity

• Reviews documented with prescriber / pharmacist involvement.

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4. Children and Adults Specific Considerations (Under 18s)

• Must consider the child’s developing autonomy and rights per **United Nations Convention on the Rights of the Child** and national educational / healthcare guidance.
• Trauma responsive explanation attempts must continue even when covert plan is in effect.
• Scotland: if person with parental responsibility consents (when **children and adults** lack capacity), covert administration may proceed; if parent declines and treatment is essential, legal advice considered.

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5. Staff Training & Oversight

• Only staff trained in covert medication law and ethics may administer.
• Annual training refresh; case reviews incorporated into reflective supervision.

APPENDIX F — "AS REQUIRED" MEDICINES PROTOCOL

1. Purpose & Scope

"As required" medicines are given to relieve intermittent or short-lived symptoms (e.g., pain, anxiety, asthma symptoms, allergic reactions, seizures), but must never be used for convenience or as a behavioural control measure, in line with **Royal Pharmaceutical Society** core principles for social care medicines.

Services require to have clear, individualised "as required" protocols, specifying dose, frequency, indication, and review triggers.

"As required" medication must be stored separately to regular medication.

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2. Legal & Ethical Frameworks

• **Consent and capacity**:
o under 16s: Gillick competence test must be applied when **children and adults** decide about "as required" medicines.
o 16–17 (England/Wales): **Mental Capacity Act 2005** applies — assume capacity unless assessed otherwise.
o Scotland: **Age of Legal Capacity (Scotland) Act** plus **Adults with Incapacity (Scotland) Act 2000** for those lacking capacity.

• **Education settings**: "As required" arrangements must be built into **Individual Healthcare Plans** as required in England, Wales, and Scotland.

• **Trauma responsive care**: "As required" administration must always be preceded by calm, collaborative explanation, use of choice, and non-pharmacological de-escalation where appropriate.

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3. Requirements for Every "As Required" Medicine

3.1 Individual "As Required" Protocol (mandatory)

Each "as required" medicine requires its own protocol, detailing:

1. Name / formulation / strength
2. Indication of symptoms requiring administration specific to **children and adults** themselves and their individual presentation – e.g. this must not be 'for anxiety' (e.g., first signs of migraine; early wheeze; specific behavioural cues) Staff refer to the Positive Behaviour Support Policy and Behaviour Plan to ensure a holistic approach towards the assessment of symptoms

3. Non pharmacological strategies outlined in Behaviour Support Plans e.g. sensory regulation, hydration, low stimulus environment
4. Dose and route as per prescriber
5. Minimum interval between doses
6. Maximum doses in 24 hours
7. Expected effect timeframe
8. Monitoring parameters (e.g., respiratory rate, level of alertness, pain score)
9. When to escalate (no response, signs of deterioration)
10. Contraindications / allergies
11. Review schedule — at least every 3 months or sooner if patterns change

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3.2 Decision Making Before Administration

Staff must:

1. Assess symptoms
2. Confirm last dose time (prevent overdose).
3. Consider non pharmacological support first.
4. Explain the purpose, effect, and alternatives (trauma responsive).
5. Gain consent appropriate to age / legal status.
6. For controlled drug “as required” medicines (e.g., buccal midazolam, morphine), follow Appendix D rules.

3.3 Administration Requirements

• Follow the Rights of Medication administration (right person, medicine, dose, time, route, right reason, documentation, assessment, right, education, right to refuse).
• Observe for effect and record outcome
• If repeat doses are considered, reassess clinical need and risk.

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4. Documentation (Medicines Administration Record & Daily Records)

Each “as required” administration must include:

• Time, dose, route Rights of Medication Administration
• Indication / symptom
• Effectiveness after 30–60 minutes
• Any adverse effects
• Whether prescriber was contacted

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5. “As Required” in Education Settings

School / college “as required” medicines must be written into:

• **Individual Healthcare Plans**, including emergency plans (e.g., buccal midazolam, salbutamol, antihistamines).
• Behaviour Support Plan.
• Staff trained and competent in administration (per national guidance).
• Clear trip / residential protocols with risk assessments.

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6. Review & Governance

• “As required” patterns reviewed monthly by Medicines Lead — high use triggers clinical review; may indicate unmet need or inadequate baseline treatment.
• Annual corporate audit and KPI reports

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7. Special “As Required” Categories

7.1 Seizure Rescue Medication

(Buccal midazolam / rectal diazepam (rectal diazepam to be administered as a last resort and only by staff who have relevant advanced training)

• Must comply with “as required” protocol and emergency plan, written by the Neurology team.
• Staff must have advanced competency training by qualified practitioner and reviewed annually.
• Medication MUST be with the individual or staff member supporting at all times.
• Controlled drug governance applies if Schedule 3 or Schedule 4 depending on product.

7.2 Asthma “As Required” (Salbutamol inhaler)

• Must have individualised asthma plan from the asthma Nurse or specialist respiratory team.
• Staff must be trained and competent in using asthma inhalers and asthma management.
• Wales and Scotland allow schools to hold spare salbutamol inhalers under specific guidance.
• Inhalers must be cleaned and maintained in line with the Health and Safety Policy.

7.3 Anaphylaxis “As Required” (Adrenaline Auto Injector)

• **Individual Healthcare Plan** must specify dose, trigger signs, and repeat dose rules
• Staff cannot write emergency care plans, they MUST be obtained by the prescriber or specialist hospital Nurse
• Training annually.

