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Western Care Association – Medication Policy

I have read and understand the policies and procedures set out in Western Care Association's Medication Policy.

I agree to adhere to these policies and procedures in my work when supporting people using services.

To be signed by all staff who work in the service so that signatures/initials can be clearly understood on drug recording sheets.

Name – Please Print	**Signature**	**Initials**	**Date**

Table of Contents

APPENDICES

1. Purpose and Scope of Medication Policy

Introduction
Western Care Association encourages people receiving services to pursue best possible health and to take as much responsibility as they can for their own healthcare, including any medications they may need to take. This preserves independence, regardless of the service supports received, and is important because it prepares people to look after their own health and medicines into the future. The organisation's philosophy is to enable the person to remain as independent as possible and to receive assistance with the administration of medication only where necessary, subject to a Self-Medication Risk Assessment.

In the case of children receiving supports, their age and what the norm is for a child of that age is an additional factor to consider.

This policy sets out the key principles that underpin the safe handling of medicines in accordance with relevant legislative and standards requirements and as appropriate to the level of support the person requires. This policy is reviewed at least annually to ensure it continues to meet best practice and legislative requirements.

The correct and safe administration of medicines depends on the good practice of staff as well as all others who have a role to play in attending to the person's health such as the medical practitioner, pharmacist, family, public health nurse and hospital medics. Therefore, good co-ordination and co-operation between all involved will facilitate good decision making. The organisation's "Medication Policy" and "Enabling People to Enjoy Best Possible Health" policies must be referenced when considering medication and health and wellbeing matters for the person.

The scope of this policy includes prescription and over the counter medicines as well as complementary and alternative therapies/remedies. The administration of medicines for emergency use is also referenced in this policy.

This policy applies to all staff, work experience participants and volunteers who support people using Western Care Association services as appropriate to their role and level of responsibility.

Key Principles
The following principles provide a summary of the main topics which are expanded throughout this policy. They are intended to ensure the safest and simplest process so that the rights of medication administration are observed i.e. **the right person** for the **right reason** receives **the right medicine** by **the right route** at **the right time** in the **right dose** and **form** for the **right action** with the **right documentation and** for the **right response.** Furthermore, the person has the **right to refuse** medication.

- **Rights and Dignity.** All activities related to medicines should be conducted in such a way to maintain the rights of the person and to preserve their dignity and control of

their own lives. Particular attention should be given to any bias or discrimination based on age, gender, disability, sexuality, culture, religion, marital or health status, for e.g. If there are any cultural or religious issues related to medications, seek advice from the medical practitioner and/or pharmacist.

- **Risk assessment to establish ability to self-medicate**. Adults must be regarded as responsible for their own medicines unless a formally recorded decision, which includes a risk assessment and consultation with the person and family members where appropriate, has been made to the contrary. Every person has a right to receive the appropriate support which will allow him/her to exercise as much control as possible over decisions and treatments that affect him/her. This includes the right to self-medicate and to choose to administer all or some of his/her medicines.
- **Review of long-term medication.** All medicines prescribed on a long term basis should be regularly reviewed by the prescribing medical practitioner at yearly intervals or more/less frequently where advised.
- **Maximum quantity of medication to be ordered.** No more than twenty-eight days supply of medicines, including those on repeat prescriptions, should be requested for an individual at any one time.
- **No sharing of prescribed medicines.** Medicines prescribed for one person must not be used for any other person.
- **Only use medicines from original dispensing containers**. Administration of medicines by staff must only be carried out from the original container in which the medicine was dispensed.
- **Record of administration.** Every dose administered by staff must be individually recorded at the time it is given. If the dose is not taken by the person, this must be recorded and the reason why the dose has not been taken should be noted.
- **Return unwanted medicines to the pharmacy.** Medicines must not be retained when no longer required.
- **Over the counter medications**: A small range of over the counter medicines may be kept for the treatment of minor self- limiting ailments, e.g. headache, which would not normally require consultation with a medical practitioner. This can be written up for the person in their MP1 in advance.
- **Encouraging Independence** People should be encouraged to self-administer and maintain independence. This can include people who self-medicate from original dispensing packs or from individual compliance aids.

Information and Training

The organisation ensures the provision of appropriate training and learning opportunities for staff to competently administer medication or assist people with the administration of their medication. Records of training undertaken are maintained for each staff member.

The organisation expects that nurses in its employ will be familiar with An Board Altranais agus Cnámhseachais na hEireann's most up to date "Standards for Medicines Management for Nurses and Midwives".
The organisation also recognises the importance of providing information to people receiving services about their health care and medicines. It will provide the person with information in a way that is accessible and understandable where possible. It provides a range of resources which can be accessed via Intranet — Health.

Additional guidance/training is provided for staff to cover specialised techniques, such as giving oxygen, administration via a PEG, diabetes management, rectal administration of medications and catheter care etc.

Some of these tasks will always require the involvement of specialists in that area e.g. Diabetes Nurse Specialist to inform practice. A written Plan/Protocol, as per "Best Possible Health Policy, Health Condition Management Plan" will be required describing the circumstances in which medication will be administered/specialised task will be carried out and this requirement will be incorporated in the training provided.

Service managers are responsible for reviewing the medical needs of people using services and identifying, in good time, the training needs of staff to respond to the person's specific medical condition.

The organisation's Evaluation and Training Department will provide information and organise training where the need arises, including any emergency requests for training which could not be anticipated in advance.

2. Learning about the Person – Taking Up Service

Initial Information Gathering
Once the offer of service has been made and accepted, the service manager will meet with the person and family before he/she avails of the service. The manager will seek advice and information about health and wellbeing as well as details of all medicines taken, including any over the counter, alternative or complementary therapies used. As part of this discussion a decision will be made about the level of support the person will initially need to take their medications, using guidance in this document to do so. The Medical Consent Form (*Appendix 10*) is also discussed and signed at this time.
Confirmation of the medical information provided will then be requested to be written up on the MP1 sheet by the person's medical practitioner which will be held in the person's I.P. Folder. The information gathered at this time is also necessary to complete the person's "My Health Action Plan" – see Best Possible Health Policy.

For people attending a Respite Service, medicines' information must be checked **each time the person attends** the service to ensure that any changes in medication from one stay to another are reflected in the MP1 sheet.

For people attending a Day Service, information must be sought about all medications taken, including those to be taken during the time of attendance. This is important lest the

person experience a health difficulty/emergency while attending the service. The MP1 needs to be written up and copied to the Day Service.

Information about any known **allergies or adverse reactions**, interactions or contraindications of medicinal products that people may have previously experienced should also be documented.

3. Determining who can take their own medicines

Consent, Capacity and Choice
Assistance with administration of medication can only be provided with the consent of the person. Having capacity means being able to make one's own decision about something having considered the options available.

Does it matter how the person gives consent?
Consent can be written, oral or non-verbal. A signature on a consent form does not in itself prove the consent is valid. The point of the form is to record the person's decision and also the discussions that have taken place.

Difficulties in communication should not be confused with incapacity. Consider the most appropriate way to communicate with the person.
Tell or show someone by:

- Using words
- Using pictures
- Using signs like Lámh or Irish sign language
- Using a communication device
- Using gestures
- Using any of these together.

Who is the right person to seek consent?
It is always best for the person planning an individual's support to seek that person's consent and/or liaise with trusted others as required.

What information should be provided?
People need sufficient information before they can decide whether to give their consent; for example information about the service/ what staff will provide in terms of medication safety, storage arrangements and administration of medicines as well as the advantages and responsibilities of keeping and taking their own medicines. If the person is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid. See Intranet – Health for resources that may be used to aid this process.

Is the person's consent voluntary?
Consent must be given voluntarily: not under any form of duress or undue influence from staff, family or friends.

Difficulty understanding options

Where the person has difficulty understanding some choices, a process which is similar to supported decision making is used. It is a safeguard to ensure the person's voice is represented by those who know them best and reflect their wishes and preferences. Typically in Western Care, this role is fulfilled by family members.
Families and trusted others such as advocates can do this through their involvement in Circles of Support, the regular Individual Planning Process or the particular individual process for communication and decision making that is in place for a person.

People should be given the opportunity to make choices and decisions for themselves. It may be the case that the person is unable to make a particular decision at a particular time but this does not mean that the person is unable to make any decisions at all. They should receive enough support from trusted others (Circle of Support) to make their own decisions. Using individuals that the person trusts to support decision-making ensures that decisions made fully consider the person's perspective.

Consent obtained must be recorded in "Self Administration of Medication Support Plan" *(Appendix 1*).

Can children consent for themselves?
Before giving medication to a child, you must seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. If, however, he/she is unable to give informed consent then family/guardian may sign the consent form.

In the case of children, considering their age and what the norm is for a child of that age is a factor that must be considered.

Children under 16 who understand fully what is involved can also give consent but their parents/guardians must be included in decision-making.

If parents or guardians are deceased, a family member who has the closest relationship with the young person will give consent.

Self-Administration Assessment
Adults are always assumed to be capable unless it is determined otherwise.

A Risk Assessment must be completed in order to determine the person's ability to self-administer his/her medicines. Use *"Self-Administration of Medication Support Plan" (Appendix 1)* to do this. The person's ability to self-medicate must be established for each medicine taken. Evidence of this assessment should be kept with the person's Individual Plan (IP) Folder. The assessment will also identify if the person requires full assistance from staff to select and take all of their medicines.

When all people involved in the assessment process are in agreement, they sign the "Self Administration of Medication Support Plan" *(Appendix 1)*.
A review of "Self-Administration of Medication Support Plan" should ideally be carried out every 12 months or when new medication is prescribed or when, the person's ability

to self-medicate changes or becomes questionable. The "Self Administration of Medication Support Plan – Part C - Progress Form", (*Appendix1),* may prove helpful when monitoring the person's ability to self medicate.

Partial Self-Administration
If the person is only able to self-administer some medicines or only wishes to take partial responsibility – that is, to self-administer some but not all medicines - this should be noted in Part B in the "Self Administration of Medication Support Plan" *(Appendix 1).*

Conflict of Wishes between Person and Staff
It is recognised that there may be situations when a person using services wishes to control their own medicines but, for various reasons, is unable or unwilling to fully do so. Every effort should be made, including the use of compliance aids, to accommodate the needs of the person if possible. For example, the person may wish to take custody of their own medicines but be unable, because of physical disablement, to administer them. A sensitive balance has to be found between the person's freedom of choice and the need to ensure that the choice made does not constitute undue risk to themselves or to others.

Checking that People can Self-Administer Medicines
Staff should make ongoing checks and carry out a review at least every 12 months to ensure that the person is managing the administration of their medicines successfully and is not placing themselves or others at risk. This review should be recorded in the "Self-Administration of Medication Support Plan" - See Part C, Progress Form.

It may be useful to talk to the pharmacist or medical practitioner to assist in making the correct decision.

Evaluating Risk to the Person
It is the duty of staff to keep an eye open for any obvious confusion among people with respect to their medication. This does not mean implementing a strict system of observation. It is more appropriate to be on the look-out for any misplaced doses of medicines, e.g. doses placed on table tops or dropped on the floor. If medicines are being looked after properly by people, there should be no evidence of any medication except when people are actually taking medicines.

Evaluating Risk to other People
It is just as important to assess the impact of a person's practice upon others. Therefore, staff should ensure that people do not offer their medicines to other people. People should also be extremely vigilant with regard to the safe storage of their medicines. If a person disregards these important safeguards they should be counselled. If persistent counselling on this matter is required it may be necessary, in the interests of safety, for staff to administer their medication.

Person no longer able to Self-Administer Medicines
If a person, who has administered some or all of his/her own medicines, is considered no longer capable of doing so, the matter should be carefully discussed with the individual

and their family. A written agreement to change the responsibility for medication administration should be obtained and recorded in the person's *"Self-Administration of Medication Support Plan" (Appendix 1).*
Every alternative measure/possibility must be explored before a decision is made to set aside the person's preferred choice. If the decision is considered a rights restriction then this must be referred to the Rights Review Committee – see *"Policy on the Rights of People Using Services"*.

4. Medication Review

Review is necessary to ensure that the person receives maximum benefit from medicines that are prescribed. The responsibility for prescribed medication ultimately rests with the person's medical practitioner.

Refer to "Enabling People to Enjoy Best Possible Health" relating to informing/educating the person about their health issues and including the review process for people taking medications to control behaviour.

Matters to be considered when reviewing repeat prescriptions:

Opinions of the Person

- Is the person satisfied with the medicines they take?
- Are there any apparent undesirable effects caused by the medicines?
- Is the medicine still needed? Has the person's condition, for which the medicine was originally prescribed, been resolved?
- Is the medicine actually being taken by the person?
- Does the person feel that they are taking too many medicines?

Opinions of Trusted Others (Circle of Support)

- Does the person seem well? Has he/she improved, got worse or has there been no change?
- Have changes been noted in behaviour of the person?
- Has the person had any slips, trips or falls?
- Has there been any recent change in medication?
- Has the person been refusing medication?

Points to raise with the Medical Practitioner

- Is the medicine still necessary for the medical condition?
- Is there an alternative medicine if the person is experiencing side-effects?
- Is there an alternative preparation, e.g. liquid instead of tablets (or vice-versa); a different strength of tablets to avoid splitting in half? Would a capsule instead of tablet facilitate swallowing?
- Could the number of administrations per day be reduced to facilitate self-administration?
- Discuss any concerns that may exist.

Frequency of Review
Refer to the organisation's policy *"Enabling People to Enjoy Best Possible Health" – Preventative Healthcare Health Checks –Appendix B* which detail the ideal review intervals for children and adults of various ages. It is very important to remain attentive for any problems associated with the use of medicines and request a review sooner if required.

Medication requiring regular monitoring
A number of medicines are prescribed which require regular monitoring to ensure that the dose is appropriate. This is usually conducted by means of a blood test at regular intervals. Examples of these medicines are **Warfarin, Eltroxin, Insulin** and oral anti-diabetic medicines. If a person is prescribed a medicine which requires regular monitoring, then an agreement should be reached with the medical practitioner concerning the frequency and manner in which the tests will be carried out.

Details must be written in the relevant forms from *Appendix A:* My Health Action Plan - *Enabling People to Enjoy Best Possible Health*.

Following a test it may be necessary to change a dose and the new prescription needs to be written up and also entered on the MP1 sheet.

Presence of others during Medical practitioners' Consultations
The person has the right to see the medical practitioner alone or to have someone they trust present during a consultation. Consent should always be sought from the person prior to anyone, apart from the medical practitioner, being present.

Recording the Outcome of a Medical Appointment
When staff are supporting someone to attend a medical appointment, they are responsible for recording the outcome of that appointment using the Medical Appointment Form (MAF) -*Appendix A - My Health Action Plan - Enabling People To Enjoy Best Possible Health.*

The findings/outcome of the person's appointment should be recorded in this way and a copy placed alongside other health related information in their Individual Plan (IP)

To ensure good practice, the Service Manager will ensure that a Medical Appointment Form is completed each time the person attends an appointment for the following:

- Medication Review
- Outpatient - Consultant appointment.
- Admission to hospital.
- Changes in long-term treatment - e.g. changes in medication for the management of behaviours of concern, changes in medication for the management of epilepsy, diabetes.
- Any other medical appointment of particular significance to the person.

The Medical Appointment Form will then be forwarded to the Regional Services Manager (RSM) where it has been agreed that this is required.
The MP1, PRN Protocols, Health Condition Management Plans, Intimate Care Plan, My Health Action Plan, Self – Administration of Medication Support Plan etc. are updated on foot of any changes made at the medication review/other appointments.

Keeping up to date records is necessary to assist safe decision making with/on behalf of the person as well as ensuring that an unbroken record of his/her healthcare history exists. See also "*Appendix A - My Health Action Plan - Enabling People To Enjoy Best Possible Health"* policy.

5. Medication Records

The Purpose of Medication Recording Documents
The purpose of medication recording documents is to enable staff and people using services, if appropriate, to trace a medicine from the time:

- The prescription is requested from the medical practitioner's surgery to the time it is received back from there.
- The prescription is submitted to the pharmacy and the medication order is received by the person/service.
- The medication is stored.
- The medication is administered to the person.
- The medication, if unused, is returned to the pharmacy for disposal.

The records are an aid to the correct ordering, receipt, storage, administration and disposal of medicines.

Medication Ordered and Received Record
The manager/ designated staff members in the service will initiate the order for new prescriptions. It is good practice to prepare and carry out this task at a time when there are no/few distractions as this helps reduce the likelihood of errors/omissions. Care should be taken to ensure that only current prescribed required medicines are ordered to prevent an overstock.

Each medical practitioner's surgery will have a different way to do this. Check what is the most suitable and efficient. In particular, find out how many days notice the surgery needs to process the repeat prescription request.

