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Cumbria Care’s home care and reablement service supports adults living at home in the community who require support to maintain or regain their independence. Providing support with taking medication may be key in enabling a Service User to continue to live at home.

It takes into account the implementation of Cumbria County Council’s Adult Social Care and Cumbria NHS ‘Community Medication Policy’ (2014) and the related document on the delivery of health care tasks.

This policy ensures that Cumbria Care meets the requirements of the Care Quality Commission by providing a quality care service that manages people’s medicines safely.

The introduction of this policy has led to an extensive training programme for Cumbria Care staff who now have the skills and competencies to support people safely, in the community, with medication and health care tasks.

The purpose of this policy is to ensure the safe administration of prescribed medication and health care support by domiciliary care staff (home care and reablement) who have been deemed competent at following the policy and procedures.

**Who is this Policy for?**
This Medication Policy is applicable to all members of staff working in Cumbria Care’s community care service, including home care and reablement staff, when providing care for Service Users in the community.

**Overall Aim**

This policy aims to:

- promote and maintain the Service User’s independence by enabling them to self-administer medication where possible
- to increase the quality of care delivered by Cumbria Care with Support Workers being able to give medication and health care support to Service Users
- provide guidance for staff to enable them to administer medication safely and provide health care support where required
- to define staff roles and responsibilities in the management and administration of medication
- to provide a standard competency and training framework for the administration of medication and health care support
- enable good communication with Social Workers and Health Professionals
- ensure compliance with the Care Quality Commission (CQC) Standards relating to the safe management of medication in the community
- enable the Cumbria Care implementation of the policy and procedures set out in the Cumbria Adult Social Care and NHS Community Medication Policy (2014) and related Health Care Tasks document
Support with Medication and Health Care Tasks

This policy will increase the support offered by Cumbria Care and will enhance our Service User’s quality of life. The need for medication support will be identified by a Social Worker during a Service User’s needs assessment for social care support. Requests for stand-alone medication support will be considered by Cumbria Care on a case by case basis.

Cumbria Care will provide medication support under the following headings:

**Category 1 Support: General Support**

General support will be given where the Service User directs their support, takes overall responsibility for their own medication, consents to the specific support being arranged but needs some assistance due to their physical ability. The Service User will be responsible, in whole or in part, as detailed in the Support Plan for the safe management of their medication.

General support may mean reminding a Service User who has capacity to make their own decisions to take their medication or carry out a task. If support is needed, the service user will remember and know which medication to take if prompted. Support could be to remind them to take their medication at a particular time or with food.

General support would be helping the Service User as detailed in the Support Plan. They may require someone to open medicines container tops due to dexterity or visual impairment and are unable to do this without the assistance of a support worker.

General support could be monitoring that a Service User has taken their medication.

**Category 2 Support: Administration of Medication**

Support with the administering of medicine will be given where a person is unable to take responsibility for their own medication due to impaired cognitive awareness or physical limitations. Support Workers will physically select and give medication to the Service User, including placing medication in the person’s mouth and application of a medicated cream or ointment to the skin.

To administer means to select, measure and give medication to a Service User or carry out a related task as specified in the Support Plan and in accordance with the directions of the prescriber, for example the GP.

The Support Plan will specify the tasks the Support Worker is able to undertake and their responsibility for ordering, recording, storing and disposing of the medication, in whole or in part.

Administering means taking full responsibility for ensuring that the Service User is given medication as prescribed.

