**2 Medication Administration in Care Homes**

Within the scope of this document it is not possible to cover all aspects of medication administration within all care homes within which the nurse may work. Local policies must be consulted and adhered to.

**A OBTAINING MEDICATION**

Although the responsibility of the registered manager of the home, staff must ensure that they inform the manager or nominated person if any medication appears to be in short supply.

All medication should be re-ordered using the repeat prescription form or other appropriate ordering form and sent to the GP practice concerned. Verbal requests for medication should be avoided wherever possible unless confirmed in writing or my email or fax machine.

Agency nurses should be made aware of the out of hours numbers of the pharmacy and NHS 24

When new medication arrives at the home it should be checked by the allocated member of staff to endure all details are correct.

**B RECORD KEEPING**

A Medication Administration Record (MAR Chart) is normally maintained for every resident within a care home. The MAR chart is *not a prescription* sheet, it is merely a document used to record administration of medicines. The instruction no the MAR chart should exactly correspond to what is printed on the dispensing label. The MAR charts contain the following information.

* Resident’s name
* Name of Home
* Allergies (including ‘not known’ if this is the case)
* Name of GP
* Medication prescribed
* Route of administration
* Time of administration
* For ‘when required’ medicines, the maximum dosage in twenty four hours)

A record of whether the resident can usually consent must also be retained.

Details of the administration of medicines will be recorded for each resident on his or her MAR chart **at the time of administration** and not prior to or at a later date or time.

**C STORAGE REQUIREMENTS**

It is the responsibility of the nurse in charge to ensure that all medication is stored correctly and safely.

Medication not requiring cold storage will be kept in a robust storage cabinet secured by lock and key. This should provide space for each individual resident to have their medication grouped together and internal and external medicines stored separately.

When a resident chooses to administer their own medication, a lockable drawer or cupboard is provided in their room for this purpose. The resident is responsible for the security of the key. A spare key is kept for use in emergencies.

Medicines requiring refrigeration will be stored in a medication fridge which should be kept locked. Drugs should be maintained at between 2 – 8 degrees centigrade. The temperature should be recorded as per the local policy and in the event of thermometers highlighting the fridge not maintain the correct temperature, advice must be sought from the pharmacist.

Oxygen will be prescribed for each resident if required and the supplier will provide guidance on storage but generally the following applies:

* Cylinders must be stored under cover and not be subject to extreme temperatures
* The area must be clean, ventilated and away from highly flammable liquids and sources of heat or ignition
* Cylinders must be stored upright and secured by way of a chain to the wall
* Empty cylinders should be stored separately and easily distinguished from full cylinders
* The statutory warning notices should be displayed on any room where oxygen is used or stored
* Oxygen therapy must only be discontinued or the flow rate altered by the direction of the prescriber as with any drug
* A record should be made in the MAR chart as with any drug

**D ADMINISTRATION**

Agency Registered nurses who work within care homes are very often required to administer medication to residents. This is often challenging to the nurse who may not know the system of work, or the residents to whom she is to administer the drugs.

If the agency nurse is working night duty it is good practice to go into the home half an hour earlier to take time to familiarise themselves with the policy and system of work.

The agency nurse will also be required to count drugs at hand over time this is especially true for Controlled Drugs but in many cases all tablets are counted.

Care homes often have senior support staff trained in the administration of medication, the agency nurse may devolve this responsibility to that person in the best interests of the residents. This is something that could be clarified with a member of the care home staff.

 Drug administration follows the same principles wherever the person works and no step should be omitted for the safety and security of both resident an nurse.

Medicines administered to residents must be done in the way and at the time the prescriber intends. The prescriber’s directions will be on the printed label attached to the medication. Additional information can be found in the *Patient Information Leaflet* provided with the medication. Another useful source of information is the *British National Formulary* which can be obtained on line on a smart phone or computer.

To avoid errors in administration the following **must** be adhered to:

* **Right Patient:** Check name on prescription, room number and if possible use another identifier as well as having the patient identify themselves
* **Right Medicine**: Check the prescription, check the medication label
* **Right Route**: Check prescription and appropriateness, confirm the patient can take or receive drug by the prescribed route
* **Right Time**: Check the frequency on the prescription, 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.
* **Right Dose**: Check name on prescription, check appropriateness, Calculate dose if necessary. Be mindful of ‘as required medication’ that the daily does is not exceeded. Where a person is taking Anticoagulant Medication, and where regular INR monitoring is taking place, the guidelines for taking verbal orders and amending MAR charts should be followed when changes to the Warfarin dose is made.
* **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 and the correct code written in the MAR chart
* Do not use another member of staff as a ‘runner’ to administer on your behalf. This is illegal. Nor should drugs be left on bed tables for another person to administer.
* Efficacy of the medication. It is your responsibility to note whether the drug has had the desired effect and record appropriately.

**E CANCELLING MEDICATION ON THE MAR**

When an item of medication is stopped, a cross through the item should be made on the MAR chart to make it clear it has been stopped. The former record should still be legible. No TIPPEX should be used. The cancellation must be signed and dated and a reference made in the resident’s notes or on the back of the MAR explaining why an item was stopped.