- Repeat prescriptions required are listed in the left half portion of the "Medication Ordered and Received Record" (*Appendix 12).* The staff member placing the order for medications must ensure that a copy of this form is retained and available in the service. Take a copy of this form before forwarding it to the medical practitioner's surgery.
- It is important for the manager/designated person to see the prescription forms when received from the medical practitioner surgery to check them against the items that were ordered via the "Medications Ordered and Received Record", before they are submitted to the pharmacy. This is to ensure that all medication ordered has been

correctly prescribed and to ensure that no new medication has been added by mistake.

- If there are unexpected changes these should be checked with the medical practitioner.
- The service should present the prescription to the pharmacy in sufficient time for the medication to be prepared and delivered before the stock in hand is finished. The pharmacist will be able to state how long this normally takes.
- On receipt of the medication, staff in the service must check the dispensed medication against the list of prescribed medicines ordered referencing the "Medications Ordered and Received Record" and completing the right half portion of the record. It is important to be attentive as changes can arise after checked prescriptions have been sent to the pharmacy. If the medication received is different from what you expect, check with the supplying pharmacist.
- When the medication check is complete, the "Medication Ordered/Received" form is signed and any corrective action necessary is recorded, comments section. When staff are satisfied the medication received is correct, the medication can be entered into the Medication Stock Book as usual.

Medication Stock Book - Overview

This holds record of all medications entering or leaving the service setting and the total amount of medication in stock at that time.

When medications are received from the pharmacy, sent home with the person for the weekend, received from home or returned to the pharmacy for disposal for e.g. each transaction **must be** recorded in the Medication Stock Book. The Medication Stock Book ensures an audit of medicines passing through the service can be conducted.

To keep transportation of medication to a minimum, and the subsequent movement of medication in and out of a service, ensure the other service location/home have their own supply.

Records should be maintained in the Medication Stock file for **one year** then archived per the organisation's "Record Management Procedure".

Instructions for using Stock Control Form – *(Appendix 4)*

Where a number of people's medication information is held in the Medication Stock Book, organise it alphabetically using dividers to clearly separate each person's information.

Each medication has its own dedicated Stock Control Form e.g. all Epilim received/sent out for a person is recorded in one page until it is full (provided there are no changes to its strength in which case a new page is initiated).

Medications Details Column

- Enter name of the person for whom the medication is prescribed.
- Enter name of medication.
- Enter the strength of medication, i.e., 25 mg, etc.

Amount IN Columns

- In the "Received From" column, enter the name of person the medication was received from.
- Enter the quantity of medication received in the "Number Received" column.
- Enter the date and time this medication was received in the "Date" column.
- Enter the total number of medication held in "Total on Hand" column.
- Sign name in the "Signature" column.

Amount OUT Columns

- Enter the quantity being sent out in the "Number out" column.
- Enter the date and time this medication is being sent out in the "Date" column.
- In the "Destination" column enter where the medication is being sent to.
- In the "Total on Hand" column enter the quantity of medication remaining.
- Sign name in the "Signature" column.

Additional Stock Control forms can be sourced via - Intranet – Procedures/Forms – Medication.

Compliance Aids e.g. Blister Pack

Services using medication compliance aids record when medication arrives and leaves the service in the Medication Stock Book.

In this instance, one Stock Control Form holds the information about all the medications contained in the compliance aid.

Medications Details Column

- Enter the name of all medications contained in the blister compliance aid, list each.
- Enter the strength of each medication.
- Enter dated the medications was prescribed by medical practitioner, if known.
- This is also the opportunity to visually check if all dispensed medications are present in each container/blister.

Amount IN and OUT Columns

- Count how many days' medication exists and enter this figure in the Number Received and Number Out column as it applies.

Medication Stock Book Recording - people who look after their own medicines.

- People, who collect, administer and store all their own medicines are not required to have these entered into the service medication stock book.
- Should the person be able to self administer and store their medicines but be unable to collect from the pharmacy and need staff support to do this, then details of the medicines collected are entered into the medication stock book and signed out to the person thereafter.
- Should the person be able to collect his/her medicine and be able to administer one or two items but not others, record all of the medicines collected in the

medication stock book and then sign out the items the person self administers per Self Administration of Medication Support Plan *(Appendix)* 1 agreement.

- Should the person be able to collect their medicines but need total support to take all their medicines then these are entered in the medication stock book and stored securely on behalf of the person in his/her own room or elsewhere.
- Should the person require total staff support for all aspects of their medication, enter these in the medication stock book and store securely in his/her room or elsewhere.
- Unused medicines should be returned to staff for disposal. A person who is self administering a medicine and who, for example, no longer needs to apply an ointment as the condition has cleared up, needs to return it to staff. This item is entered in the medication stock book to show it was received from the person and signed out when it is sent to the pharmacist for disposal. The arrangement for disposal will be recorded in the person's "Self Administration of Medication Support Plan".

Cold Storage Records

Medicines which require cold storage should be identified by the supplying pharmacy and, upon delivery, be placed in a refrigerator in order to maintain the 'cold chain'.

To ensure the refrigerator is operating between 2^0C and 8^0C at all times, a maximum/minimum fridge thermometer **must** be used. See **Maximum/ Minimum Fridge Temperature Recording Chart** (*Appendix 13)* to ensure the refrigerator continues to operate as required. Daily temperature checks are required.

Prescribed Medications (MP1)

White Medicines Prescription Sheet (MP1) See *(Appendix 2).*

The white medicines prescription sheet (MP1) details all the medications prescribed for the person. This includes all regular; As Required PRN medication and Short Term Medication. All regular medication is listed on one side while As Required PRN medication and Short Term Medication is listed on the other. The MP1 is written up by the medical practitioner in black ink or otherwise so as to be indelible and it contains:

- The name, date of birth, addresses, medical practitioner's name and address, allergies and photograph of the person for whom the medicines are prescribed.
- The date medication commenced.(where known)
- The name of each medication will be written beside a letter (A, B, C, D. etc.) listed in the first column. The generic name of the medicine is used. In circumstances where a non generic medication is indicated by the person's clinical condition, it should state the brand name and "Do Not Substitute" alongside.
- For the - As Required (PRN) Medication and Short Term Medication - side of the MP1, the name of each medication will be written beside a letter (A1, B1, C1, D1. etc.) listed in the first column. The number 1 is used beside the letter to ensure no confusion arises with regular medication prescribed.
- The strength of the medication and route of administration.
- The frequency of medication administration

- Time(s) of day/week/month medication is to be administered.
- Prescriber's signature
- Medication discontinued - date
- Medication discontinued - signature.
- A date for MP1 review is captured at bottom of the form.

A list of the approved prescribing abbreviations such as BD, TDS, Mane and what they mean can be found via Intranet- Health.

Recording Medication Administered (MR2)
Administering Medications - use the **Green Drug Recording (MR2)** sheet, see *(Appendix 3).*

The green Drug Recording sheet (MR2) is used to hold record of all medications administered to the person, at what time and by whom. The manager of service or person who has been assigned that responsibility, enters the time that medication is to be administered in the space designated at the top of columns as per prescriber's instructions on MP1.

Each medication prescribed has an identifying letter on the MP1. Each identifying letter is entered in the MR2 as that medicine is administered by staff. The MR2 also has a notes section. This is where one records the refusal or withholding of medication, spoilt dose for example. An Incident Report, per the organisation's *Incident Reporting Procedure (WCA 1.10) is also completed.*

These two sheets, MP1 and MR2, are used together each time medications are being administered. The MP1 is checked to ensure the prescriber's instructions are followed and the administration of same is recorded in the MR2.

A new MR2 recording sheet must be used/started whenever a new MP1 Prescription Sheet is issued. The out of date MP1 should be attached to the last MR2 Recording Sheet which was used up to that date.

The MP1 and MR2 sheets are legal documents. If problems occur regarding a person's medication, these forms will be taken as an accurate record of all medication administered and will be referred to for such information. These documents are for the protection of staff as well as the person and it is in the interests of both that they are completed accurately and at the time medicines are administered. All medicines administered to the person are recorded immediately on the MR2 and initialled by the administering staff member. All entries will be made using indelible ink. No pencil or tippex should be used.

Records - People who Self-Administer Medicines
People who administer all their own medicines should be clearly identified. Their "Self-Administration of Medication Support Plan", *(Appendix 1),* will be placed in their I.P. Folder. A record must be maintained of all the medications the person takes, dosage

strengths etc. so that there is full knowledge of the person's medication regime at any given time.

For people who partially self-administer their medication, their MP1 holds record of all medication prescribed. Their "Self Administration of Medication Support Plan" *(Appendix 1)* and their MR2 sheet should show clearly which medications are administered by staff and which are administered by the person. These records are held in the person's I.P. Folder - Medication Section.

- All medications staff administer to the person are entered on the MR2 recording sheet.
- In the MR2 notes section, the letters – SELF- along with the corresponding MP1 identifying letter are used to signify which items are self administered.
  For example, an individual has four medications written up on the white MP1 sheet. The letters in the first column of the MP1 A, B, C, and D identify each medicine. A, B, C are administered by staff and this is recorded in the green MR2 sheet and initialled by the administering staff. The fourth medicine is a topical preparation for a skin condition that the person applies without staff support. Therefore D is written only in the notes section as follows: D= Self

When staff place their initials in the space provided on the MR2 sheet, it is to confirm **only** the medications they have administered to the person.

When a Medication is finished

It can be difficult at times to access the prescriber when a short term medication has ceased and one needs to have it confirmed as finished on the MP1. Given these circumstances proceed as follows:

- Where a medical practitioner writes in the Medicines Prescription sheet, MP1, that the medication should be ceased when the course is finished, e.g. a course of antibiotics or a topical cream, it is not necessary for the medical practitioner to be contacted to sign off the medicine.
- The person in charge draws a line through that medicine on the MP1, signs and dates it.
- However, if there is any doubt about the end date or uncertainty about the person's condition, consult the medical practitioner.

When the MP1 needs to be re-written - Transcribing

When the MP1 is full or has a lot of changed/discontinued medication listed it is necessary to have a new MP1 written up and signed by the prescriber.

- The MP1 **must not** be rewritten by staff as it is recognised that transcribing any clinical information is a high risk activity and there are serious risks of inadvertent transcription errors or duplication of medication. Best practice indicates that the responsibility for this lies with the prescriber to prevent the possibility of error.
- There is **one exception** to this rule. An Bord Altranais agus Cnáimhseachais has issued guidance to registered nurses which state "A nurse who transcribes a prescription is professionally accountable for their decision to transcribe, and for the

accuracy and the safety of the transcribed information. It is expected that nurses engaged in transcription have clinical knowledge to recognise a potentially dangerous dosage or therapeutic duplication" (*Draft Standards for Medication Management for Nurses and Midwives, 2015*). Additionally, prior approval must be given by Western Care to permit the transcription of an MP1 by a nurse in its employ.

The nurse transcribing the MP1 should sign and date it and have the prescribing medical practitioner check and co-sign it within a timeframe of 48 hours.

If the transcribed MP1 is ambiguous or unclear, verification and confirmation must be sought from the prescriber or pharmacist before administering the medication to the individual.

The practice of transcribing is subject to audit.

Recording - more than one location involved

- When the person travels daily between service settings e.g. from Day Service to Residential Home/Respite and medication is given in both places then the MP1 and MR2 should accompany the person daily to these locations. Where this recommendation would be complex given transport arrangements, local derogations can apply.
- Where one service provides another service with a photocopy of the Medication Prescription, MP1, the person in change of the service maintaining the original is responsible for ensuring that each time the MP1 is changed, a new copy is sent to the other service.
- For some people travelling between Day/Residential/Respite services, they may be able to carry their own MP1 and MR2 sheets.
- When the person attends Day or Respite Services from home, family are requested to send the completed MP1 sheet to the service. The service photocopies the MP1 sheet and returns the original MP1 to the family, to be used again whenever they need to attend a medical appointment.

Storing Medication Records

The completed medication MP1 and MR2 sheets must be maintained in the person's I.P. folder for a period of one year and are then archived per the organisations "Record Management Procedure"

Recording - PRN Medicine – e.g. Analgesic

Where a medication is to be taken PRN (as required) there needs to be clear direction concerning the circumstances in which it is to be given. "Protocol for Administering PRN Medicine", *(Appendix 5),* must be completed and stored with the person's MP1. This needs to be revised if there are any changes to the prescription and annually otherwise.

Recording - PRN Medicine to Control Behaviour (Chemical)

In some instances the use of PRN medicine to manage a person's behaviour may be viewed as a form of chemical restraint.

To guard against this occurring it must only be given in the circumstances as outlined in 1.9 Listening and Responding to People *(Appendix 1- Protocol for administering PRN Chemical Restraint to manage behaviours of concern/medical appointment)*
In addition staff must ensure that:

a) All administrations of PRN for chemical restraint are recorded on an Incident/Injury form and the PRN box must be ticked appropriately.
b) The name of the medicine and the dose administered must be recorded on the incident form.
c) The circumstances in which the PRN chemical restraint was administered must be fully explained in the narrative section of the Incident form.
d) Where people are administered PRN for chemical restraint prior to a medical/dental appointment evidence must be shown of the steps taken to desensitize the person to the aversive experience and/or the non-medication methods employed to reduce the person's stress and anxiety associated with particular medical/dental appointments.
e) All administrations of PRN for chemical restraint that occur in the organisation must be collated and presented to the Executive Director on a quarterly basis.
f) Where a person is prescribed PRN for chemical restraint and it has not been administered in the previous six months, the Consultant Psychiatrist must be informed and the advice of the Psychiatrist must be sought in relation to having the prescription discontinued.

Refer to "Enabling People to Enjoy Best Possible Health" Policy.

Recording Medication Related Incidents
An Incident Report in accordance with the organisation's *Incident Reporting Procedure* must be completed in such circumstances.

A Medication Administration incident refers to a range of events that are broader than errors. They include the following:

1. Refusal to take Medication
2. Administration error - any deviation from how medication is prescribed and written up in MP1 i.e. different time; different dose; different tablet ;different person; missing a dose (person vomiting following medication administration or forgetting to give medication)
3. Pharmacy error
4. PRN (analgesic), non-prescribed
5. Other (spoilt doses, recording errors, stock errors, tablets found on floor etc.)

The Front Line Manager (FLM) is required to review all incidents in their service each quarter to determine if there is a pattern or trend; this includes medication administration incidents.
Whenever a medication incident occurs, consideration should be given to how this can be avoided in the future. This information should be included in the incident report and should form part of the learning from incidents that inform improved practice. The quarterly review of incidents by the FLM should address any patterns arising from medication administration incidents.

All medication administration incident reports are reviewed and collated centrally and form part of the quarterly organisational incident/injury report.

Recording Topical Preparations
Topical preparations are also medication and their application must be recorded on the MR2 in the same way as all other medication.

Additional Recording Issues for Day/Respite Services
When a person takes medication during the time they attend Day/Respite service, family are responsible for sending in the MP1 sheet to the service. However in the event of a signed prescription sheet not being available from home, the person in charge can follow this up with the relevant medical practitioner and record the outcome on file.

Where there are ongoing issues regarding the MP1 sheet not being available from home, a meeting with the family and relevant personnel should take place to discuss the issue.

Disposal of Medication Record
Medication should be disposed of as soon as a course of treatment is completed, discontinued or when the expiry date of the medicine is reached, or the person dies. It is *advised* that all medications returned to the pharmacy should be for an individual rather than a number of people.

When returning medication, the **"**Medication Returned to Pharmacy" form is used (*Appendix 9).* Note the person's name on the form. This record is signed and dated by pharmacy staff and it is stored in the Medication Stock Book, alongside the person's other medication information. It is archived after one year in accordance with the organisation's *"Record Management Procedure"*

Other Medication Records
A number of other important medication records, referenced elsewhere in this policy, are also used to support people's medication requirements. These are:

- Self Administration of Medication Support Plan - *Appendix 1*
- Protocol for Administering PRN Medicine (non psychotropic) *Appendix 5*
- Administering Medication in Food and Drink because of Swallowing Difficulty *Appendix 6*
- Administering Medication Covertly in Food or Drink - *Appendix 7*
- Administration of Homeopathic/Alternative Medication - *Appendix 8*
- Medicines Returned to Pharmacy - *Appendix 9*
- Medical Consent Form - *Appendix 10*
- Medication Audit Checklist - *Appendix 11*
- Medication Ordered/Received - *Appendix 12*
- Maximum/ Minimum Fridge Temperature Recording Chart - *Appendix 13*

The organisation's Policy - *Enabling People to Enjoy Best Possible Health* provides further important direction when supporting people's health needs. Policy extract as follows:

***My Health Action Plan**:*

- ***My Health Issues/Long Term Conditions** – What are the person's health issues/conditions. How does this affect the person and what are the support needs.*
- ***My Immunisations** – List any immunisations the person has had/needs to have.*
- ***My Family Health History** – If known, are there any family illnesses or conditions that the person/staff /healthcare professionals need to be attentive to/aware of?*
- ***People I see about my Health** – Who, when and why the person attends health appointments. When next appointments are due to occur.*
- ***My Medication** – Medication the person takes, why and any side effects. When is next review due?*
- ***Medical Appointment/Admission Form (MAF)** - Staff must track health appointments and admissions attended throughout the year. These must be recorded using this form. This tracks appointments attended and/or admissions, records the decision/result and identifies when the next appointment is due.*
- ***Health Condition Management Plan** - When the person has a diagnosed health condition such as Epilepsy, Diabetes, Asthma, Constipation or an Allergy, for example, a management plan for that condition must be completed by Named Staff which clearly outlines the nature of the condition, how it affects the person, the risks associated with the condition and the strategies/practices that will be used to manage it. For a template for a particular health condition, - refer to Intranet – Health -or contact the Training Department.*
- ***Health Action Planning Form** – Review all the health information contained in the Health Action Plan. The Named Staff should assist the person to stay informed about and access health checks that are consistent with their age and risk factors using checks available in -Preventative Health Care Checks- and any other guidance pertinent to the person's health condition.*

The Health Action Planning Form will help identify what action needs to be taken to help the person stay healthy or become healthier.