**Category 3 Support: Administration of Medication by Specialised Techniques**

There may be occasions when Support Workers are asked to give medicines that registered nurses normally administer. This is helpful in many situations and avoids people having to wait for a nurse or paramedic to attend. Referrals for support with Category 3 tasks will always require training and clinical supervision from a Health Care professional, usually the District Nurse, for every Support Worker for each individual Service User. The tasks include:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection including testing of blood sugars
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
Health Care Tasks

Cumbria Care are supporting new ways of working by undertaking health care tasks to people living at home. This will reduce duplication with NHS services for people with complex long term conditions and help to facilitate timely discharge from hospital. There are three levels of health care tasks, A, B and C. Level B and Level C tasks require sign off from a health professional as confirmation of delegation of the task to Cumbria Care. Key health care tasks include:

Level A:
- Assisting customers with the management of continence e.g. catheter bag change and empty
- Assisting customers with dementia, those who are confused or displaying challenging behaviour
- Helping to prevent falls
- Infection control
- Assisting customers with nutrition, hydration and reducing the risk of malnutrition and dehydration
- Assisting customers with, and where needed administration of, prescribed medication including eye drops (including post cataract procedures), ear drops, nose drops, inhalers, patch based medicine, emollient and barrier products
- Application of medicated creams including prescribed medicated creams, ointments, lotions for external use (where skin is unbroken)
- Assisting customers who are dying in achieving a peaceful and dignified death
- Assisting customers with skin care and preventing pressure sores
- Assisting customers with equipment to use oxygen
- Assisting customers who use nebulisers/spacers/inhaler

Level B:
- Eye drops including post-surgery, variable dosage and multiple eye drops where combination or order of drops is important
- Application of support stockings where skin is intact and hosiery has been prescribed including recovery from leg ulcers and where there is a risk of deep vein thrombosis and pulmonary embolism
- Use of patch based medicine including controlled drug pain relief like Fentanyl

Level C:
- Assisting customers with nutrition using PEG feeding
- Assisting customers with simple wound dressing
- Assisting customers with stoma management
- Assisting customers with supra pubic catheters
- Assisting customers who have dysphagia
- Application of medicated creams – prescribed medicated creams, ointments, lotions for external use where skin integrity is compromised
- Assisting customers with insulin
- Assisting customers with specialist medication including buccal midazolam and rectal diazepam

Roles and Responsibilities

Cumbria Care’s Responsibilities
- To provide medication and health care task training
- To ensure staff competency in supporting people with medication
- To maintain a record of medication training attendance
- To maintain a record of incidents relating to medication and identified action from learning

Supervisor Responsibilities
- To understand, be familiar with, and follow this medication policy, procedures and health care tasks
- To ensure that a medication risk assessment is carried out for all Service User’s prior to care commencing and that the nature and extent of support required is detailed in the support plan
- To ensure the Service User’s written consent is given for Cumbria Care Support Workers to assist with medication and/or health care tasks
- Obtain a Medication Administration Record (MAR) from the Pharmacist listing medication to be administered by/with the assistance of Support Workers following first assessment
- To ensure that follow up reviews of medication are carried out six monthly or sooner when changes occur that may impact on medication
- To assess/ensure Support Worker competencies with regards to medication and health care tasks before assigning work
• To ensure that care staff only carry out medication support tasks that have been identified in the Medicines Management (MM) referral and risk assessment
• To discuss referrals for health care tasks with the District Nurse or appropriate health care professional and to make arrangements for training and 'sign off' of Level B and C health care tasks
• To respond to queries and concerns raised by Support Workers
• To communicate with Social Workers and Health Care professionals as required

Support Workers Responsibilities
• To understand, be familiar with and follow this medication policy, procedures and health care tasks
• To complete Cumbria Care’s medication and health care training and update courses as determined by the Competency Framework
• To provide safe assistance with medication to a client within their own home
• To request immediate assistance from Supervisors for any medication situation in which they do not feel confident
• To inform the Supervisor of any changes that may impact on medication or any concerns or issues with regard to medication
• To seek the consent of the Service User each time you assist with medication and maintain their right to independence and choice at all times
• To diligently and correctly record all assistance with medications
• To keep all information about a Service User’s medication and treatment confidential
• Not to introduce, sell, recommend or offer advice with regard to medication or over the counter/homely remedies etc.