APPENDIX G — MEDICINES TRAINING & COMPETENCY FRAMEWORK

1. Purpose

To ensure all staff administering or supporting medicines are trained and competent in line with national regulatory expectations.

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2. Training Levels

2.1 Level 1 — Awareness (All Staff)

Covers:

- Trauma-responsive medication communication
- National laws (MCA 2005, Gillick competence, Adults with Incapacity (Scotland))
- Common risks and incident reporting
- Homely remedies governance

Assessment: Short e-learning test or induction quiz

2.2 Level 2 — Core Medicines Administration (Care/Education Staff)

Mandatory for anyone administering medicines:

- TEN rights of administration
- (E)MAR interpretation
- Storage and disposal
- PRN administration (Appendix F)
- Basic inhaler/spacer use
- Recognising adverse reactions

Assessment: Observed practice and written scenario test

2.3 Level 3 — Advanced / Specialist Medicines Competence

For staff administering:

- Controlled drugs (Appendix D)
- Buccal midazolam and rectal diazepam (rescue medication)
- Insulin and blood glucose monitoring

- Enteral tube medicines
- Eye drops
- Ear drops
- Prescribed topical preparations
- Sublingual medicines
- Inhalers (with and without spacers)
- Nasal sprays

Training must align with nation-specific competency expectations.

Assessment: Practical competency assessment and annual refresher

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3. Competency Assessment Requirements

- Annual competency assessment required
- Two components:
  - Knowledge test
  - Observed practice (minimum of 10 administrations for Level 2 and 3 staff)

Where performance concerns are identified:

- Further assessment must be completed
- Temporary supervised practice must be implemented

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4. Education Settings: Additional Requirements

- Staff supporting children with medical conditions must receive training aligned to each Individual Healthcare Plan (IHP), in accordance with statutory guidance
- Settings must ensure appropriate staffing so that trained medication staff are always available

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5. Governance and Record Keeping

- Individual training file maintained for each staff member, including:
  - Certificates
  - Competency checklists
  - Observation records
- Quarterly report provided to Senior Leadership on compliance levels
- Annual internal audit completed, with external pharmacist review encouraged

6. Refresher Requirements

- Level 1: Every 2 years
- Level 2: Annually
- Level 3: Annually, and following any medication incident involving the specific technique (reflective debrief required)

7. Supervision and Reflective Practice

The Medicines Lead must facilitate reflective reviews of incidents and near misses with staff.

APPENDIX H — INCIDENT, NEAR MISS & ORGANISATIONAL LEARNING FRAMEWORK

1. Purpose

To provide a robust and transparent system for identifying, reporting, investigating and learning from medication-related incidents across all settings.

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2. Definitions

- **Medication error:** Any preventable event leading to inappropriate medication use, harm, or omission of any part of the administration process *(e.g. missed signature, medication given late/early, records not completed in a timely manner)*
- **Near miss:** An error identified before reaching the child or young person
- **Adverse drug reaction (ADR):** Harm caused by a medicine when used correctly

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3. Immediate Response (Within Minutes)

1. Ensure the safety of the child or young person
2. Seek clinical advice from prescriber or pharmacist where needed
3. Provide first aid or emergency response (e.g. call 999 for anaphylaxis or non-resolving seizure)
4. Inform the manager and Responsible Individual where required
5. Record factual information at the time

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4. Reporting Requirements

- MAR records must be corrected with a clear explanation — never overwritten
- Stock discrepancies must not be amended without:
  - Full investigation
  - Senior Leadership notification
  - Clear audit trail (including time, date, and person making the amendment)
  - Amendments completed by the senior trained staff member on shift
- Internal incident report completed on the same day
- Prescriber must be notified
- Parents, carers, social workers, or the young person (where appropriate) must be informed

Statutory Notifications

- **England:** Ofsted / CQC (depending on service)
- **Wales:** CIW where harm thresholds are met
- **Scotland:** Care Inspectorate for notifiable events

All regulators require timely reporting where there is harm or risk of harm.

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5. Investigation (Within 24–72 Hours)

The Lead Investigator (Medicines Lead or Senior Manager) must:

- Secure evidence (MAR charts, controlled drug registers, medication labels)
- Obtain staff statements
- Complete Medication Error documentation
- Use structured analysis tools (e.g. Skills for Care or NHS contributory factors framework)
- Complete internal investigation documentation
- Seek pharmacist advice where clinical interpretation is required

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6. Root Cause Analysis (RCA)

- Identify human factors, system issues and environmental influences
- For controlled drug discrepancies, involve the Controlled Drugs Accountable Officer (CDAO) where required
- Consider contributing factors such as:
  - Covert administration
  - Transcription errors
  - PRN decision-making
  - Storage systems

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7. Learning and Corrective Actions

Actions may include:

- Updating PRN protocols
- Improving storage systems
- Additional staff competency assessments
- Reviewing homely remedies processes
- Pharmacist-led training
- Updating Individual Healthcare Plans (IHPs) in education settings

All actions must be reviewed monthly until completed.

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8. Feedback and Transparency

- Lessons learned shared through:
  - Team meetings
  - Safeguarding forums
  - Medicines governance groups
- A non-punitive culture must be maintained, aligned with national safety and safeguarding principles

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9. Trend Analysis and Audit

- Monthly monitoring of incident themes (e.g. timing errors, near misses, controlled drug discrepancies)
- Annual Board-level report to include:
  - Trend analysis
  - Learning outcomes
  - Improvement actions