Medication Audit Checklist

The purpose of the Medication Audit Checklist, (*Appendix 11)*, is to assist services to review their medication systems and to help identify areas that may require improvement. Some services will need to conduct this review quite frequently if they handle a large amount of medication while others with little/no medication to handle will need to do this less often. However in the interests of good and safe practice, a medication audit should be carried out at least once every 3 months.

6. Medication Reconciliation

Medication reconciliation is the process of creating and maintaining the most accurate list possible of all medicines a person is taking – including drug name, dosage, frequency and route – in order to identify any discrepancies, deletions, omissions, additions and to ensure any changes are documented and communicated, thus resulting in a complete list of medicines (HIQA 2014).

Medication reconciliation aims to provide people with the correct medications at all points of transfer between hospital/health services and where they live.

It is considered complete when each medicine that a person is taking has been actively continued, discontinued, held or modified at each point of transfer, and these details have been communicated to the next care provider.

There are three steps in the medication reconciliation process;

1. **Collecting** – this involves collecting information about the person's medications and medication history, allergies, treatment and ongoing support provided by medical and other professionals.

2. **Checking** – This is the process of ensuring the medications, doses, frequency times and routes, etc. that are prescribed for the person are correct. Any anomalies between the pre – admission list and those subsequently prescribed and written up on the MP1 need to be resolved. Identify any difficulty experienced by the person with current medications, identify any known allergies and any previous adverse drug reactions.

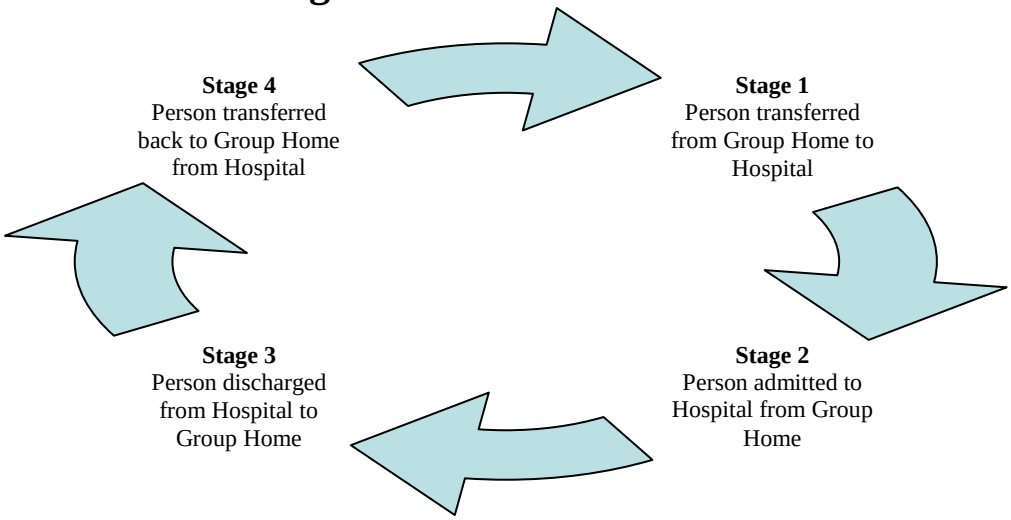
3. **Communicating** – This is the final step in the process where any changes that have been made to the person's prescription are documented, dated and communicated to the person into whose care the person is being transferred.

Before the person leaves the service or transfers elsewhere, such information must be provided by the person in charge to the next care provider. Along with the person's MP1, PRN protocols etc. "My Health Action Plan" is a valuable information source. As well as providing detailed information about the person's health, medications (including nutritional support or herbal products) treatments, appointments etc. it also holds information about any health conditions including any invasive techniques/processes/response strategies in place for the person.

The medication reconciliation process starts when the need arises to transfer or move the person from one service to another, e.g. residential service to hospital. It is a continuous process and takes place when the person is admitted to and continues whenever the person is again moved, transferred or discharged.

Medication reconciliation can ensure that people and those treating them have accurate, up to date information on medications at all points, see under.

Stages of Medication Reconciliation



Medication Reconciliation – When is this required?
This is required at each of the four stages identified above. It is required when:

- A person is being admitted to hospital or is returning from hospital.
- A person about to take up a place in a residential service for the first time, coming from a health care setting or their family home, for example.
- A person being discharged from a residential service to another service provider or to their family home.

Medication Reconciliation – What is involved?
For vulnerable people likely to need admission to hospital because of existing health condition, it is necessary to have pre-prepared information which includes:

- Name, Address, DOB, Medical Card Number, Religion,
- Names, roles and contact details of other medical professionals involved e.g. neurologist, physiotherapist.
- Doctors name, address and contact details
- Family – NOK and contact details for primary, secondary and tertiary contact people.
- Allergies
- MP1 and Copy of MR2 showing when meds were last administered.
- My Health Action Plan to include any Health Condition Management Plan e.g. Seizure, Diabetes, Constipation, Management Plan.
- Previous Operations/Illnesses
- Fears/Anxieties

- How person communicates
- How person takes medication
- Expressing pain
- Mobility
- Personal/intimate care
- Sight and hearing
- FEDS recommendations concerning food texture, fluids, swallowing medication.
- Safety matters
- Sleeping routine
- Likes and Dislikes

See Intranet – Health – for Hospital Passport document template.

7. Supply of Prescribed Medication

Prescription Forms

The majority of medications received are those that have been prescribed for the person by their medical practitioner on a GMS prescription sheet. Prescription forms are signed by the medical practitioner, the signature is the authority to supply and to administer the medicine.

The prescription record form includes:

a) The person's name.
b) The date.
c) The name of the medicine.
d) The dosage to be administered.
e) The strength of the medicine.
f) The time of administration.
g) The frequency of administration.
h) The route of administration.
i) The period over which it is to be administered e.g. short term medication

The prescription shall not be transcribed.

- Medication shall only be commenced or discontinued by a medical practitioner with the following exceptions - Non Prescriptive Medication and Withholding Medication in case of adverse reactions.

- The person in charge at any given time is responsible for ensuring the white prescription sheet (MP1), *(Appendix 2*), has been signed by the medical practitioner for all medication.

- In exceptional circumstances, where the medical practitioner has not furnished staff with a prescription for medications that are required for the person, the onus is on staff to contact the medical practitioner and make a request for a prescription. The medical practitioner can verbally instruct the pharmacist of the contents of a prescription to dispense **provided that a prescription form is supplied to the pharmacist soon after.** The medical practitioner shall record same on the white prescription sheet – MP1 – at the earliest possible opportunity

and no later than 72 hours (this is to allow for the possibility of a weekend or public holiday)

Repeat Prescriptions
Many people are prescribed medication on a long term basis but this should not be taken to mean that such medication can or should be taken 'ad infinitum'. Any uncertainty about whether a prescription can be repeated should be discussed with the person's medical practitioner. The pharmacist may also give additional advice about repeat prescriptions but this is ideally a matter for discussion with the medical practitioner. See also Medication Review.

Generic Substitution
Generic substitution, under The Health (pricing and Supply of Medical Goods) Act 2013, permits pharmacists to substitute medications which have been designated as interchangeable. Previously, when a specific brand of medicine was prescribed, the pharmacist could only supply that brand.
The Act allows pharmacists to substitute different versions of some prescribed medication which are less expensive generic versions of brand name medication.

If the person needs a particular brand of medicine for medical reasons, the prescriber can write "Do not Substitute" on the prescription and the proprietary or brand name will be dispensed.

Quantities
Staff may, on behalf of the person, make a request to the medical practitioner for further supplies of medication on a 28 day basis however different pharmacies will have different practices in relation to this and amount supplied will depend on pharmacist and their typical practice.

Quantities of medication requested must not exceed a 28 days supply because of the risk of excessive stocks accumulating. This can result in overloading of the available storage space and give rise to possible confusion when staff administer medication.

Excessive quantities of medication also lead to a waste of resources when they are discontinued or changed. This advice should also be given to people who have custody of their own medication and who may order their own medication. If there are large quantities of medication in a house it may be useful to consider collecting medication more frequently.

"When Required" (PRN) Medication
If a person is taking "When Required" (PRN) Medication, it can be carried forward at the end of the month to the next month and it does not have to be discarded providing:

- The medication is still being prescribed by the medical practitioner at the same dose and frequency
- The medication is in an original pack with an expiry date so it can be checked that the medication is still in date. Examples include paracetamol tablets, salbutamol inhaler etc.

If the stock of 'When Required PRN' medication held is considered sufficient to meet needs for the following month then staff need to ensure that this medication is not ordered along with the other repeat medication. This is to reduce waste and unnecessary costs.
As with all medications held in a service, The Medication Stock Book will show what quantities of PRN medications are held at any given time.

Ordering Controlled Medication
These are prescribed and dispensed in the same way as other medication. Allow extra time for these prescriptions to be hand written as there are particular legal requirements the prescriber must observe.

Prescription - Left Outside of Pharmacy Opening Hours
If a medical practitioner visits a person out of normal hours, at night or at the weekend, and requires the person to receive new medicine immediately, he/she will leave a prescription for the medicine and possibly a supply of the first few doses. If an urgent prescription is required outside of normal pharmacy opening hours, staff need to know how or where prescriptions can be obtained. This information together with relevant pharmacy contact telephone numbers must be available at all times.

If it is known that it would not be possible to obtain medication out of hours because no arrangements exist locally, this should be discussed with the visiting medical practitioner before he/she leaves.

Remote or Telephone Orders
These were formally known as verbal orders. The only acceptable time a remote or telephone order is taken from a medical practitioner is in an emergency situation where there is an immediate unplanned need and the prescriber is unable to issue a new prescription in person at that time.
Remote/telephone orders have a higher potential for error as these orders can be misheard or misinterpreted. Safety is the overriding principal in accepting remote or telephone orders.

Best practice for the receipt of a remote or telephone order involves the medical practitioner repeating the order to a second staff member, where this allows.

A record of the remote or telephone order, with time, date and signature of recipient, should then be made and stapled to the person's MP1 so that it is available to the person administering the medication,

The medical practitioner should provide the original prescription within 24 hours (72 hours for weekends and Public Holidays) and also document the changes to the person's MP1 within 72 hours, maximum.

Emergency Supplies of Prescription Only Medication (POM)
The pharmacist is permitted to make 'Emergency Supplies' of prescription only medication available under very strict conditions. Emergency supplies may be made at the request of a prescriber or at the request of a person, or staff acting on his/her behalf.

In the latter case, the pharmacist must be satisfied that:

- There is an immediate need for the medicine and that it is not practical to obtain a prescription.
- That the medicine has been prescribed on a previous occasion.
- No more than five days medication can be supplied (except for complete packs such as a cream or an inhaler)
- Controlled medication may not be supplied in this way.

Medication for Emergency Use
Supplies of prescription-only medication for emergency use should not be kept in stock except for specific products for named individuals – e.g. Stesolid, Insulin. Only staff who have received training may administer such treatments.

Change to Prescription
Any change to a prescription has to be made by the prescriber. Requests made by others, either verbally or in writing, to change any aspect of the person's prescribed medication regime cannot be accepted.

Medication Purchased by Person - Interaction with other Medication
People may sometimes decide to purchase medication. The use of purchased medication in addition to those prescribed by the medical practitioner may constitute a health risk due to interactions between medications. Additional medication may have an adverse effect on the condition being treated. The person should therefore be asked not to purchase medication without first discussing this with his/her pharmacist who will advise whether or not it is safe to take these simultaneously.

Any medication purchased in this way must be stored in the same place as prescribed medication.

Oxygen
If a person is assessed to need oxygen, e.g. when admitted to hospital then the medical practitioner will provide information about its supply, usually via the County Clinic. The supplier will provide the necessary hazard awareness information and user instructions. As there are risks associated with the use of oxygen, e.g. fire risk, the person in charge will need to review the service setting from this perspective. See Intranet – Health – Oxygen for further safety advice about oxygen in the home.

As with other medical conditions, A Health Condition Management Plan is required for any person using oxygen. A template for this is available via Intranet – Health –Oxygen.

8. Obtaining Dispensed Medication

The role of the pharmacist
The role of the pharmacist is to dispense prescribed medicine upon receipt of the prescription. Dispensed medication will be clearly labelled by the pharmacist and state: Individual's name.

a) Date

b) Name of medicine
c) Strength of medicine
d) Dosage to be administered
e) Frequency of administration
f) Expiry date
g) Storage requirements, where applicable

The pharmacist is always available to provide advice on medication concerning its safe custody, storage, administration and disposal.
In addition to the Patient Information Leaflet (PIL), they are particularly good sources of information when new or unfamiliar medications are prescribed, when special requirements for administration are involved or when particular risks exist or side effects may arise.

The pharmacist will send patient information leaflets with the medication ordered.
Pharmacists keep records of all prescriptions dispensed, unless an individual requests otherwise. Reference to these records enables the pharmacist to give valuable advice and to respond to queries regarding medication.

Each service setting should have reference sources available which allow staff to learn about the medication they are administering such as Mims. See also information sources listed on the organisation's Intranet - Health.

Medication Supplier – Personal Choice
The person has the right to have his/her prescriptions dispensed at a pharmacy or dispensing medical practitioner of their choice and their preference should be supported.

Containers for Medication Administered by Staff
Different names are used to describe medication administration compliance aids such as monitored dosage systems, blister packs, medication systems, unit dose packages, multi-dose packages and dose administration aids.

The pharmacist will make an assessment of a suitable container for each medicine. Ideally, the pharmacist should meet the person who takes their own medication to discuss the most suitable dispensing container. Any queries should be discussed with the pharmacist.

It is quite acceptable for medication to be dispensed in traditional bottles and packs. If this system is used the medication for the person should be kept together in drawers or boxes in the medication cabinet/locked press in the person's room.

Medication administration compliance aids are used solely for oral solid dosage medications. If a new dispensing system is introduced, the supplying pharmacist will need to demonstrate the system to the person and/or staff.

Not all medications are suitable for inclusion in a Blister Pack/other compliance aids such as large dosage forms and liquids, short course of antibiotics or those that become unstable.. The pharmacist will make a judgment at the time of dispensing about the best option.

Medication to be administered 'when required, PRN' should not be packaged into a compliance aids as their expiry date will be affected by the repackaging and, while they will be quite stable for several weeks, tablets or capsules should not be left for months at a time.

It is imperative that all medication packed into a compliance aid can be identified. Some systems are the type of which only one tablet is put into each pocket, thus identification is by referral to the label on the card containing the tablets or capsules. In some systems, however, tablets and capsules may be placed together in a pocket to be given at a particular dose time. This type of system has time saving advantages, however, tablets and capsules which are similar in appearance and cannot be easily identified should ideally not be put together. Labelling should enable individual medication to be identified. As staff need to be able to identify each medicine contained in the blister pack, the pharmacist may be able to provide a picture of each to aid identification.

The use of compliance aids does not remove the need for staff to be aware of the medication an individual takes.

In the event of a change to any of the person's medication, the entire compliance aid will have to be returned to the pharmacy for adjustment/dispense new medication and repackaging.

Containers for People who Self-Administer

Medication dispensed for people who administer their own medication may be provided in standard containers, i.e. original packs, or glass or plastic bottles which will have child-resistant closures. If the person has difficulty removing such closures, ordinary caps can be supplied if the pharmacy is notified of the problem. Alternatively, people who administer their own medication may require a compliance aid. These should preferably be filled at a pharmacy but all pharmacies may not offer this service. Some people may be able to fill their own. Alternatively, family members or a friend may fill a compliance aid for the person.

Under no circumstance should staff put medication into compliance aids for use by a person who administers his/her own medication.

Labelling

Pharmacists have a legal and ethical obligation to label all dispensed medication.