Training and Staff Competencies

Training for staff will be provided or arranged by Cumbria Care and will cover both support with medication and health care tasks. A training record should be kept for each member of staff along with a record of training and competency assessments.

Staff providing support with medication must clearly understand the limits of the support to be provided, and work strictly within the instructions in the support plan. If they have any concerns regarding this, or the Service User appears to require a greater level of support, the Support Worker must report this to their Supervisor promptly.

Support Workers are not permitted to give support with medication or health care tasks until they have:

• Successfully completed the Safe Handling of Medication workbook
• Attended and successfully completed the Cumbria Care policy and procedure training sessions on the Medication Policy for Domiciliary Care
• Attended and successfully completed the Cumbria Care training sessions (sessions 1-3) regarding underpinning knowledge and to support the undertaking of health care tasks
• Been assessed as competent against the elements set down in the Cumbria Care Medication Staff Competency Framework

Care staff will be observed undertaking each medication support task on a minimum of three occasions before they are able to undertake the task independently. Competency will then be reassessed on an ongoing basis, but at least annually. The purpose of the competency assessment is to ensure the Support Worker can confidently and correctly, support people with medication and related tasks.

Care staff will only be authorised to give Category 3 support with medication once they have received the necessary specialist training from a health professional for the task, for each individual Service User, and are deemed competent by the health professional, in addition to the requirements above.
Care staff will only be authorised to give support with Level B and Level C health care tasks once they have received the necessary specialist training from a health professional for the task, for each individual Service User, and are deemed competent by the health professional, in addition to the requirements above.

The Cumbria Care Staff Competency Framework for Medication details the requirements for ongoing support, training and assessment of competency and specifies when reviews and further training are required.

**Monitoring and Audit**

Cumbria Care’s internal audit process will demonstrate that care staff are working to the procedures set out in the policy. Completed MAR charts and communication sheets should be returned to the Domiciliary Care office for regular audit purposes before they are archived.

These audits will assist in improving safety and care for Service Users and will include:

- A check of coding and completion of MAR charts for accuracy
- A review of regular administration of a ‘prn’ medication to check understanding with carer or review with health professional
- A reflection of all medication issues written on the Communications Sheet such as swallowing difficulties, refusals, no medication available etc.
- A check of the timeliness of the Support Worker reporting problems to the Supervisor for discussion with health care professionals as detailed in this policy such as regular refusal.

**Medication Incidents**

There are several ways in which errors can be made when medicines are administered such as incorrect administration, omitted doses, duplicated doses, administration of discontinued medication and medication being lost or stolen, amongst other reasons.

Every employee has a duty and responsibility to report any errors. Some errors may appear trivial but all mistakes in assisting with medicines must be reported by staff to the line manager or on call service immediately so that appropriate action can be taken to avoid harm to the Service User. In the event of the Support Worker being unable to contact line management, they should seek medical advice from the GP, Pharmacist or CHOC.

Cumbria Care recognises that occasionally a member of staff will make an error for various reasons. It is important that the reasons for all mistakes and ‘near misses’ are established and collected so that recurring problems are identified and acted upon. Regular errors may indicate a problem with the procedures which can then be reviewed and improved.

All mistakes must be recorded on a Medication Incident Report and the procedure followed as soon as incorrect administration is identified. Mistakes will be dealt with in a constructive manner that addresses the underlying reason for the incident and prevents recurrence.

Where the medication error has resulted in harm or potential harm, a referral should be made to the Safeguarding Team.

Any incidents will be regarded as a learning process and will be shared with all staff to raise awareness of safety issues.
Glossary

**Assessment/ Care assessment:** The process of identifying and recording the health and social care needs and risks of an individual, and evaluating their impact on daily living and quality of life, so that appropriate action can be planned.

**Care Manager:** The person responsible for an individual package of care, including assessment, commissioning and review.