**F ADDING A MEDICATION TO A MAR**

This must only be done when authorised the by prescribed and written confirmation obtained.

Care must be taken to ensure the record is printed in capital letters. The information that is printed on the medication label must be copied directly onto the MAR chart. There must be reference in the resident’s notes or on the back of the MAR detailing the date, and time and prescriber and explaining why the item was added. It is safe practice to have this witnessed.

**G CONTROLLED DRUGS**

The Misuse of Drugs (Safe Custody) Regulations 1973 imposes controls on the storage of Schedule 1,2 and 3 CDs. All care homes must comply with the requirements and ensure that relevant CDs are kept in a locked cabinet or room constructed and maintained in accordance with the law.

Nothing should be displayed on the outside on the cabinet, cupboard to indicate that CDs are kept within the area. A designated person within the premises should take overall responsibility for the keys / codes of the cabinet. The keys should never be given to an unauthorised person. The ultimate responsibility for the safe storage rests with the key holder.

The care home staff should see the signed prescription sheet and it is advisable that the home kept a copy as evidence that at the time of administration, there was a current prescription in existence ( as with other drugs).

When administering a CD the procedure detailed above is followed with the addition of the following:

* Before administering the CD the care worker should measure and check the dose with another appropriate member of staff acting as a witness.
* The CDR should contain a separate page for each drug for each resident and the name, dose and strength of the drug should be written clearly at the top of the page. A column for recording running balances should be on each page to maintain effective control and identify any discrepancies relating to the use of CDs
* Both care workers should witness the resident taking the drug and sign the register to verify this. The resident MAR chart can then be updated appropriately.
* CDs should be administered by appropriately trained care home staff. The administration should be witnessed by another appropriately trained member of staff. In some cases the resident may be able to verify and record that they have been given the CD
* CDs should be returned to pharmacies at the earliest opportunity for appropriate destruction. This includes CDs no longer required, passed their expiry date or when the resident has died. Even when still in date, CDs no longer required must not be used for other residents. Homes should record the form and quantity of all returned CDs.
* CD patches, when removed from residents, still contain small quantities of the drug and should be folded in half following removal to render the content irretrievable. The care home should have a policy and arrangement with the local pharmacy for safe disposal of these patches.
* If on counting CDs, a discrepancy is found, it should be reported to the manager of the care home and the agency immediately. They should investigate the discrepancy promptly.
* If the discrepancy is found to be due to an error in subtraction or addition in the stock control do not change the balance column or use correction fluid. The following details should be entered under that last entry:

: the date

: the error in subtracting/ addition ( indicated with an Asterix)

: the correct balance

: the signature member of staff and the witness

* In care homes where a dose is given, but the care worker fails to complete the CDR at the time of administration, the following details should be recorded under the last entry:

: the current day’s date

: the dose administered but not recorded at the time followed by the resident’s details

: the correct balance

: the signature of the administering care worker and witness

* If the reason for the discrepancy cannot be found, and the CDs appear to have gone missing, then all relevant people, including the police should be notified.

**COVERT ADMINISTRATION OF MEDICATION**

Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. While this is sometimes necessary and justified, it must never be given to someone who is capable of deciding about medical treatment. Mental Welfare Commission document Covert Administration Legal and Professional Guidance 2013 states that is it generally unlawful to administer medication without consent and that it could be regarded as assault.

Under the law in Scotland ,there are mechanisms forgiving medical treatment to people who lack capacity. The two significant pieces of legislation are: The Adults with Incapacity

(Scotland) Act 2000 The Mental Health (Care and Treatment) (Scotland) Act 2003

Decisions on whether to covertly administer medication to individuals should not be taken lightly and should be discussed with the MDT concerned including the resident’s significant others. The Mental Welfare Commission document above gives suggestions for a proforma which should be filled out and retained on the resident’s record after having satisfactorily answered number of questions. All staff would then be legally allowed to administer the drugs in the most appropriate way in the person’s best interests.

**CRUSHING TABLETS AND OPENING CAPSULES**

Staff should never assume that this practice is acceptable. It may adversely affect the efficacy and safety of the drug and render the manufacturer’s responsibility for safety null and void.

Many drugs are available in liquid form and the pharmacist should be consulted should a resident be unable to take a tablet or capsule.

If an alternative is not available, the pharmacist may be able to suggest other methods appropriate to the medication.

**HOMELY REMEDIES**

A Homely Remedy is a medication used for a minor ailment such as toothache, which can be bought over the counter and used without a prescription. Due to the risk of cross contamination no creams or ointments will be on the list.

Care homes will have an agreed list of Homely Remedies agreed by the GPs. They are not labelled for individuals as they may be used for several residents.

They are administered at the discretion of the senior trained care staff to residents with their consent taking The Adults with Incapacity (Scotland) Act 2000 into account.

Any Homely remedy should be recorded in the resident’s notes and the MAR chart as with any other drug.

No resident should have a Homely Remedy for more than 48 hours without advice being sought from the GP.

**MONITORED DOSAGE SYSTEMS (MDS)**

Many care homes no longer use MDSs since over that past number of years there has been evidence to suggest that the systems may not be as useful as once thought