Every label should carry the following information:

a) The name of the person.
b) The name and strength of the medicine.
c) The quantity of the medicine supplied.
d) The precise dose to be administered, (clarify if not clear).
e) Any mandatory warnings, (e.g. take with or after food).
f) The date the medicine was dispensed.

- Labels **must not** be altered in any way by staff unless instructed to do so by a medical practitioner.
- In exceptional circumstances when a medical practitioner dispenses medication directly to the person, staff should request that the medical practitioner identify the medication and write the directions on the medication container in this instance. Staff should also ensure that a supply of blank labels is available should the medical practitioner dispense on a home visit. The medical practitioner should be asked to identify the medication and its directions using the blank label which can be placed on the dispensed medication container.
- It is the role of the person in charge to ensure the pharmacist provides a second, labelled container with medication to be administered when the person attends a Day Service.

Changes to a Dose

Occasionally, a medical practitioner may issue a remote or telephone order (formally known as a verbal order) to change a medication or dose. A written protocol **must** be set up for the recording of remote or telephone orders received by the staff on duty whether from the medical practitioner in person or by telephone. For verbal orders received via telephone, written confirmation should be requested to be sent by email/ scanned document/fax if possible.

A visiting medical practitioner should be asked to sign or initial a note of the change. Details of the change should be recorded on the MP1, and also recorded and highlighted in such a way that the change is obvious to anyone who may be administering medication after the change.

The name of the medical practitioner authorising the change and the member of staff making the change **must** be recorded. The member of staff must record the time and date the information was received and sign the document. This must be attached to the MP1 for reference by the person administering medication.

NB. Only **changes** to medication can be authorised by a medical practitioner verbally. A new Prescription Only Medicine (POM) cannot be initiated in this way**.**

Clarity of Dosage Instructions on Labels

Instructions on labels should be clear and unambiguous. 'As directed' is unacceptable and should be clarified with the medical practitioner, pharmacist. Instructions such as 'when required' should be expanded with a reason, e.g. 'when required for pain'. The dose range and a maximum dose should be stated.

Complicated dosage instructions which would not fit onto a label should be discussed with the medical practitioner. Clear instructions should be put into the person's *My Health Action Plan* - Health/Medication section of the person's I.P. and also attached to the Medication Prescription sheet (MP1) for the duration of its administration.

Labels on products for application to the skin should indicate the areas of the body to which it should be applied. This is particularly important for a person who has several different creams, ointments or lotions, many of which may be potent.

A container **must** be returned immediately to the pharmacist for re-labelling if the label is detached.

Medication Received from Home
For people living at home and attending Day and/or Respite Services arrangements must be made with the person/family/guardian regarding medication to be sent to the service. Agree when/how frequently they will be sent. Only medication received in original packs and bearing a recently dated pharmacy label can be accepted for administration by staff.

When entering details in the Medication Stock Book, particular attention should be paid to the medication strengths and dosages. Look for any changes from those listed previously or as written in the MP1. If a change is detected, this should be confirmed with the family, medical practitioner or pharmacy. An examination of the medication should also be made to ensure that the pack or bottle contains the tablets or capsules described on the label. If in doubt, contact the pharmacy.

Patient Information Leaflets (PIL's)
It is the responsibility of the person in charge to ensure that the person administering medication is familiar with procedures and has access to information on effects, and possible side effects, of any medication being administered. A patient information leaflet must be supplied by the pharmacy with each medicine, including those supplied with compliance aids. These should be made available to people self-administering their medications and to staff.

PIL's provide a wealth of information and can be a useful reference source if they are filed in alphabetical order in a ring binder using polythene pockets It is further recommended that the counter indications of any medication being administered are photocopied and placed alongside the MP1 and MR2 sheets, so that the person administering the medicine has a way of checking any counter indications easily.

9. Storage of Medication

Storing Medication – Options
All medication should be stored in a locked cabinet/press which is **only** used for the purpose of storing medication.

Where medication will be stored should be determined considering the person's preference, privacy, heat/humidity, ease of access to the medication when they are administered and by how secure they are.

- One way to store medication is to have individual locked presses or drawers in people's rooms. This would be essential for people who take some or all of their own medication but it can also be used where staff give medication.

- Each person's prescribed medication for internal use should be kept together. If medications are received in a compliance aid or in traditional dispensing bottles or packs, those for each person should be kept together in individual drawers, boxes or compartments. Where medications are stored in the person's own room, this will not be required. If two people share a room then two presses or drawers in that room will be required, one for each person's medication.

- Medication for external use should be kept in a separate locked cupboard or within a distinct area within a cupboard (compartment). It will probably be more practical for creams, ointments and lotions which are in use to be kept in the person's own room in any event as it will usually be applied there. The preparations must, however, be kept securely locked within the person's room.

Eye, ear or nose preparations and inhalers may be kept with medication for internal use. That is, they should also be locked away securely unless the person needs to carry the medication on their person e.g. inhaler.

Storage of Medication for Self-Administration
People who have custody of and administer their own medication must keep them locked in the secure storage drawer or cupboard in their bedroom or their personal locker in a Day Service, for example. They may keep medicine containers on their person (e.g. in a pocket or handbag) so long as this does not place other people using services at risk.

People who self-medicate must be asked to keep their medication secure at all times to prevent access by any other person.

Staff **must** be alert to any signs of medication not being kept secure and to report any concerns to their manager.

Duplicate keys for people's lockable drawer or cupboards must be available in case a person loses their own key. These keys should be identified and kept secure at all times.

Storage of Medication to be administered by Staff
All medication **must** be kept secure at all times. Medications which are the responsibility of staff **must**, when they are not being administered, be stored in a locked drawer/cabinet/press/refrigerator box in accordance with the pharmacist's directions.

Key Security
The keys to the medication cabinet must be clearly identified and must at all times be in the possession of a designated staff on duty, who is responsible for their safe keeping. They should not be part of the master set for the service setting.

Location of duplicate keys should be known to staff. The location should be secure but always accessible. Losses of keys **must** be reported to the service manager and, if missing keys are not recovered within a short period, the locks **must** be changed.

In services where staff are unable to hand keys over directly to staff coming on duty (due to make up of rosters), the person in charge will designate a safe place for keys to be placed in the house/service setting. A combination operated key safe is recommended.

Site of Medicine Cabinet
Medication should not be stored at a temperature above 25 degrees centigrade. Medication should not be stored in a humid atmosphere. Permanent storage sites, therefore, should not be located near a heat source or within a humid environment, e.g. above a radiator or in the kitchen. Whenever possible, cupboards should be sited away from windows to prevent observation by passers-by and away from busy areas.

A secure place **must** be available for storage of the monthly medication delivery when it arrives, until it can be checked and eventually put in the cabinet/press in people's rooms from which the medication will be administered.

Cold Storage
Medications which require cold storage should be identified by the supplying pharmacy and should be placed immediately upon delivery into the refrigerator in order to maintain the 'cold chain'.

A separate secure fridge is required, which is only used for medication, when there is a constant need to refrigerate medication that an individual takes regularly e.g. insulin. However, if only occasionally storing medication and if the quantities are small, then a lockable medication box stored in a fridge, away from food stuffs, will suffice.

It is important that the temperature inside the refrigerator does not rise above 8^0C or fall below 2^0C at all times. To ensure this, an appropriate maximum/minimum fridge thermometer **must** be used, an ordinary fridge thermometer will not do. The maximum and minimum temperatures reached in the medication fridge **must** be recorded at the same time each day using the Maximum / Minimum Fridge Temperature Recording Chart ***(see Appendix 13).***

This recording chart is only required to be used when medications are being stored in fridge .It should be kept in a polythene pocket and discreetly attached to the door of the fridge. It is important to be sensitive about displaying signage and other materials such as charts so that it does not detract from the homeliness of a domestic setting.

It may be necessary to adjust the setting of the fridge in order to maintain the correct temperature through seasonal changes. If the temperature inside the fridge varies outside the designated range, the fridge should be checked for correct operation and, if necessary, replaced. Fridges storing medication should be cleaned regularly and defrosted monthly. A cleaning log of this activity needs to be retained.

Certain products, e.g. suppositories and some creams are specified by manufacturers to be stored in a cool place. These products may not necessarily require refrigeration. For further information or guidance consult the Patient Information Leaflet (PIL) and/or the pharmacist.

Eye Drops Requiring Cold Storage

Some eye drops which are required to be stored in a fridge, e.g. Xalatan may be removed from the fridge when in use and will remain stable for four weeks. This information is stated on the patient information leaflet (PIL) in the pack. If eye drops are to be kept at room temperature for use, the date of removal from the fridge MUST be written on the pack and on the MR2, Notes Section, and the item replaced after four weeks.

It must be noted, however, that this does not apply to all eye drops so it is important to refer to the patient information leaflet and the pharmacist's advice.

If the person prefers eye drops straight from the fridge, this will do no harm.

Storage of Insulin

It is recommended that insulin should be at room temperature when it is injected**.** Refer to the Patient Information Leaflet (PIL) in the pack of insulin.

Insulin which is not 'in use' must always to be stored in the fridge. Vials and/or cartridges and pens of insulin which is being used should be stored at room temperature either in secure storage in the person's room or in the locked medication cabinet/press.
It is imperative that insulin remaining in the fridge **and** that which has been removed for use is all fully labelled, as when received from the pharmacy. The service manager should liaise with the pharmacy to devise a system that ensures that every single vial of insulin is labelled and that when a cartridge is removed from the pack and put into an insulin pen, that the pen is contained in a fully, up to date, labelled box.

Most insulin is stable for four weeks at room temperature and some is stable for six weeks. This information is stated on the patient information leaflet. If in doubt, opt for four weeks.

When insulin is removed from the fridge the date of removal **MUST** be written on the container. A note must also be made of the date after which the insulin must no longer be used and the container of insulin **MUST** be replaced at this point.

Quantities of Medication in Stock

As a general guide, 28 days supply of medication should be kept in the service for any individual. The supply for the following 28 days should be requested half way through the period so that a maximum of 42 days supply may be held at any one time.

Prescribed Nutritional Supplements

Nutritional supplements, while not medication, may be prescribed for people in order to improve their nutrition and wellbeing. The prescriber will specify the type of supplement and the frequency with which it is to be given.

Such products should be stored in a designated place, preferably a secure press either in or close to the kitchen area. Each person's supplements must be identifiable. Staff who are responsible for giving nutritional supplements or incorporating them into food do so according to the prescribed directions. A record must be kept in the same way as medication administration is recorded and to provide an audit trail.

Storage of Staff's Medication

Medication used personally by staff while working must be stored safely as they may present a risk to people in that service setting. Medication left unattended/accessible in handbags, jacket pockets or in staff's own car when carrying people, for instance, is unsafe.

Storage of Medication – Transport

People are increasingly using a variety of transport modes and providers to move around their community and access services. This guidance refers to all of the organisations owned vehicles and its staff/volunteers driving these, including its usual busses and drivers. This guidance also applies in many other transport situations, including when staff use their own cars to carry people using services.

- People assessed as capable of safely carrying their own medication without risk to others must be supported to do so.
- Medication is held in safe storage while being transported. Vehicles use a locked compartment while in transit such as a locked glove compartment or a locked portable box similar to a cash box.
- It is the responsibility of the parent/guardian to ensure medication is handed over to the escort/person driving to be placed in safe storage in the vehicle. Depending on circumstances, e.g. for people who do not carry medication often or who may forget, it may be helpful to enquire before setting out on the journey if there are any medications in bags etc.
- The driver/escort is only responsible for medication handed to him/her by parents/guardians, or the person in charge of the service.
- Where the organisation's bus driver/escort is providing the transport he/she will record the medication received in the Bus Medication Log. It will not be necessary to record the amount of medication received, just the name of the person who handed the medication over, the name of the person who it is for and the date. The driver/escort should also record the name of the person who took receipt of the medication in the bus log book.
- On arrival at the destination, the person driving/escort will hand over medication to the person in charge of the service. A designated staff member should be available to the person driving or escort to collect any medication.
- It is the responsibility of the person in charge or designated staff to place medication in safe storage in the service and record the arrival of the medication in the Medication Stock Book.

Transportation of Oxygen
The Health and Safety Officer should be contacted by the person in charge to establish how oxygen may be stored and transported safely.

Storage of oxygen
Oxygen can be kept in the person's room, taking into account the relevant safety advice and precautions advised, see Intranet – Health- Oxygen.

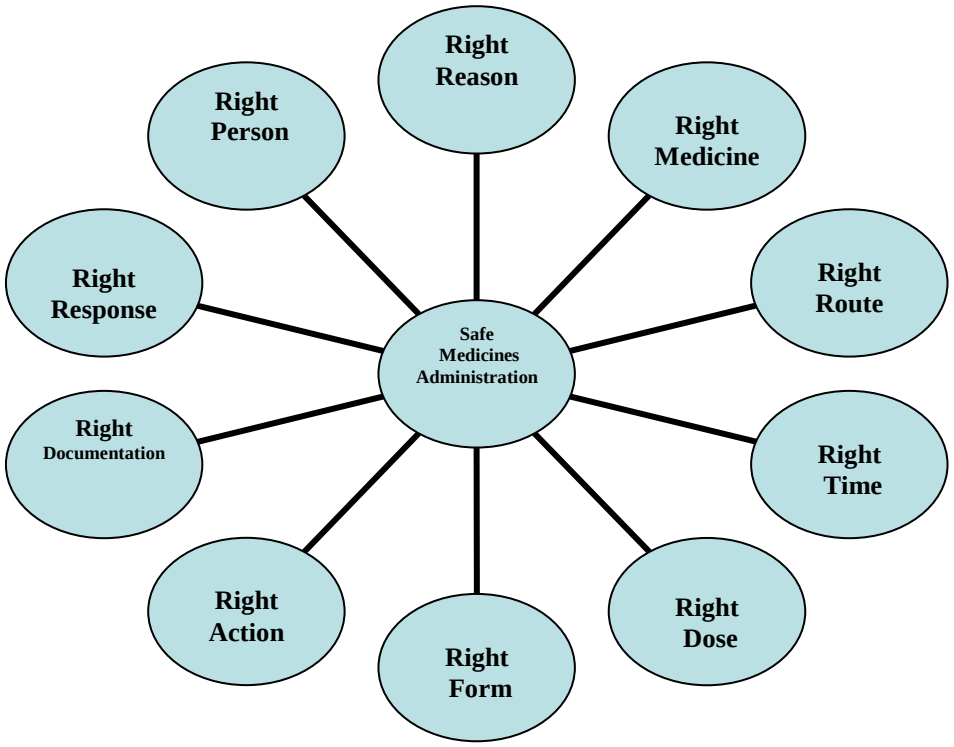
In the event of a fire, the Emergency Services should be told about oxygen and where it is kept. All rooms/areas where oxygen is used should display the required warning notices.

Storage of Dressings, Ostomy Products, Catheters
As these products can be quite expensive, it is important to understand how to use them properly and how to store them until use. Proper use and storage will avoid waste.

- These products should be held in a sufficiently large and locked storage press.
- Generally, supplies should be stored in a cool, dry location. Too much heat can melt or weaken many of the materials used in such products.
- Keep supplies in their original container/packaging. By doing so, the brand name, product identification number, lot and date information are preserved. This is necessary lest a quality control problem arises.
- Store according to manufacturers instructions. Some items may need to be stored horizontally while others will have different requirements.
- Avoid stockpiling supplies.
- Some products have a "shelf life." Check for expiry dates.

10. Administration of Medication

The 10 Rights of Medication Administration which staff must observe



Administration by the Person
People who wish to administer their own medication must be assessed as able to do this and the relevant form must be completed and signed "Self-Administration of Medication Support Plan", *Appendix 1.* People who are able to collect their own medication from the pharmacy should be encouraged to do so if they so wish.

Where staff collects medication, a record should be made of the medication signed out to the person who self-administers via the medication Stock Control Form. Details of the precise arrangement will be documented in *Appendix 1*. When the person has responsibility for taking his/her own medication, controlled medication are treated in exactly the same way as other prescribed medication, no extra records are needed.

The pharmacist should be informed/meet the person who will be administering their own medication and an agreement reached about the most suitable dispensing container to be used.
A variety of aids are available to assist self-medication and this should be encouraged where possible. Advice on appropriate aids and their methods of use to ensure correct doses are taken should be obtained from the pharmacist.

Under <u>no</u> circumstances should staff fill compliance aids for service users who self-administer their medications.

Administration by Staff
Medication prescribed for people should be administered in accordance with procedures described below by using either:

- A compliance aid or
- Ordinary medicine containers.

Medication prescribed for one person **must not** be used for any other person. Administration from a compliance aid and traditional dispensing containers is acceptable. Whatever systems are used, staff involved in the administration of medication must be familiar with the system.