**Care Record:** The daily record of care actually provided.

**Care Staff:** Staff employed by Cumbria Care

**Care Visit:** A visit to a service user's home for the purpose of providing care.

**Compliance Aid:** A device used to aid compliance. This includes special bottle tops or opening devices, reminder charts, Haleraid® devices, eye drop guides. They also include devices such as ‘multi compartment compliance aids’, also known as ‘dosette boxes’, which are usually filled by service users or their families/friends. They also include pharmacy-filled monitored dosage systems, which are sometimes known as blister-packs (not to be confused with manufacturers’ original blister strips).

**Healthcare Professional:** Healthcare staff that are registered with a professional body e.g. doctor, dentist, pharmacist, nurse, pharmacy technician.

**Informal Carer:** A person who provides care for a service user without receiving remuneration, usually a family member, friend or neighbour.

**Medication, Medicine:** The terms ‘medicine’ and ‘medication’ are used interchangeably. For the purposes of this policy they relate to medicines prescribed for the service user by a doctor, dentist or non-medical prescriber.

**MAR Chart:** Medicines Administration Record Chart. The form used to record the administration of medicines.

**Medicines Risk Assessment:** Systematic check of the hazards and risks for the Service User and care staff associated with the medicines in use. It addresses problems such as difficulties with compliance, forgetfulness, complex drug regimes, hoarding of medicines etc.

**Monitored Dosage System (MDS):** A system or device which separates different doses and is used as an aid to compliance. It doubles as a container and is prepared by a pharmacist / doctors’ dispenser. As such labelling requirements must be complied with, and any particular storage requirements must be taken into account. This includes, but is not limited to, pharmacy-filled blister packs, but does NOT include manufacturers’ original blister strips.

**Service User:** Person receiving a service from Cumbria Care.

**Support Plan:** Cumbria Care's plan which sets out the agreed care objectives, following assessment, and sets out how these are to be achieved. The plan will indicate times of call, tasks to be completed and the level of assistance with medicines.

**Support Worker:** A member of the Cumbria Care staff team.
Section 2: Procedures
**Referrals**

Referrals from Adult Social Care for support with medication will usually come in the first instance via a telephone call. The person taking the call should prompt the caller to provide as much information as possible.

Adult Social Care will then send through the initial reablement task sheet on IAS which will include some information on the Service User’s medication needs on the IAS task instruction.

Adult Social Care will send the Medicines Management (MM) form which will identify the medication needs of the Service User including the risk assessment. The MM form will identify the category of support and any health care requirements.

**Arranging Medication Support**

The Supervisor should arrange a visit to the Service User to complete the Cumbria Care Medication Risk Assessment, taking into account the information contained in the MM form, which will provide the detail of the support to be provided.

Although Adult Social Care have obtained the Service User’s consent for support, it is important that the Service User agrees to the support with medication that will be provided by Cumbria Care.

The Supervisor will need to compile the reablement/support plan based on the information provided. Cumbria Care, through the Service User’s assessment, should determine and document the following in the Service User’s reablement/support plan:

- The nature and extent of help that the Service User’s needs
- A current list of prescribed medicines for the Service User, including the dose and frequency of administration, method of assistance
- Details of arrangements for medication storage in the Service User home and access by the Service User, relatives or friends.
- A statement of the person’s consent for Cumbria Care to support with medication. (There is space on the risk assessment and the reablement/support plan for the Service User’s signature).

It is important that the support plan is clear to Support Workers whether they are providing general support or medication administration for each adult they are supporting. This will be recorded in the support plan and must be monitored and reviewed regularly.

The reablement/support plan should be recorded on the system. Copies of the MM form, the Cumbria Care risk assessment and the support plan should be made and kept at the Service User’s house for the Support Worker to refer to.

