1. **Medication Administration in Home Care**

**A PRINCIPLES OF GOOD PRACTICE**

* Every person who receives support at home has the right to manage and administer their own medication.
* Any assistance that is offered must be carried out in a manner which promotes the individual’s independence and respect for their rights, dignity, privacy and cultural beliefs.
* Every adult who has capacity to make a decision, has the right to refuse medicine even if refusal will adversely affect their health.
* Each worker who prompts, assists or administers medicines to another must take responsibility for their actions and ensure that the safety of the person is paramount.
* Information related to the person’s medicines should be treated in the same way as other personal care information and remain confidential.
* In order to maintain the safety of the person and improve and promote good practice, all discrepancies and medication errors must be reported and investigated.

**B ROUTES OF ADMINISTRATION**

The majority of people who receive care at home are taking medicines that come as oral preparations in the form of tablets, capsules and liquids, but many individuals need eye and ear drops, inhalers and products that applied to the skin.

A small number may also require specialist treatments such as insulin, administration via a tube and anti-cancer medication. The latter list will require specific training tailored to the person in receipt of the care.

**C ORDERING AND STORAGE**

Generally speaking it is not within the carers role to influence:

A How the person chooses to obtain the medicines

B How and where the person chooses to keep the medicines at home

C How medicines that are no longer in use are disposed of

D The choice of over the counter medicines that the person wishes to buy.

The person receiving the care, or their significant other, is generally responsible for the ordering and storage of the medication but the care worker must be aware that many older people at home have limited or no support from friends or family so may require help to order repeat prescriptions, collect the drugs from the pharmacy and safely store them. Errors can occur when drugs are haphazardly stored.

Out of date drugs can be taken to the pharmacy for disposal with the service users written consent. It is advisable that the pharmacist also gives written proof of having received the drugs. This is especially the case with controlled drugs.

**D ADMINISTRATION**

**Prompting and Assisting**

An issue of uncertainty is the difference between prompting and administering medicines. An assessment may show that the service user is essentially able to retain control of their own medicines but needs help with mechanical tasks such as requesting repeat prescriptions from the GP, or an *occasional*reminder/prompt from the care worker to take their medicines. [A persistent need for reminders may indicate a service user no longer has the ability to take responsibility for their own medicines and this should stimulate a review of the person’s care plan].

 Another simple task that the carer could do is opening containers of medication at the request and under the direction of the service user. In this basic level of care *the service user* makes the active choice about what they take, when they take it and how they take it.

**Administer:** Where the person for either physical or cognitive reasons is unable to take the medicine themselves and the carer is required to open the packaging, place medicine on a spoon or in a container and place in the person’s mouth or hand.

When administering medication the following riles apply :

* **Right Patient:** Check name on boxes, MDS
* **Right Medicine**: Check the typed list which will have been prepared by the manager, check the medication label
* **Right Route**: Check label and appropriateness, confirm the patient can take or receive drug by the prescribed route
* **Right Time**: Check the frequency on the typed instructions, check you are giving at the right time, confirm when the last dose was given. Be mindful of ‘as required medication’ that the frequency of administration is correct. e.g Paracetamol
* **Right Dose**: Calculate dose if necessary. Be mindful of ‘as required medication’ that the daily does is not exceeded.
* **Right to Refuse**: Check is the patient capable of making this decision, is there an order in place which allows you to covertly administer medication.
* **Documentation**: Complete and sign the necessary documentation to prove that you have witnessed the person has *taking* the medication. Any refusal should be documented in the resident’s care plan .

**E MONITORED DOSAGE SYSTEM (MDS)**

MDS is a medication storage device designed to simplify the administration of solid oral dose medication. However, MDS although simple and convenient for a range of medicines, carry their own pros and cons. E.g. if a service user did not want to take the ‘water’ tablet in the morning for social reasons could the staff identify the tablet in the MDS?

Not all medication formulations can be dispensed into MDS. obviously oral liquids, eye-, ear- and nasal-drops, external formulations, suppositories and powders cannot be put into MDS

MDS units can be physically difficult to manipulate. Puncturing the thin plastic seal over the medicine compartments can present a challenge which may require the assistance of the carer.

There has been a move away from MDSs in the care home sector for a variety of reasons but individuals in receipt of care at home may still have their medicines dispensed weekly in these packages.

 In many circumstances the most appropriate and safest presentation of medicines to people in receipt of care, is to use the original container. This method is desirable since medicines are not transferred to other containers and the directions of the prescriber will be clearly shown on the typed label.

**F CONSENT**

There should not be an assumption, that because a person receives support at home, that they are unable to make decisions and choices about their care as regards medication. It is important that care staff know that an individual who is of sound mind can refuse a drug even one which is there to improve their quality of life.

If this happens then the care manager should be informed and a decision as to whether the service user requires to be further assessed will be taken in conjunction with the social work and the family. The carer should note the refusal and reason in the person’s care notes.

**G OVER THE COUNTER MEDICINES (OTC)**

The service user is entitled to use whatever OTC they wish and may in fact do so. Carers must not suggest any form of medication to the service user and should inform the manager if a person is taking an OTC which may prove hazardous along with the prescribed drugs. E.g. person is prescribed Paracetamol and the service user is taking LEMSIP

**H PALLIATIVE CARE**

Individuals who do not wish to die in hospital are increasingly opting to receive palliative care at home.

Following assessment by the manager in conjunction with other multi-disciplinary agencies, it will be decided which level of care is required (see D above) this will be recorded within the personal plan and retained in the service user’s home.

The person receiving end of life care often required a controlled drug. Although all drugs have the potential for harm, controlled drugs are especially hazardous to life if given contrary to the prescribers instructions. These drugs include: Fentanyl Patches, Dihydrocodeine, Morphine, Pethidine, Oxycodone, Tramadol.

Special care should be taken by all staff who administer controlled drugs and where possible have them checked before administration.