Times of Administration of Doses
Always refer to the dosage instructions on the MP1, the label of a medicine, and possibly to the patient information leaflet when checking the time(s) of doses. If there is any doubt, contact the pharmacist for advice. Pay particular attention to a dose stated as "ONCE daily" to ensure that it is given at the optimum time. Most "once daily" doses are given with breakfast but statins are best taken at night. Some medication, for instance, Lansoprazole and some antibiotics should be taken while the stomach is empty between 30 to 60 minutes before food. Doses should indicate quite clearly how the medicine should be given. A dose such as 'take three daily' is unacceptable as it could mean 'take three at once' or 'take one three times daily'. Such a dose must be clarified before any medicine is given. The pharmacist will have put the medication in a Blister Pack/ compliance aid/ system into the appropriate dose times, however the question of before or with food should be addressed if it is not stated on the label.

Where medicine is directed to be taken 'when required', clarification **must** be sought from the medical practitioner **before** it is needed and the circumstances in which it is to be administered must be written in the "Protocol for Administering PRN Medication" *(Appendix 5)* and held in the person's I.P. Folder.

The circumstances in which PRN medication to control behaviour may be administered must be outlined in Listening and Responding to People *(Protocol for administering PRN Chemical Restraint to manage behaviours of concern and Protocol for administering PRN Chemical Restraint to manage a Medical Appointment)*

Issues concerning the time medications are administered to an individual e.g. the time morning medications are given, must be discussed with and approved by the prescriber. The actual administration times must be reflected in the MR2.

Identification
Where a small number of people live together, there is no difficulty recognising people but care needs to be exercised particularly when new staff are involved. As an additional safeguard, all MP1's must carry a photograph of the person.

Direct Administration
The administration of a medicine **must** be directly from the original dispensed container and only to one person at a time. There must be no "re-dispensing" of doses into secondary containers in advance.

The procedure for administering medication described below must be followed. The procedure also applies to the occasional administration of medication e.g. a PRN dose of Paracetamol.

A list of all staff in the service who are administering medication must be available together with their signatures and their initials so that the identity of people can be established at any time. This includes occasional or relief staff who should ensure that their details are entered on the list before they administer medication in the service. Should staff work across a number of service locations, they must sign the register in each location.

Staff Signatures and Initials List, (page 2 of this policy), must be completed and retained in the service.

Each dose administered by staff **must** be recorded on a MR2 Sheet **at the time it is given**.

- The letter beside each medication on the MP1 is written into the MR2 to identify each medication administered.
- The MR2 creates a record to show the name and strength of the medicine given, the date and time of offering the dose and the initials of the staff who offered the dose. The record must also indicate if a medicine is **not** taken when it is presented and the reason for this is recorded in the notes section, MR2 and in the person's I.P. Folder – Health - Medication section for further follow up and an Incident Injury report completed if indicated.
- If there is an option to give one or two tablets, the record must show how many were taken.
- The recording system **must** provide a detailed picture of exactly what has taken place during medication administration.

Procedure for the Administration of Medication by Staff
If a person takes medication in an unconventional manner or needs more time or encouragement to take their medication, this should be noted in their I.P. Folder-health/medication section so that anyone, particularly new/relief staff, who may be administering medication are aware of the situation.

The Basic Principles

- Before starting out, wash and dry hands thoroughly and ensure that all utensils to be used are clean and dry.

- Have water ready for the person needs to drink. Security of medication must be maintained at all times. Medication must be selected from the medication cabinet/press which must be closed and locked if left unattended.

- The person who prepares the medicine(s) should also witness the person taking the medicine. This is particularly important if a medicine is prepared in one place and then taken to the person in another part of the house/building.
  If medication is to be taken from one area to another e.g. to a person who remains in their room, it is essential that it is carried in a secure container or box so that if it was dropped, it could not be lost or spilled.

- The staff preparing the medication needs to witness all administration including that taken by another staff member to a person's bedroom, for example. The person preparing the medicine should only give the other staff member the medication to take to one person at a time, particularly where a person is elsewhere in the house.

- **1. Right Person** is identified. Great care should be taken when it is known that people with the same or similar names live together. It may be appropriate to mark the MP1 and MR2 Sheets of such people with a warning, e.g. 'Please note we have two ladies called "Elizabeth McDonnell'. In such a situation the date of birth should appear on the MP1. If the person is known by another name that too could be included, Elizabeth McDonnell could be known as Betty. It would be possible to request the pharmacy to express her name as Ms. Elizabeth (Betty) McDonnell on medicine labels. The photograph on the MP1 will also assist identification.

- **2. Right Reason –** the staff member understands the intended purpose of the medication to be administered.

- The person's MP1 and MR2 are present and the medication is located in the cabinet/press.

- **3. Right Medicine -** each medicine is checked in turn matching the details on the MP1 with the details on the dispensing label, properly packaged medicine, strength, dosage instructions, within its expiry date. Any changes in dose are checked for. The person is asked, allergy information on MP1 checked, whether there is a known allergy to the medicine.

- Care should be taken that certain medication which should be given before or after food are given at the correct time in relation to meals. This will have been established with reference to the patient information leaflet and/or or the pharmacist and a record of same maintained alongside the MP1 and MR2.

- **4. Right Route –** administer the medicine via the prescribed anatomical route and site.

- **5. Right Time -** by reference to the MP1, it is established whether a dose is due at this particular time, observing the prescribed times and prescribed intervals.

- The MR2 is checked to ensure that the dose has not already been given.

For ‘when required’ medication, the need for a dose should be established first by discreet reference to the person, to their MP1, PRN protocol and the details of the dose entered on the MR2 as above if given. It is good practice to record in the Notes Section of the MPR2 each time a PRN medicine is offered, even if it is not accepted by the person.

- **6. Right Dose –** confirm that the dose of the medicine being administered concurs exactly with the dose prescribed. While double checking the administration of medication with a colleague is not a statutory requirement, it is advised, where possible, for the administration of high risk medication or where complex arithmetical calculations are required.

- **7. Right Form –** confirm that the form of the medicine that has been dispensed matches with the specified route of administration.

- When taking tablets or capsules, the person should be asked to sit upright or to stand to reduce the possibility of the medicine sticking in the oesophagus (gullet). For the same reason, tablets and capsules should be swallowed with at least half a glass of cold water, hot drinks should be avoided as many medications are badly affected by heat.

- If the person takes more than one tablet or capsule at a time, it will probably be most convenient to place all these into a small medication pot and then hand this to the person. Tablets and capsules should not be handled by staff as this could result in the medication becoming contaminated either by bacteria on the staff’s hands or with residue from other tablets.

- Tablets which are to be dissolved before administration should be put into a glass and sufficient water added to allow them to dissolve completely (about half a glass).They should be stirred and allowed to dissolve completely before being handed to the person.

  It should be noted that some tablets given in water do not completely dissolve but disperse. These should be added to a smaller volume of water, allowed to break up and disperse and the liquid should be swirled around before handing to the person to ensure that no particles are left in the bottom of the glass.

- Liquid medication should be selected in the same way as tablets and capsules, the label being checked against the MP1. The bottle should be shaken well and the dose poured into a small medicine pot and handed to the person.

- Managers should ensure that staff who are required to assist the person with the administration of eye/ear/nose drops and inhalers are competent to do so. The pharmacist can be asked to give guidance. Further guidance in relation to the administration of these medications can be sourced via Intranet - Health.

- Topical preparations, i.e. creams, lotions and ointments, must be applied using protective gloves. This should be carried out in the privacy of a person's room. Directions on the label should indicate how much to use and how long the treatment will last. Topical preparations may be stored centrally in a locked cupboard, or they may be kept in the person's room. If this is done, they must be stored securely and not left on an open shelf. Topical preparations are medication and their application must be recorded in the MR2 in the same way as all other medication.

- **8. Right Action –** ensure the medication is prescribed for the appropriate reason and state to the person the action of the medication and why it was prescribed.

- **9. Right Documentation** -the person who prepares the medication should also witness the person taking the medication. The MR2 should be initialled immediately after each medication has been administered. Where there is a choice of dosage, e.g. 1-2 tablets, the record must show how many were taken. If a dose is not taken, the MR2 should record this, notes section and the reason why it has not been taken. Initials or details of medication not taken must not be added until after administration has taken place. Sign, date and retain all documentation recording the administration of medication.

- **10. Right Response –** observe the person for adverse effects and assess the person to determine if the desired effect of the medication has been achieved.

Suspected Adverse Medicine Reactions (ADR's).
All effective medications have some side effects, most of which do not cause problems. Many medications interact with other medications and the computer systems used by medical practitioners and pharmacists are programmed to warn of interactions and grade them according to seriousness. However, occasionally a person may suffer an adverse medicine reaction (or interaction).

Particular care should be taken to observe the person when a new medicine is introduced. If staff observe an adverse reaction or suspected adverse reaction, they must give immediate priority to the person's safety and monitor their health status. If there is at least a reasonable possibility of there being a casual relationship between a medicinal product and an adverse event, staff should report the suspected adverse reaction to the prescriber who can advise of any intervention needed. Any change to the person's medication will be recorded in the Notes Section, MR2.The service manager will be informed and an incident report completed.

Difficulty taking Medication
People should not be forced to take medication against their will and no medicine should be used as a means of punishment or control. Most refusals are attributable to physical problems or to fears and anxieties that can often be resolved by expressions of care and concern. If a person refuses a dose of a medicine then the medication record, MR2, **must** be marked to indicate this, Notes Section and the matter recorded in an incident report. Seek medical advice.

If the person is asleep and the dose is not given the MR2, Notes Section, must record this fact and an incident report must be completed.

Seek advice from the medical practitioner or pharmacist in the event of regular refusals or inability to swallow a solid dose. Alternative forms of medication may be available (liquid instead of tablets or aids to support swallowing of tablets) which may be easier for the person to take.
Very occasionally, it may be necessary to give medicine in food or drink because no liquid form is available and the person simply cannot swallow tablets. The suitability of the medicine to be given in this way **must** be checked with the pharmacist and the details of the method of administration **must** be agreed and documented, see *"Administering Medication in Food and Drink because of Swallowing Difficulty" Appendix 6*

If any swallowing or choking concerns exist then it must be discussed with one's line manager in the first instance, to establish the appropriateness of onward referral to the Speech and Language Therapy Department.

Refused Doses and Covert Administration
The organisation recognises the right of the individual to refuse to take medication. A person may indicate this in different ways and the response will differ depending on what occurs.

- Takes medication in his/her mouth but does not swallow it or spits it back out – this is then considered a spoiled dose and it must be treated as such. Steps to follow are highlighted in section titled "Spoiled Doses".
- Refuses to take medication at all – if this is a known risk then a strategy to address it must be highlighted in the individual's PRMP and followed. If it has never occurred before then medical advice must be immediately sought and followed.

In each of these instances an Incident Report must be completed in line with organisational policy as this is a medication related incident and it must be highlighted as such.

In the case of a person who refuses medication, the lack of which would be detrimental to his/her health, the Circle of Support, along with medical practitioner/health care input must consider the situation. The person should be represented at any such meeting by family, or other person who has the person's best interests at heart. Particular attention and respect should be given to any previous instructions given by the person when better placed to make an informed decision, which may have a bearing on the outcome of this meeting. If the conclusion of the person's trusted supporters/circle is that it would be in the persons best interest to give medication hidden in food, details must be documented, using - *"Administering Medication Covertly In Food or Drink" (Appendix 7)* and all involved in the decision must sign the document. While it is hoped that the medical practitioner will sign this form, if he/she will not sign but still agrees with the method of administration, just note the medical practitioner's name and the date on the form.

The decision must be reviewed and a new document prepared and signed every 4 months or sooner if the condition/circumstances of the person changes. The pharmaceutical stability of the medication given in such a manner should be confirmed with a pharmacist. Because of the significance of the decision for the person's rights, the Rights Review Committee also needs to review the decision.

When Medicine may be given with Food

People have every right to refuse medication and they should not be forced or coerced into taking medication against their will. Medicine must not be given with food unless it is with the person's knowledge, for instance, because it is easier for the medicine to be taken that way, or it is administered covertly in accord with above.

In such cases, it is necessary to confirm with the pharmacist that the stability of the medicine is not impaired when given with food or drink.

Medication should not be given mixed with a full meal portion as any uneaten quantity will result in an insufficient medication dose being consumed. Where the need arises, medication should only be offered along with a small quantity of food.

Details of the medicine and the way it is given must be written and held for reference in the person's I.P. Folder-Health/ Medication Section. Others that the person trusts such as family members must be involved in this decision making process and asked to sign this to indicate that they are aware that the medicine is being given in such a way. This must be completed - *"Administering Medication in Food or Drink Because of Swallowing Difficulty (Appendix 6) or "Administering Medication Covertly in Food or Drink" (Appendix 7)* as it applies to the person. If an individual is having a Feeding, Eating, Drinking and Swallowing assessment (FEDS) consideration can also be given to such matters at this time.

Withholding Medication

Where the person in charge decides to withhold medication (e.g. night sedation when the person has gone to sleep) the following will apply:

a) In unprecedented circumstances the medical practitioner will be informed and an incident report completed.
b) Where circumstances for withholding frequently occur, criteria for withholding will be outlined by the person in charge, with approval from the person's medical practitioner. Record of the criteria applying will be held in the person's IP and any instance of withholding medication will be recorded in the MR2, Notes Section. In this instance there is no requirement to complete an incident form.

Spoiled Doses

Occasionally, the person or staff may drop a tablet or capsule. Staff must take into account the following risks:

- Is the surface that the tablet or capsule dropped on clean?
- Can the medication be identified as the medicine you are to administer?
- Is the tablet or capsule still dry and clean?

- Are staff 100% sure they are picking up the correct tablet or capsule (i.e. can it be accurately identified using the shape, size and markings?)
- Does the person consent to take medication that has been dropped?

All of the above factors should be considered carefully before giving any medication that has been dropped. If the answer to any of the above questions is 'no', then you should dispose of the medication appropriately.

It may be impractical to visit a pharmacy each time to return single tablets or capsules for example, if the person refuses a dose. In these circumstances, staff can source an empty tablet bottle to keep wasted doses in. This bottle should be labelled by the staff with 'waste medication' stored safely and then returned to a pharmacy thereafter.
If medication is supplied in a compliance aid, the replacement dose needs to be selected from doses at the end of the 28 day period. If in conventional packs, take another tablet or capsule from the pack.

In either case, a replacement tablet or capsule must be obtained from the pharmacy otherwise medication will be short at the end of the month. A prescription will be needed for this replacement dose. It will be entered in the Medication Stock Book when received. A note must be included in the person's I.P. folder to indicate that the last dose of the month is in a separate container.

Regular occurrences of difficulties administering a medicine or particular dose should be discussed with the medical practitioner to explore an alternative way of giving the medication.
The spoiled dose should be noted in the Medication Stock Book and an Incident Report Form completed in relation to this.

Crushing Tablets / Opening Capsules (Off-Label Use of Medication)
The opening of a capsule or crushing of a tablet before administration will in most cases render its use "off-label", that is, the product was not intended to be used in this way. In some cases, the practice of altering the form of medication may result in reduced effectiveness, a greater risk of toxicity, or unacceptable taste or texture.

However, there may be occasions when tablets or capsules may need to be crushed or opened to enable the person to take their medication e.g. swallowing difficulty, feeding tube in situ.

Since the crushing of medicine renders it an exempt medicine, staff should only administer in this way when it has been prescribed by a medical practitioner. A general authorisation to crush medication does not meet the requirements under legislation for exempt medication. It should be authorised for each individual medicine.

If it is determined that a change in the form of medicine is necessary, staff should consult with the medical practitioner and pharmacist to discuss alternative preparations or forms of administration for the person. A liquid formulation or suppositories is nearly always preferable.

If no alternative to crushing is available, such as liquid form or other medicine, then:

- Staff must only administer medication in this way when there is a written direction from the medical practitioner to e.g. to crush or disperse the tablets or to open capsules
- It should only be carried out following discussion and with the consent of the person.
- Any health and safety events that may result from crushing the medicine have been identified and considered.
- Crushed medicine is added to a small amount of suitable foodstuff (according to person's preference) such as a teaspoon of yoghurt or jelly.
- Crushed medication can only be added to foodstuff if there is evidence that it is a suitable method of administration and does not adversely affect the bioavailability of the medicine, absorption, stability. Ask the pharmacist for advice and record the outcome.
- Medication should not be added to beverages or meals.
- Staff understand the reason for administering the medicine.
- Staff document the rational for crushing the medicine and record the alternatives considered.
- Staff have access to an updated list of medication which should not be crushed.
- Crushing the medication should never be used as a mechanism to disguise or covertly administer medication.

Splitting Tablets

It is always preferable for solid dose forms (tablets or capsules) to be administered as single or multiple units (e.g. one or two tablets) per dose. Occasionally it may be necessary to split a tablet to achieve the required dose. In such cases tablets may be split if they are scored by the manufacturer. Non-scored tablets should only be split after confirming with the pharmacist that splitting is safe. Ask the pharmacist for a splitting device: it makes cutting easier and more accurate. Alternatively it may be possible for the medicine to be prescribed in a liquid form so the correct dose can be easily and accurately measured.