**Category 1 support:**

- A Medication Support Record form may be required. The list of medication should be included on this form when prompting people with their medication
- Ensure a copy of the relevant procedures and Do’s and Don’ts’ document is available for Support Workers and kept with the reablement/support plan at the Service User’s house
- Agree the start day for medication support with the Service User

**Category 2 support:**

- Ensure Medication Signature Record sheet is completed by everyone
- Ensure a copy of the relevant procedures and Do’s and Don’ts’ document is available for Support Workers and kept with the reablement/support plan at the Service User’s house
- Arrange for a MAR chart from the Pharmacy/dispensing GP surgery
- Provide a controlled drugs MAR chart for the balance count if required
- Complete a PRN Protocol if required
- Complete a body map if creams are to be applied
- Agree the start day for medication support with the Service User
Form 03B – Medication Management Form (MM)

| Name       | Joe Bloggs                           | D.O.B.    | 01/01/1954 | Post Code | CA1 5LJ |

**Category One Support Required** - please tick if yes

**Category Two Administration Required** – please tick if yes

**Category Three Specialised Technique** – please tick if yes

**Health Task** – please tick if yes

Please outline agreed arrangements for safe storage/and or disposal of medication.

**Information on physical location of medication:**

**Cat 1 example:** Joe has capacity but will sometimes get confused about if he’s taken his medication or not. He is happy for the medication to be stored out of sight. Medication is to be stored in the cupboard next to the fridge. As he has capacity, if he asks for his medication to be left out team member is to follow his instructions and record actions in the communication sheets.

**Cat 2 example:** Joe has category two medication support. Medication is to be stored in the locked box next to the fridge. Medication is to be stored in the locked box at all times

**Cat 3 example:** Joe has category three medication support. Medication is to be stored in the locked box next to the fridge. Medication is to be stored in the locked box at all times

**Information on how medication is physically stored:** All medication is in original packaging.

**Information on how medication is to be disposed of:** Joe’s family will dispose of any medication that has not been taken

Please outline any requirement to provide verbal prompting or reminder to Service user regarding order of prescriptions and/or requirement for home care agency collect Service Users Prescriptions.

**Information on how medication is ordered and collected:**

Joe’s family order and collect the medication, there is no need for Cumbria Care to support with this.

Please outline any requirement to remind Service User to take their medication

**NB. Include whether care staff should check and record the Service User has taken their meds.**

**Information on the specific medication that will need assisting with:**

**Cat 1 example:** Joe would like to be reminded to take his medication. Once prompted he recognises what medication needs to be taken and can take the majority of it independently.

**Cat 2 & 3 example:** Joe needs to be given his medication by the support worker at the relevant time
Form 03B – Medication Management Form (MM)

Information on the specific medication that will need the team member to assist:

**Cat 1 example**: Joe struggles to get some medication out the package. Joe would like the team member to physically remove and pass to him the medication.

**Cat 2 example**: Joe is unable to get medication out the package. Joe needs the team member to physically remove and give him the medication.

**Cat 3 example**: Joe receives his medication through a PEG.

Please outline medication administration requirement *(risk assessment required)*

Specific information on the assistance required:

**Cat 1 example** Support worker to bring medication from kitchen cupboard to Joe.

Support worker to physically remove the medication from its original packaging as per procedure and to pass to Joe. Joe is then able to take the medication independently.

**Cat 2 example** Support worker to bring medication from the locked box and give it to Joe.

Support worker to physically remove the medication from its original packaging as per procedure and to pass to Joe.

**Cat 3 example** Medication through PEG

………………………………………… Signed by Care Manager Date: ……………..

………………………………………… Name of Health Professional involved Date: ……………..

**Note 1**: Health Professional refers to the following range of professional bodies e.g. General Practitioner (GP), GP Surgery Medicines Manager/GP Dispensing Practice, Community Pharmacist, Practice Nurse, Speech and Language Therapist, District/Community/ Learning Disability/Mental Health Nurse, Consultant, Ward Nurse, Dietician.

**Note 2**: Initially advice around medication may be sought from the GP surgery Medicines Manager and the GP surgery dispensing pharmacist or the Community Pharmacist.