Administering 'when required' (PRN) medicine

There are 3 main categories of such medications.

a) Analgesics, anti-pyretics, e.g. *Calpol, Panadol*.

b) Medication for managing behaviours of concern.

c) Medication for status epilepticus.

Administering PRN Analgesics, Anti-pyretics

All analgesics and antipyretics should be prescribed by the medical practitioner and administered and recorded in the same manner as any other medication, referencing MP1 and MR2 sheets and the *"Protocol for Administering PRN Medication" (Appendix 5).*

If a person is prescribed a medication to be taken when required for example, 'Paracetamol 500mg' one to be taken three times a day when required, the following process needs to be followed to prevent risk of overdose.

Medication with a 'when required' dose (PRN) is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly. In such circumstances the person may not need the medicine every day.
To ensure the medication is given as intended, a specific plan for administration must be recorded on the *"Protocol for Administering PRN Medication" (Appendix 5)* and kept in the person's I.P. Folder-health/medication section alongside the MP1 and MR2 sheets.
Staff should know why the medication has been prescribed, the circumstances in which to offer it and how to give it.

As it is for occasional use the person should be offered the medication at the times they are experiencing the symptoms either by telling a member of staff or by staff identifying the person's need as described in the *"Protocol for Administering PRN Medication" (Appendix 5.)*

The responsibility for the safe use of P.R.N. lies with the person who administers it. Therefore, where its use is indicated and before it is administered, staff must refer to the MR2 sheet to check when it was last administered to ensure the interval/maximum allowed in any 24 hours is observed. The exact time the medication is given and the amount given should be recorded on the MR2.

For people attending Day or Respite services, staff must contact the person's family to establish if/when PRN was last administered. If the person receives services in different locations, the receiving service must be informed when PRN was last given. Services may agree to use the same green recording sheet (MR2). Where services agree to do this the MR2 card should travel with the white prescription sheet, MP1. The person should be encouraged to carry his/her own records where possible.

If PRN medication is given regularly then a referral to the prescriber should be considered for a review of the person's medication as their medical condition may have changed and the treatment required may need altering. Similarly if the medication is not having the expected effects the prescriber should be contacted. In both cases the response to the medication should be clearly recorded in the person's I.P. Folder.

PRN medication that is still in use and in date should be carried over from one month to the next and not disposed of. PRN medication is best supplied in its original container/ box. This allows for a check of the expiry date and reduces waste.

Administering 'when required' PRN Medication to Manage Behaviour of Concern
Ensure there is a PRN protocol in place, as in Listening and Responding to People *(see Protocols for administering PRN Chemical Restraint to manage behaviours of concern/medical appointment)* agreed by family, supporters and health professionals which clearly describes the circumstances in which PRN to manage behaviour can be given.

It will only propose medication is administered after all other possibilities have been exhausted. The risk plan must be reviewed regularly. The person and his/her family/supporters need to be involved in this discussion and decision making.

As the use of medication to manage behaviour is a restrictive practice an incident report must be completed outlining the circumstances under which it was administered and the manager of service must review its use in service as part of quarterly review process of incidents.

It is also a Rights Restriction and its use must be reviewed by the Rights Review Committee.

People prescribed mediation for the control of behaviour must have regular appointments with a psychiatrist where their medication is reviewed.

See "Enabling People to Enjoy Best Possible Health" - Person's Safety, Rights and the use of Restrictive Practices and "Listening and Responding to People" and "Policy Guidelines on Risk Management for People using Association Services" for further guidance.

Administering Emergency Medication (Buccal Midazolam/Stesolid)
The administration of medications e.g. Stesolid, for the management of seizures is only permitted when the prescriber confirms the circumstances in which this medication is to be administered. The direction given will be tailored to each individual's medical needs.
Staff that need to administer these medicines require training so they can administer them safely and confidently in an emergency.

The prescriber's instruction forms part of the person's – **"Supporting My Epilepsy Management Plan" - Supporting Individuals with Epilepsy – Use of Emergency Medication** which is contained in the person's *My Health Action Plan*.
This information is stored in the person's I.P. folder - Health/ Medication Section.
It will include:

- The circumstances when the medicine is used and the time to wait before administering the medicine
- The initial dose
- The timing of respective doses.
- The maximum dosage in 24 hours
- Action to be taken if symptoms persist.

If a second dose of medicine is required, then the prescription must state the period of time after the administration of the first dose in which the second dose can be administered. A record must be maintained of any seizures the person may experience. See "Seizure Recording Chart" -Supporting People with Epilepsy
This information is shared with family/medical practitioner to assist review of medications. See also section - Administration of Medications using Specialist or Invasive Techniques.

Administration of Medications using Specialist or Invasive Techniques
Examples include, not an exhaustive list:

- Medication given via a Percutaneous Endoscopic Gastrostomy (PEG) tube.
- Administration of medication into the eye, ear, nose, topical, rectum or vagina.
- Administration of emergency medication to manage seizures.
- Administration of intramuscular and subcutaneous injections.
- Giving oxygen
- Use of nebuliser
- Transdermal Patches.

Some of these tasks will require the involvement of community healthcare professionals e.g. Diabetes Nurse Specialist to inform practice.
Administration of medications may only be carried out by staff that have received the required instruction and are competent in administration using the specialist techniques.

The specialist task undertaken must be clearly described in, for example:

- Guidance for the use of PRN medication- PRN Protocol
- Guidance for the use of Oxygen
- Supporting My Epilepsy Plan
- Diabetes Management Plan
- Guidance for the Administration of Medication via a feeding pump through a gastrostomy (PEG)
- Guidance for the use of Nebulisers

Refer also to "Best Possible Health Policy" which describes the requirement and provides direction for the development of individualised health condition management plans.

Administering Enemas and Suppositories
The administration of enemas and suppositories is only permitted by staff when the prescriber has provided clear directions. Instructions will differ from person to person.
The practice to be followed must be outlined in individuals "Personal/Intimate Care Plan".

- When suppositories are being administered, a reasonable effort should be made to ensure two staff are present.
- In services settings where there is one staff on duty at any given time, and in the case of a regular enema, the person in charge should liaise with staff of nearby services to agree a time when the suppository can be given when two staff are present.
- The use of suppositories as a laxative will only be used when all other measures have failed. It is the responsibility of the person in charge, in consultation with the circle of support and medical practitioner to review practices using suppositories as laxatives on a regular basis. A health condition management plan to address constipation needs to be in place to ensure all the proactive and reactive responses are known and observed.

- In the case of an emergency enema such as Stesolid, it is recommended that two staff are present although given the nature of emergencies, this may not be possible.
- Administration will be recorded on the green recording sheet (MR2).

See organisational policy *"Personal/Intimate Care"* for further guidance in this area.

Administering Medication – Transdermal Patch

Guidance

- Where possible the person should be given opportunity to self administer their medication. The assessment outcome will be recorded in the person's "Self Administration of Medication Support Plan"
- The first patch, i.e. newly prescribed, should be applied ensuring a particularly watchful eye is maintained in case of allergic reaction.
- Details of where the patch is to be sited and the frequency of changing must be clearly noted in the MP1.
- Details of what the patch is prescribed for e.g. pain relief rheumatoid arthritis must be described in the person's "My Health Action Plan – My Health Condition Management Plan"
- Ensure the patient Information (PIL) is available.
- If the patch is listed as a High Alert or Controlled Drug (CD), the appropriate procedure must be observed.
- Staff need to check with relevant medical personnel what to do in the event of the patch coming off the person

It is possible for a person to wear more than one patch at a time. If this is the case, it may be simpler for them all to be changed on the same day. Verify with medical practitioner.

Application

- Check the label on the box with the MP1 to verify identity, dosage and time.
- Wearing disposable gloves remove the old patch per instructions under. Check the site for signs of allergic reaction, redness, itching, blistering etc. Any concerns need to be addressed with the medical practitioner.
- Check the MP1 to confirm where the new patch is to be sited.
- The site will need to be on a flat, dry area of skin above the waist on chest or back. Avoid areas where there is excessive body hair and if necessary and with the person's permission, clip any hair before applying.
- Tear open the envelope and remove the patch.
- Peel off the stiff plastic liner.
- Avoid touching the sticky side.

To Wear

- Press hand firmly over the entire patch for 30 seconds, paying particular attention to the edges. Be aware of possible allergies such as rash, reddening of the skin etc.
- Should the patch loosen, tape the edges with first aid tape.

Changes to Medication
The person or their family/guardian should be asked, regularly, to inform staff of any changes in medical condition, medication or allergic reactions so that the information held by the service is accurate. This is particularly relevant for people who attend Day and Respite services. This applies whether the person is self administering their medication or not.
Should the person experience a medical emergency, the attending medical practitioner/paramedics will need to know what medication the person is currently taking, dosages, frequency etc.

This information is also required for Emergency Response Planning.

Where a person attends both Day and Respite services, the Named and Link staff of both services must liaise to ensure any medication changes are communicated in good time to staff in both services.

Administering Feeds
Feeds are listed on MP1 and administration is accordingly recorded on MR2.
In some instances, due to nature of feeding regime that person is on, recording it on the MR2 will indicate the commencement of a feed.
Where this is the case, a protocol outlining this should be developed and attached to the MP1 for person.

Alternative Remedies
There may be occasions when the person or their family requests medication or alternative remedies e.g. herbal/homeopathic to be administered by staff. Alternative refers to using a non-mainstream approach in place of conventional medicine. Staff **must not** administer these non-prescription medications without checking with the medical practitioner to ensure they are safe. If this is to proceed, a consent/disclaim form must be signed – see *"Administration of Homeopathic/Alternative Medication" (Appendix 8).*

Herbs and homeopathic remedies can sometimes interact with prescription medication and cause side effects. One must keep all health carers, medical practitioner and complementary therapist informed of all medication, treatments and remedies being taken to ensure medications are being used safely.
Great caution should be exercised if any alternative therapy practitioner advises the abandonment of conventional medical treatment. Always follow the advice of the person's medical practitioner.
Complementary generally refers to using a non- mainstream approach together with conventional medicine.
Where complementary or alternative therapies are being considered, it is necessary to ensure they do not adversely affect conventional medication that the person is prescribed.

See also *"Enabling People to Enjoy Best Possible Health"* Complementary Therapies.

Medicinal Oxygen
As with other medical conditions, A Health Condition Management Plan is required for any person using oxygen.

Injections
In medical terminology injection is referred as a shot or jab and is a popular way of infusing liquid medicines in to a patient's body.
Injections can be given in various ways but the most commonly used are intramuscularly or subcutaneously. Each type of injection is used for a specific health problem, specific purpose.

Intramuscular injections: This is the most common way of injecting medication directly into a patient. For rapid absorption of the medicine this is a very useful process because the medicine from this injection is inserted directly into the muscle. This allows the medicine to gain easy access to the blood stream and quickly begin its healing work. Intramuscular injections are the best and the safest way of injecting medication into a patient.

Subcutaneous injections: Such types of injections are used where the medicine needs to be absorbed slowly. In this type of injection, the needle has to go through the first 2 layers of skin that is the epidermis and dermis. The needle should further penetrate into the fatty layer of the skin, known as the subcutaneous tissue. Medicines administered through subcutaneous injections have the least chances of having an adverse reaction. Insulin is one type of medicine that is injected in this way.

Injections will only be administered if prescribed by a medical practitioner and under clear direction from the prescriber outlining the circumstances in which this medication is to be administered to the person. If specialist training is required then staff should link with the Evaluation and Training department in relation to this

- Diabetes: *Insulin* should only be administered by staff who have received training in relation to Diabetes.
- All depot injections such as *Dipixol Modecate*, prescribed by consultants in Mayo Psychiatric Services will be given by relevant medical personnel.

Note:
This policy recommends that, in the main, injections are to be provided by medical practitioners and community support services where appropriate to do so and where this would typically be the norm for any member of the community.

Where suitably qualified members of staff are approved to provide support in this area then this practice must be discussed and agreed within the service.

11. Medication Related Incidents

Medication Related Incidents

A Medication Related incident refers to a range of events that are broader than errors alone.

They include the following categories:

1. Refusal to take medication.

2. Administration Error -

An error in administration of medication is any deviation from the prescribed dose whether there are adverse consequences or not. i.e. Different time; different dose; different tablet; different person; missing a dose (person vomiting following medication administration or forgetting to give medication)

If a dose is given in error or the person misses a dose for instance, the person affected should be informed when it is identified and the medical practitioner should be contacted for advice. The detail of the medical practitioner's direction/advice is recorded in the person's MR2 Notes Section, I.P. Folder - health/medication section and in an incident report.

If a prescribed dose is deliberately withheld following medical advice then there is no requirement to complete an incident form .Record of conversation with medical practitioner is recorded and held in persons IP and note is made in MR2 notes section reflecting this.

If a prescribed dose is administered at a different time than that prescribed, an incident form must be completed .Medical advice must be sought and the detail of this outlined.

Issues concerning the time medications are administered to an individual e.g. the time morning medications are given, must be discussed with and approved by the prescriber. The detail of this conversation should be recorded and held in persons IP.

3. Pharmacy Error - typically this is noted by staff when recording medications received. Examples include inaccurate medication which differs from that prescribed, inaccurate dosage, missing tablets from blister packs or tablets included at times for administration that differ from those on MP1 etc.,

4. PRN (analgesic) – Administration of any PRN analgesics which is not prescribed for the person.

5. Other - spoilt doses, recording errors, stock errors, tablets found on floor etc...

Medication related incidents can result from a number of causes: distraction, fatigue, trying to rush, respecting the wishes of an individual, human error or a systems error. Identifying the cause of an error is important in deciding if any changes need to be made to the way things are done in order to make the system safer and prevent a repetition of the same error. This is part of risk management.

Errors may vary in seriousness, however, prompt attention must be given to what has occurred and an Incident Report, in accordance with the organisation's *Incident Reporting Procedure* must be completed in such circumstances.
Incident forms are completed so that the service can reflect on what's occurring and develop solutions to address identified difficulties.

Major errors must be reported to the service manager and/or Regional Services Manager (RSM) by telephone as soon as possible. Family must also be informed in keeping with the agreed away of sharing such incident information.

Each Front Line Manager (FLM) is required to review all incidents in their service each quarter to determine if there is a pattern or trend - this includes medication administration incidents.

Whenever a medication related incident occurs consideration should be given to how this can be avoided in the future. This information should be included in the incident report and should form part of the learning from incidents that inform improved practice. The quarterly review of incidents by the FLM should address any patterns arising from medication related incidents
It is possible that a pattern of incidents can be addressed by obtaining medical advice from the prescribing physician which may lead to some leeway in the time of administration of medications or withholding of medications in certain situations. The Manager must ensure that any derogation from the prescription that is advised by the prescribing physician is recorded on the MR 2 Notes section and a record of physicians advice is held in the person's IP file.

All medication related incident reports are reviewed and collated centrally and form part of the quarterly Organisational Incident/Injury Report which is reviewed by senior management.

12. High Alert Medications

High alert medications hold a heightened risk of causing harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of error are clearly more devastating to people. Therefore, it is important that high alert medications are closely monitored and necessary precautions taken when prescribing, ordering, dispensing, storing, administering or disposing of these medications. Examples of some high alert medications are Warfarin, Insulin, Methotrexate, Fentanyl patches, Metformin, Midazolam. A number of consumer leaflets with safety tips for a number of the more commonly used high- alert medication are also available here. The purpose of identifying high-alert medications is to establish safeguards to reduce risk of errors in all phases of the medication use process.

Cause of Errors
Ongoing review of medication errors helps to establish their root cause. To understand why the error occurred is important as it will help inform subsequent risk reducing strategies. This is why all errors relating to medication must be reported per the organisation's incident reporting policy. Errors can occur at any stage along the medication use process i.e. at prescribing, transcribing, preparing, dispensing, storing, administering and disposing of the medication and in preparedness to address an adverse event should it occur.

Common Risk Factors include:

- Poorly written prescriptions
- Look/sound alike names
- Look alike packaging
- Branded/generic drug name confusion
- Confusion between strengths of the same medication
- Incorrect dosage/dilution rate

Therefore, as with all other medications and to ensure the safe management and administration of high- alert medication, staff must diligently observe the direction provided in this policy.

Managing High Alert Medications
People in receipt of high alert medications have particular health issues which are being managed or treated.

- The particular health condition and how it is managed/treated must be described in "My Health Condition Management Plan" see "My Health Action Plan" *Best Possible*

  The Health Condition Management Plan/Protocol is developed in consultation with/under the direction of the relevant medical personnel e.g. Diabetic Nurse Specialist, G.P. The Plan/Protocol, along with the MP1 and Patient Information Leaflet, form the primary information source for all people to follow when supporting the person's health condition. All staff needs to follow its instruction.

Strategies to Avoid Errors – High Alert Medication

	Prescribing
Correct Prescription	Any confusion or doubt about any aspect of the prescription, – double check with the prescriber. (e.g. 5.0mg can be mistaken as 50mg)
	Pharmacist
Clear Communication	When high-alert medications are dispensed, the recipient is always advised about its use by the pharmacist. As many people do not collect their own medications or may not fully comprehend the significance of what is being communicated to them, they will rely on staff to be well informed and vigilant on their behalf. Each service needs to agree how it communicates the pharmacist's advice to the person in a way that he/she can understand and to the wider staff team.
Pre-prepared Limit Stock	Any change to the person's medication regime e.g. warfarin, will be communicated to staff at shift change and the necessary documentation updated to this effect. Use pre- mixed solutions of high alert medications where possible. Keep sufficient but not excessive stock.
	Storage
Individualised Storage	Medication should be checked into the service – medication stock book – at a time when there are no distractions. Where a second staff is on duty in the service, he/she will independently double check the medication and records. Both staff will sign the stock book. Given the practice of storing each person's medication individually e.g. in their bedroom or in their own container within a larger stock cabinet, this reduces error possibility.
Separate and Distinguish	Where possible, do not store look alike/sound alike or different strengths of the same medication side by side. Putting the medication in its original container into a see through plastic bag with a label on the outside "High Alert Medication", for e.g. is another way to make it easy to quickly distinguish it. If space allows, store it on its own shelf and affix a label to shelf – High Alert Medication.

	Administration
Distractions **Double Check**	Limit/avoid distractions during administration of medications. In addition to the usual essential checks made before administering any medication to a person, a second staff will, where this is possible, independently check all the particulars of the person and the medication prior to administration.
	Monitoring
Observe	Closely monitor the person's response before and after administration.
	Disposal
Separate and Dispose	Discontinued, expired, damaged and contaminated products are segregated and isolated until removal from the service. They must continue to be stored securely e.g. within the person's usual medication press but away from other medications. Return to pharmacy without delay. Patches must be disposed of with great care. Some, if applied by another, could cause death. Follow direction provided with product.
	Support Learning
Supporting Family	For people who stay with family on occasion, it is important that they are also supported. Provide information on: • Name and purpose of medication • How much and when to take the medications • How to take the medications • Common side effects • Storage of High Alert medications • Disposal arrangements for expired/unused High Alert medications •
	Evaluate
	Monitor adverse drug reactions and medication errors related to all medication.

13. Controlled Drugs

Definition
Some prescription drugs contain medication that are controlled under the Misuse of Drugs Act 1977 and 1984 and the Misuse of Drugs Regulations, 1988, as amended. These drugs are called "controlled drugs" because they are potentially harmful if misused or abused and therefore have additional safety precautions and legal requirements for their storage, administration, record keeping and disposal.

- Examples include: Morphine and Ritalin.
  See list of "Controlled Drugs – MIMS Ireland".

The receipt, administration, management and disposal of controlled drugs are recorded in accordance with An Bord Altranais agus Cnáimhseachais na hEireann and the relevant legislative requirements.

People who take their own medication are excluded and are not governed by these legal requirements. However, as with all medicines, the "Self Administration of Medication Support Plan" must be completed to determine the person's ability to self administer medication and to consider the possibility of risk to others.

Controlled drugs are classified into five schedules according to different levels of control.
The receipt, storage and administration of **Schedule 2 - Controlled Drugs (CDs)** is strictly controlled and documented. The person in charge may consider it appropriate as an additional safeguard to provide a second staff member to support the administration of these drugs. Where a second staff is not available and there are specific concerns these should be discussed with the Regional Services Manager. In any event, strict adherence to the procedure as outlined in this policy is a sufficient safeguard.

Supply and Receipt of Schedule 2- Controlled Drugs
Controlled drugs may only be prescribed via an individual written prescription by an authorised medical practitioner.

- On receipt of the controlled drugs, the staff member must check the contents of the container with the quantity on the container label. Any discrepancy **must** be reported to the pharmacist at once.
- If correct, the staff **must** enter the quantity into the Controlled Drugs Register on the appropriate page. A CD Register (in bound book form) must be used to record incoming and outgoing controlled medication. The balance of the drugs now in stock must be calculated, checked and entered at this time. The lead staff and second staff must sign the register. If the medications are correct they **must** immediately be locked in the appropriate Controlled Drugs cabinet.
- It is good practice to book in and out and administer all controlled drugs in the presence of a second staff member. This helps prevent discrepancies arising. However, people should not go without their controlled drugs just because a second staff is not available.

Storage of Schedule 2 - Controlled Drugs
Controlled drugs (excluding those for self-administration) are stored in a manner that meets legislative requirements.

They should be locked in a separate cupboard/container from other medicinal products to ensure further security.

The CD cabinet should be located in an appropriate private area away from public view, attached to a brick or block wall. Keys to the Controlled Drugs cabinet **must** be kept in the possession of staff on duty.

If the person is looking after their own controlled drugs, (self administering), then they can be stored safely with their other medications in their room. There are no additional or special storage requirements in this case.

Where staff collect such medicines on behalf of the person, a record of the medication handed to the person must be maintained in the CD register.

Administration of Schedule 2- Controlled Drugs
In order to administer controlled drugs, the same steps involved in giving any other drugs apply (see Medicine Administration).

It is good practice for a second staff to witness this process where this is possible.

In addition to the procedures relating to the administration and documentation of other medication the following additional procedures **must** be carried out:

For the purposes of stock control an entry **must** also be made in the service's Controlled Drugs Register, including:

a) Date and time of administration;
b) Name of person to receive the drug;
c) Dose administered;
d) Signature in full of giver and witness;
e) Remaining balance of stock, this should be checked on returning stock to the cabinet.

A separate page in the Controlled Drugs Register must be used for each person and each medicine and strength. Any Controlled Drug prepared for administration and not used, or only partly used, **must** be treated as a spoilt dose and returned to the pharmacy supplying them at the earliest opportunity for safe disposal. Details of the controlled drug(s) returned must be entered in the CD register and a signature obtained from the pharmacist in the *"Medication Returned to Pharmacy" (Appendix 9)* for receipt of same.

Any discrepancies **must** be brought to the notice of the service manager and/or Regional Services Manager (RSM). Discrepancies **must** be investigated by the RSM or person assigned on his/her behalf as soon as possible after discovery on that day and an explanation made on the CD record, (within 48hrs).

Previous entries in the CD register **must not** be altered if a recording error is identified at a later date. A clear and legible explanation of the recording error must be made in the register.

Disposal of Schedule 2- Controlled Drugs

If a controlled drug is no longer required, the drugs may have been changed for example, it must be disposed of by returning to the pharmacy supplying them at the earliest opportunity for safe disposal. Details of the controlled drug(s) returned must be entered in the CD register and a signature obtained from the pharmacist in the *"Medication Returned to Pharmacy" (Appendix 9)* for receipt of same. It may be appropriate to telephone the pharmacy to inform them that a CD is being returned as they will have a special protocol for disposing of it.

The following details should be recorded:-

a) Date
b) Name of person
c) Controlled Drug name and strength
d) Number (or volume) of tablets (or liquid)
e) Signature of the staff
f) Signature of witness witnessing the entry in the Controlled Drugs Register
g) A count of stock should be conducted at roster change over times.

Transdermal patches must be rendered unusable before disposal. This is done by folding the patch in half with the adhesive edges joined thereby sealing the transdermal surface so the medicine can not be absorbed through the skin of anyone who may handle it. See Disposal of Medication – Transdermal Patches.

If controlled drugs are removed from the service because the person is moving to another location, details of the circumstances and people involved should be noted in the CD Register.

Record Keeping for Schedule 2 - Controlled Drugs

All medication administration records that are used for all other prescribed medication apply, MP1 and MR2. Additionally, services should keep a separate record of the receipt, administration and disposal of CDs.

- Administration should be recorded on the MR2 Sheet and in the CD Register.
- These records must be kept in a CD bound Register with numbered pages, loose pages are not acceptable.
- There should be a separate page for each CD for each person.
- Include the balance remaining for each medicine. This should be checked against the amount in the pack or bottle at each administration and on a regular basis, e.g. monthly.

Entries in the CD register must be clear and must never be changed or obliterated. If a discrepancy is discovered, it must be investigated and an explanation added to the register so that it is quite clear what has happened.
Records pertaining to all CDs should be retained and archived in accordance with the Records Management Procedure.

Controlled Drugs Register
A suitable and appropriate Controlled Drugs Register may be developed within the service by using a hardback bound book with no loose leaf pages that can be easily removed or fall out.

14. Disposal of Medication

General Information
Medication should be disposed of as soon as a course of treatment is completed, discontinued, when the expiry date of the medicine is reached or the person dies. However, since medications are the property of the person, their permission should be sought prior to destroying these on their behalf.

There should be no need for large quantities of medication to be destroyed if stocks of medication are regularly inspected.

It is good practice to check stocks of medication as part of the monthly re-ordering process which will identify medication no longer required and quantify "when required" medication in hand.

Unwanted medication must be returned to the pharmacist. They can be returned every month if wished but must be returned at least every six months. Ideally, medication should be returned in original containers so the pharmacist can identify the medication. Discuss with your pharmacist how they may require 'spoiled' tablets to be returned. Transdermal patches for return can be made safe for disposal by folding skin side surfaces together so that the adhesive edges stick to one another enclosing any remaining medication in a sealed 'pouch'. See Transdermal Patches.

When returning medication, the **"**Medication Returned to Pharmacy" form is used (*Appendix 9).* This record signed and dated by pharmacy staff is kept in the Medication Stock Book.

- In the event of the person's death, the medication should be retained for at least a week in case they are required by the Coroner's Office. Thereafter, the medication becomes the property of the person's estate and therefore is the responsibility of the executors to dispose of.
- Under no circumstances may unused medication be disposed of in the refuse bin or by any other means. Medication should not be flushed down the toilet or sink.
- Where syringes and needles are used by a medical practitioner or other health professionals, they should be safely disposed of by the person using them.

Controlled Drugs
Special arrangements **must** be made for medications that are identified as Controlled Drugs. In this case a signature **must** be obtained from the pharmacist because of the legislative requirement.

Needles and Syringes
Needles and syringes will be discarded intact into a "Sharp's" safety container, not into plastic bags. Syringes must never be re-capped. The "Sharp's" container will be closed and locked away when not in use. The container will be sealed when ¾ full and stored safely, prior to removal for incineration.

The person in charge will arrange for removal of the containers.

Collection points for incineration are:

- Ballina District Hospital.
- Ballinrobe Primary Care Centre
- Belmullet District Hospital.
- Castlebar Primary Care Centre
- Claremorris Primary Care Centre
- Mayo General Hospital, Castlebar.
- Swinford District Hospital.
- Westport Primary Care Centre.

Disposal of Transdermal Patch

To Remove

- Lift the edge of the patch and take it off gently. Fold the sticky sides down over itself. Put it in the empty foil pack that the new patch came out of and return to the pharmacy. Record as other medications returned to the pharmacy.
- If one's hands inadvertently come into contact with the patch, wash hands. This should not arise if disposable gloves are used when applying and removing the patch.

Non Infectious Soiled Dressings
Soiled surgical dressings, swabs and other contaminated waste must be placed in double plastic bags and sealed. These will be placed in the outer bin for refuse collection.

Non Infectious Spillage of Blood/ Vomitus/Urine
Disposable gloves and plastic aprons must always be worn when dealing with spillage of blood, vomitus or urine. The spillage will be cleaned up using disposable paper towels and disinfectant and then placed in double plastic bags and sealed; these will then be placed in the outer bin for refuse collection.

Where there us a suspicion that material to be disposed of is infectious, the medical practitioner should be contacted who will in turn arrange with the hospital that the infection is identified and appropriate safeguards communicated to staff.

15. Administering Medication in Other Settings

Overview

A good life is about spending one's day in satisfying and meaningful ways, enjoying one's work/activities and living and spending time with people we care about in the heart of community life. Therefore, people will inevitably need to take their medication in a variety of places/situations. It is necessary to ensure that the person's opportunities/experiences are not limited or curtailed because of the need to be somewhere to receive their medication at a particular time. Rather, provision will need to be made to ensure people have opportunity to take their own medication or to receive them wherever they may be with the necessary privacy when the need arises.

Day Outings

In the case of a day trip where staff accompany the person, medication administration must be treated in the same way as it would be in the service setting. A suitable container should be found in which to carry the medication and the administration records, (e.g. a rucksack which can be discretely secured with a lock). This should be kept in the possession of staff at all times, hence the usefulness of a rucksack. In this way medication can be administered and recorded as they would be in the service setting.

Medication entering and leaving the service should be recorded in the Medication Stock Book.

If there are a lot of bulky containers to carry then the exact dose can be transferred to a labelled container. Two staff will be present when medication is being transferred and labelled. Its administration is recorded in the MR2 as usual.

If the person administers their own medicine, they can carry it on their person as anyone else when out and about for the day provided it is secure and the safety of others is well considered.

Home Visits

- When a person goes home on a regular basis, the family will have their own supply of medication, preventing the need to transport same. In the event of the person going home unexpectedly, or on an occasional basis, any medication will be given in its own labelled container by the person in charge to the family member / person driving / escort. Staff will record the date and amount sent in the Medication Stock Book.

- Where the person goes home on an infrequent basis and on a short term basis, where the family are unable to have a supply of medication and when it is unsafe to send the entire supply home with the person, the person in charge may transfer the exact dosage required for the break into a labelled container. Two staff should be present when medication is transferred and labelled. This practice should only be undertaken when it is the only option available to support the person in maintaining his/her medication regime during the time at home.

- Medication sent home is recorded in the Medication Stock Book.

- If the person self-administers medication, staff should ensure that he/she takes their medicine away with them and that they have sufficient for the whole of their time away.

On Holiday

- If a person to whom medication is administered is going to be away for a week or more it is preferable, on grounds of safety, to obtain a separate prescription to cover the medication needed for the specific leave of absence. The pharmacy should be asked to supply the medicine in standard dispensing containers or a compliance device, depending on discussions. This circumvents the need for staff to re-dispense and label. The MP1 and MR2 are referred to and used to record as usual and these will be necessary should the person need to see a medical practitioner while away.

- Only sufficient supplies of medication for the period of absence should be taken.

- Medication must not be placed in envelopes or other types of temporary containers.
  Any medication leaving or entering the service under these circumstances must be appropriately recorded in the Medication Stock Book.

- If the person self-administers his/her medication, staff will ensure that the supply is sufficient for the whole of the time away.

A short un-planned event (e.g. lunch out with a relative).
Person who does not self –medicate.

- Confirm that medication is needed during the absence.
- Place the required dose(s) into a suitable labelled container (tablet bottle or lidded pot). The label should clearly state the name of the person, the number of tablets and the time the tablets should be taken. NB: Envelopes are not suitable for this purpose.
- Hand the medication to the person who will be responsible for the person during the absence.
- Record the details on the MR2 – *medications administered by named relative.*

16. Going to Hospital

Hospital Admission - Information about the Person - Medication Reconciliation
The *Medical Consent Form (Appendix 10)* is completed when an individual starts in a service and it is updated on an annual basis in line with good record-keeping practices.
It ensures that staff have received consent from an individual/family to consult relevant medical practitioners as to the best course of action to take in the event of a medical emergency and to follow any direction they are given.

If an individual needs to be admitted to hospital who cannot reliably provide the required information him/herself, then information should be provided to help hospital staff understand the person's support needs e.g. medication regime, communication, mobility, personal care, eating and drinking, pain, daily routines, likes/dislikes etc. For people who need this, a "Hospital Passport" type document should be completed for people living in residential and individualised support settings *(see Enabling People to enjoy Best Possible Health - Appendix C - Hospital Passport).*

This information should be reviewed at intervals to keep the person's information up to date. In the event of the person being admitted to hospital, the information is ready to give to the paramedics/hospital staff along with the person's MP1 and medication. People who do not speak, or who find taking medication problematic or who find hospital environments especially upsetting for e.g. will rely on this information being available to hospital staff. See also Medication Reconciliation.

Medication related incidents are more likely to arise at times of transition between services e.g. between the person's home and hospital, when transferring within levels/departments in the hospital setting and upon discharge. Great care and attention is required at these times to ensure errors or omissions do not arise.

While in Hospital – Diary
Where a person is admitted to hospital and is being supported by staff during that period, then it is necessary to maintain records of how the person is during this time.
It will remain with the person during their time in hospital and when discharged is maintained in IP folder as part of daily records.

While in Hospital - Roles and Communication
The Service Manager /Designated Staff will liaise with the Ward Sister for up-dated information.