**Note 3**: NB. Cat 3 support cannot be ordered without health professional input and oversight.
Form 03B – Medication Management Form (MM)

Please outline identified risk factors regarding medicines management

Specific information on what the possible risks are if service user is not supported with medication:

**Cat 1 example** If Joe’s medication is not stored out of sight, he is likely to take it at irregular times. Without the verbal prompt Joe will not remember to take his medication. Without physical assistance, Joe will not be able to take the medication out the packaging and so will not be able to take his medication.

**Cat 2 example** If Joe’s medication is not stored out of sight, he is likely to take it at irregular times. Without the support Joe will not remember to take his medication. Without physical assistance, Joe will not be able to take the medication.

**Cat 3 example** Without support medication will not be received.

Please outline steps already undertaken to address above risks

Specific information on what has been done prior to referral to enable service user to take meds independently:

**Cat 1 example** Joe has agreed for medication to be stored out sight. Joe lives alone so no other individual is able to support with medication. GP has been contacted and confirmed that all medication is necessary in existing format.

**Cat 2 example** It has been agreed that Joe’s medication is stored in a locked box at all times. Joe lives alone so no other individual is able to support with medication. GP has been contacted and confirmed that all medication is necessary in existing format.

**Cat 3 example** It is not possible for Joe to take his meds independently.

Health Tasks – please outline tasks to be undertaken and any risk management issues to be addressed – risk assessment to be included.

Specific information on any health tasks that need to be supported by the reablement / care worker:

**Level A example** Joe has a catheter, he needs supporting emptying his catheter and fitting the night bag.

**Level B example** Support worker to support with support stockings – skin intact.

**Level C example** Support staff to support with stoma care.

……………………………………….. Signed by Care Manager Date: ……………..

……………………………………….. ………..Name of Health Professional involved Date: ……………..

*See Notes 1 to 3 on page 2 relating to Health Professional*
# Medication Risk Assessment Form

**Service User Name:** ________________________________  **IAS Number:** ________________

**Address:** ____________________________________________  **Date of Birth:** ________________

<table>
<thead>
<tr>
<th>Possible Risk</th>
<th>If no</th>
<th>Outcome/Actions Taken</th>
</tr>
</thead>
</table>
| Is the service user able to order and collect prescriptions if needed? | Yes / No | • Can family/informal carers collect?  
• Does community pharmacy deliver?  
• Consider support if no other option |
| Can service user provide a list of their medicines? Do they know where all medicines are stored in the home? | Yes / No | • Contact GP if unable to establish what service user should be taking  
• Can informal carers tell you where medicines are kept? |
| If able to assess, do medicines appear to be stored appropriately? | Yes / No | • Advise  
• Seek advice from community pharmacist if necessary |
| Do quantities of medicine in the house appear to be appropriate? | Yes / No | • Advise service user or informal carers to return unwanted medicines to the pharmacy  
• Advise service user to contact GP surgery if large amounts of waste medicines – so repeat prescription can be checked.  
**Note:** medicines are the property of the service user. Disposal should only be arranged by SU themselves or informal carers, or as detailed on the care / reablement plan. |
| Does the service user know and understand what medicines they should be taking? | Yes / No | • Advise service user/carer to contact GP surgery or community pharmacist  
• (Simplification of regime, explanation and/ or issue of reminder chart may help)  
• If unable to cope with regime after advice, consider Category 2 support |
| Is service user aware of date, day, time? | Yes / No | • Is help available from informal carers?  
• Consider safety/storage issues  
• Consider Category 2 support  
• Inform all relevant parties if storage out of service user’s reach is planned  
**Note:** If Category 2 support is being considered, liaise with GP or district nurse |
| Does the service user always want to take their medication? | Yes / No | • Explore reasons – Encourage service user to discuss with GP, or Community Nurse.  
(or assessor to liaise on service user’s behalf as appropriate)  
• Inform GP or Community Nurse if service user considered to be at risk.  
**Note:** It is the service users right to refuse treatment, but this should be based on an informed choice as far as possible |
## Possible Risk