Returning from Hospital and Medication Reconciliation

- People are usually discharged from hospital with a supply of medication and appropriate documentation. It is essential to check this information against the record of the previous medication and The Discharge Summary document. Where changes have arisen, the medical practitioner's surgery should be contacted by the service manager/designated staff to have the MP1 updated, to verify that they have received the discharge information and to request new prescriptions.

- The Service Manager/Designated Staff liaises with the Medical practitioner to confirm and request reports and results of investigations.
- On discharge from hospital, the "Medical Appointments/Admissions Form - MAF" *(Best Possible Health Appendix A)* is completed by the Service Manager/Designated Staff.
- The Service Manager/Designated Staff forward the Medical Appointments/Admissions Form (MAF) to the Regional Services Manager where this has been agreed.

Palliative Care

Most people as they approach the end of their life would prefer to die at home. A residential service, for instance, may have become the person's home and if they wish it, and it is possible to meet the needs of the person, they should be allowed, wherever possible, to stay there until their life ends. This will be a decision arrived at involving all the people involved in the person's life, family, staff and health care personnel. The person and staff can expect the same help and support from health professions that are available locally to people who are living in their own homes.

The care of a person with end of life and/or palliative care needs will at all times require a 'team approach' which will include external support.

Where it arises, all staff involved in the direct care of the person will need support to give them an awareness of what to expect and what to do at each stage. Staff will be working closely with the palliative care professionals and will know how to access out of hours services.

Medication will be administered during palliative care and staff involved in the administration and control of medication, will be required to observe the direction contained in this policy.

However, in palliative care, medication may be changed frequently in order to control pain and other symptoms. It may be necessary to hold some medication, prescribed for the person, in stock in case they are needed suddenly or over a weekend. It may be necessary to obtain new medication at short notice. Staff should work closely with the palliative care advisers and with their supplying pharmacy to ensure that there is as little delay as possible in providing such medication.

Self-Administration of Medication Support Plan

Part A The Risk Assessment

A Risk Assessment is designed to establish if the person is able to take control of all or some of their own medication and if any help or special arrangements may be needed in order to allow them to do so.

Name of Person	**Date of Birth**
Name of Person Conducting this Assessment	**Assessment Date**
Current Medication	**Dose**

Person's Knowledge of Medication – List each of the medication taken; does the person understand the need for each of these medication and the importance of taking them at the correct time?

Physical ability - Is the person able to :	Yes	No
Read labels		
Open containers		
Pick up tablets and capsules		
Use eye drops		
Use ear drops		
Apply ointments		
Person's mental ability - Is the person forgetful or confused, may they need reminding to take medication?		
Secure storage - Is secure storage available, is the person aware of the importance of secure storage at all times?		
Disposal arrangements discussed - Does the person understand that ALL unused medication MUST be returned to staff for disposal?		
Arrangements for new supplies - Would these to be ordered by the person or the staff? Explain that all new supplies must be checked in and recorded.		

Outcome of this Assessment

The outcome of this assessment is that _____
will/will not (delete as appropriate) take control of his/her own medication.

Part B Details of the Arrangements. **If the person is to control and self administer medication, details of the arrangements and any help needed must be entered below and filed in their plan.**	
Will the person order his/her own medication?	**Yes/No**
Where will the medication be kept?	**Details**
List below all medication to be self-administered by the person. **NB this list must be updated as necessary.**	**Partial self-administration.** **List below medication to be administered by staff.**
Will the person need reminding to take medication?	**Yes / No** **How will this be done?**
Are there any special requirements regarding medicine containers? Eg plain tops on bottles, compliance aid?	**Details**
Is it necessary to inform pharmacy of requirements?	**Yes / No** **Who will do this?**
Number of days supply to be given to person.	**7 days / 28 days**

Record of people involved in this assessment, including family, medical practitioner, if appropriate.	
Name of Manager: _____	**Signature**
Name	**Signature**
Name	**Signature**
Name	**Signature**
Name	**Signature**
Name	**Signature**

Person's Statement:
I agree that I will keep all my medication secure in the locked drawer/cupboard in my room (or on my person) and I will return unused medication for safe disposal. I understand that the staff are required to make adequate recording and monitoring arrangements of my medication, and I am ok with these arrangements.

Signature:

Date of Assessment	**Date for Review**

Part C - Self-Administration of Medication - Progress Form

This assessment is designed to establish if the person continues to be able to administer some or all of their own medication, in keeping with the agreement in place. It can be used at intervals to confirm if the person is/is not self administering their medication as agreed. It can also be used to establish how well the person is managing their medications if concerns arise for their mental health, changes to medication regime etc.

Name of Person	**Date of Birth**
Name of Person Conducting this Assessment	**Assessment Date**

Date of Compliance Check	**Findings? Any Discrepancies? (**Record Details**)**	**Action/Comments Other issues**	**Staff signature**

PRESCRIPTION SHEET (MP1)

REGULAR MEDICATION

Persons Name: _____

Address: _____

_____

Service : _____

_____

Date of Birth: _____

Doctor: _____

Address: _____

Allergies: _____

	Date	Medicines (BLOCK LETTERS)	Dosage	Route	Frequency	Time of Administration												Medical Practitioner Signature	Discontinued Date	Discontinued Signature
						am 8	am 10	MD	pm 14	pm 16	pm 18	pm 20	pm 22	Other Times		Other Times				
A																				
B																				
C																				
D																				
E																				
F																				
G																				
H																				
I																				
J																				
K																				
L																				
M																				
N																				
O																				
P																				
Q																				
R																				
S																				
T																				

Date MP1 due to be reviewed: _____

AS REQUIRED (PRN) MEDICATION

	Date	Medicines (BLOCK LETTERS)	Dosage	Route	Frequency	Maximum Dose in 24 Hours	Medical Practitioner Signature	Discontinued Date	Discontinued Signature
A1									
B1									
C1									
D1									
E1									
F1									
G1									
H1									
I1									
J1									
K1									
L1									

SHORT TERM MEDICATION

	Date	Medicines (BLOCK LETTERS)	Dosage	Route	Frequency	Time of Administration									Medical Practitioner Signature	Discontinued Date	Discontinued Signature
						am 8	am 10	MD	pm 14	pm 16	pm 18	pm 20	pm 22	Other Times			
M1																	
N1																	
O1																	
P1																	
Q1																	
R1																	
S1																	
T1																	
U1																	

WESTERN CARE ASSOCIATION

MEDICATION RECORDING SHEET

MR2

Always use a new Medication Recording Sheet with every new Prescription Sheet issued

Persons Name: _____ **Service:** _____

ENTER LINE CODE LETTER FROM THE PRESCRIPTION SHEET AND INITIAL	DATE	REGULAR AND PRN MEDICATION *(Insert Times of Administration - as per MP1)*									
		Time	Time	Time	Time	Time	Time	Time	Time	Time	NOTES

STOCK CONTROL FORM

Name of Person: _____

MEDICATION DETAILS	AMOUNT IN					AMOUNT OUT				
Name of Medication(s):	**Received From**	**Number Received**	**Date and Time**	**Total on Hand**	**Signature**	**Number Out**	**Date and Time**	**Destination**	**Total on Hand**	**Signature**
Strength:										

PROTOCOL FOR ADMINISTERING PRN MEDICINE (Non-Psychotropic Medication)		
Person's Name:		
Medicine:	**Strength:**	**Form:**
Directions (dose and frequency):		
When should this medication be given?		
What should the medication do?		
What time gap should be left between doses?		
What is the maximum dosage in 24 hours?		
How long should the medication work for?		
When should MEDICAL PRACTITIONER or other medical advice be sought?		
Signed *(Person completing form)*:	**Name of Person information obtained from i.e. Medical Practitioner Pharmacist/Nurse/Other:**	
Your Name *(Printed)*:	**Date:**	

ADMINISTERING MEDICATION IN FOOD OR DRINK BECAUSE OF SWALLOWING DIFFICULTY

Name of Person: _____

Name of Service: _____

_____ has requested that the prescribed medication listed below be given to him/her in food, as detailed below, because he/she is unable to swallow tablets and capsules and no liquid forms of the medication are available. The suitability of this medication to be given in this way has been verified by:

Pharmacists Name: _____ Pharmacy **Name:** _____

Medicine	**List food/drink to be used**

(N.B. The medicine must be mixed with a small quantity of cold food to ensure the whole dose is taken)

I have requested that the medication listed above be administered to me in food as detailed above.

Signature of Person: _____ Date**:** _____

This matter has been discussed with the person's next of kin, or representative, who signs below:

Name: _____ Signature**:** _____ Date**:** _____

This matter has been discussed with the relevant health professional/medical practitioner who signs below:

Name: _____ Signature**:** _____ Date**:** _____

ADMINISTERING MEDICATION COVERTLY IN FOOD OR DRINK

Name of Person…….

Name of Service…….

…… is refusing to take medication. He/she is unable to understand the necessity to take the medication prescribed for him/her. This matter has been discussed fully with the his/her family and medical practitioner who agree that it would be in his/her best interests to administer medicine covertly in food or drink in order to maintain health and well-being.

We are not aware of any previous instructions given by …… that medication should not be given in this manner.

The suitability of these medications to be given in this way has been verified by the Pharmacist. (Name)…… Pharmacy (name)…….

Name of Medical practitioner…… Signature…….. Date…….

Name of Medicine	**List food/drink to be used**

This matter has been discussed with the person's next of kin/family/trusted others.

Views of the next of kin/family/trusted others:

This arrangement will be reviewed in (enter date)…….. or at an earlier date if the person's situation or condition changes.

Name……..... Signature……. Date……

APPENDIX 8

CONSENT FORM
For the Administration of Homeopathic/Alternative Medication

The person's medical practitioner must be consulted when a request to administer an homeopathic/ alternative remedy is made to establish the likely benefits and risks for the person.

The Person, Parents/Guardians/Next of Kin who are requesting that alternative medications, which have not been prescribed by a medical practitioner, be administered to the person must sign this form disclaiming any responsibility by Western Care Association.

I/We give my/our full permission to have

_____
(Name(s) of Alternative Medication(s)),

administered to _____
(Name of Individual)

I/We understand that a Medical Practitioner has not prescribed these medications and I/We take full responsibility for any consequences that may arise.

I/We understand that this form must be discussed with the person's medical practitioner before commencing any new conventional or alternative medication.

Signed: _____ Date: _____
Person

Signed: _____ Date: _____
Parent/Guardian/ Next of Kin

Medication Returned to Pharmacy

(Retain in Medication Stock Book)

Name of Service **Person's Name** (to whom the medication belongs) **Signature of Person Returning Medication**	**Date Medication Returned**	**Name of Pharmacy Receiving Medication**	**Signature of Pharmacy Staff**	**Reason why medicine was returned. Tick box**							
				Expired or outdated	Discontinued by medical practitioner	Medical practitioner ordered new medicine	Person felt better	Side effects or allergic reaction	Person moved away or deceased	Refused to take medicine	Other
Medicine	**Strength**	**Form e.g. Liquid, Capsule**	**Quantity**								

Medical Consent Form

WESTERN CARE ASSOCIATION

I hereby confirm that I authorise the placement of _____ in

_____ for _____ service.

I agree that in the event of illness or incident the staff on duty may, on my behalf, contact the relevant medical practitioner and follow recommended course of treatment as deemed necessary by them

I further agree that any relevant records required to ensure continuity of care may be shared with medical personnel.

In cases of extreme urgency, where there is a general anaesthetic required, I hereby authorise the staff on duty to be consulted on my behalf.

In matters of emergency, Western Care Association will endeavour to contact the Parent/Guardian of _____ at the earliest possible opportunity.

SIGNED: _____

DATE: _____

Medication Audit Checklist – Service

Name of Service: _____

	Yes	No	Not Applicable	Action
Is the policy in place, available?				
Have all staff read and signed the policy?				
Is the staff register completed with specimen signature and initials?				
Is there a BNF/MIMS or similar?				
Are Stock Control sheets kept in an orderly and complete manner to enable an accurate audit?				
Has each drug or compliance aid e.g. blister pack its own individual Stock Control Recording Sheet?				
Is all medication entering and leaving the service recorded in the Stock Control Sheet?				
Is the Controlled Drugs Register properly maintained?				
Are Controlled Drugs stored per regulation?				
Is medication stored appropriately according to recommended/pharmacy guidelines?				
Is a Spoiled Medications container in place?				
Is storage of spoiled medications appropriate?				
Is there a medication fridge?				
Is the fridge temperature between 2° and 8° C?				
Is fridge temperature recorded daily?				
Is fridge cleaned/defrosted monthly and log kept?				
Is there safe storage of keys?				
Check for any medication errors/near misses?				
Has follow up action taken place and was incident injury report completed for error?				
If oxygen is used, are warning notices displayed?				
Has all staff involved in administration of medication completed training?				
Is there a plan in place to address this?				
Is there any additional training required for the service e.g. Diabetes, Stesolid, Oxygen, PEG?				

Audit completed by: _____ **Date:** _____
Print

Signed: _____

Medication Audit Checklist - Individual

Person's Name:	Yes	No	N/A	Action
MP1				
Name, Address, Date of Birth and Photograph				
Date medication started?				
Name of the medication?				
Dosage to be administered?				
Route of administration?				
Frequency of administration?				
Any discontinued medication appropriately deleted (line through the entry and initialled and dated by the service manager/prescriber)?				
Time(s) of day/week/month medication to be administered?				
If MP1 was changed recently, has a new MR2 sheet been commenced and is out of date MP1 stapled to last MR2?				
Any allergies?				
If MP1 photocopied, is copy of good quality and complete?				
Signature of Prescriber for each medication listed on MP1?				
MR2				
Person's Name and Date				
Centre (day and residential/respite)				
MR2 relevant to MP1?				
Have medications been administered per prescriber's instruction?				
Do medication letter identifiers and times of administration listed on MP1 correspond with those on MR2?				
Do staff sign MR2 each time medication is administered?				
Other Forms				
Stock Control Recording forms being used appropriately?				
Self-Administration of Medication Support Plan completed?				
Relevant Patient Information Leaflets (PIL's) available?				
Accessible medication information available (PIL's)?				
Medical Appointments/Admission Form (MAF) (Appendix A - 1.6 Best Possible Health)?				
Protocol(s) for administering PRN Medication (non- Psychotropic) in place?				
Protocol(s) for administering PRN Medication (Chemical Restraint) in place?				
Do all PRN protocols (including those for Rescue Medication) correspond with the MP1?				
Administering medication covertly in food or drink?				
Administering medication in food or drink because of swallowing difficulty?				
Medications Returned to Pharmacy Form in Stock Book?				
Health Condition Management Plan in place?				
Do medications identified in MP1 correspond with those listed in *My Health Action Plan* and *Self Administration of Medication Support Plan?*				
Forms archived annually?				

Person's Name:	Yes	No	N/A	Action
Consent Form - for the administration of Homeopathic/ Alternative Medication?				
Medical Admissions Form- (Hospital)?				
Medical Consent Form completed?				
Incident/Injury forms filed in IP for medication errors?				
Any other relevant protocols/forms (fill in below)?				
Other Medication Storage and Administration Matters				
Is medication stored in person's room in a locked compartment or centrally in the house/building?				
Are all the person's medication within Expiry Dates?				
Are products with short shelf life clearly labelled with an opening date and a cease using by date?				
Are all liquid medication measured in syringe/spoon/graduated pot as supplied with the medicine/by the pharmacist?				
Do labels satisfy all the requirements, name, date etc.				
Do labels cover identifying details on medication?				
Is the administration of creams, ointments, drops, oral nutrition etc. properly stored (including refrigeration) and recorded in the MR2?				
Self Administration – Full/Partial *There are particular policy arrangements in place for people who look after some or all of their own medication. Refer to Medication Policy 1.7*				
Have medications been administered/person supported per Self Administration of Medication Support Plan?				
If the person partially or fully self administers their own medication, are there any concerns about their practices?				
If concerns arise, do you need to revisit the Self Administration of Medication Support Plan?				
Other				

Audit completed by: _____ Date: _____
PRINT

Signed: _____

Medication Ordered

Medication Received Record

Name:	**Address:**	**Name**	**Address:**
DOB:		**D.O.B**	

Prescription Requested				**Medication Received from Pharmacy** Enter ✓ or ✗ to confirm receipt or otherwise.			
Name of Medicine (Strength if appropriate)	**Dose**	**Frequency of Administration**	**Quantity Requested**	**Name of Medicine (Strength if appropriate)**	**Dose**	**Frequency of Administration**	**Quantity Received**
Notes				**Notes**			

Signed: _____ Service:_____ Date:

Signed: _____ Service:_____ Date:

TEMPERATURE RECORDING - MAXIMUM / MINIMUM FRIDGE CHART

Name of Service: _____

Record of Maximum and Minimum Fridge Temperatures to be recorded at the same time each day

Please keep a copy of this chart in a plastic sleeve taped to the fridge door

Day	Date	Time	Maximum	Minimum	Day	Date	Time	Maximum	Minimum

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