<table>
<thead>
<tr>
<th>Possible Risk</th>
<th>If no</th>
<th>Outcome/Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the service user usually remember to take his/her medication at the right time?</td>
<td>Yes / No</td>
<td>• Can informer carers help?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can community pharmacist offer reminder chart?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seek advice from pharmacist/GP, community nurse or community matron.</td>
</tr>
<tr>
<td>Can service user read the labels on medicines?</td>
<td>Yes / No</td>
<td>• Can an informal carer help?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seek advice from community pharmacist – may be able to produce larger print labels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or consider alternative packaging</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider Category 1 support if no other options</td>
</tr>
<tr>
<td>Can service user remove tabs/caps from the container him/herself?</td>
<td>Yes / No</td>
<td>• Can an informal carer help?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community pharmacist supply alternative packaging, or aids to open?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider Category 1 or 2 support</td>
</tr>
<tr>
<td>Is the service user able to swallow their tablets/capsules?</td>
<td>Yes / No</td>
<td>• Can community pharmacist advise alternative options?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seek advice from GP</td>
</tr>
<tr>
<td>Can service user pick up a bottle and pour out a dose of liquid medicine accurately?</td>
<td>Yes / No</td>
<td>Refer to GP / Community Nurse if swallowing problems give rise to concern.</td>
</tr>
<tr>
<td>Does the service user take any PRN medication?</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Does the service user need support with homely remedies?</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Are any nursing tasks required?</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>If applicable, does service user describe any problems using inhalers?</td>
<td>Yes / No</td>
<td>• Seek advice from community nurse or pharmacist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider Category 2 support if physically unable to manage, even with device to assist</td>
</tr>
<tr>
<td>If applicable, does service user describe any problems instilling eye/ear/nose drops?</td>
<td>Yes / No</td>
<td>• Can an informal carer help?</td>
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<td></td>
<td>• Can community pharmacist advise on a device to assist service user?</td>
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<td></td>
<td></td>
<td>• Consider Category 2 support if eye drops routine or request assistance from the</td>
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<td></td>
<td></td>
<td>district nurse if a level B health care task</td>
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<tr>
<td>Are the eye drops routine?</td>
<td>Yes / No</td>
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<tr>
<td>Are drops post-operative/multi dosage /variable dosage?</td>
<td>Yes / No</td>
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<tr>
<td>Does the service user require support with prescribed creams?</td>
<td>Yes / No</td>
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</table>

### Key Points
- The aim should be to promote independence with medicines wherever possible,
- Informal carers should be encouraged to help if able. If substantial help is given by informal carers, their contact details should be available and arrangements agreed for unexpected situations e.g. carer illness
### Medication Risk Assessment Form Outcome of Assessment

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Details of the assessed level of support required</th>
</tr>
</thead>
<tbody>
<tr>
<td>No support required</td>
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<tr>
<td>Informal carer can assist</td>
<td></td>
</tr>
<tr>
<td>Support to be provided by support workers</td>
<td></td>
</tr>
<tr>
<td><strong>Category 1:</strong> Service user takes overall responsibility for their own medication and consents to the specific support being arranged but needs some assistance due to their physical disability, e.g. reading labels, reminders on safe storage, occasional verbal prompting to take tablets, physical removal of meds from packaging etc.</td>
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</tr>
<tr>
<td><strong>Category 2:</strong> The service user is unable to take responsibility for their own medication due to impaired cognitive awareness or physical limitations. Support Workers physically choose and give medication to the Service User, including placing medication into the Service User’s mouth and apply medication cream or ointment to the skin. Details to be included in the support plan.</td>
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<tr>
<td><strong>Category 3:</strong> Administration of medication by specialised techniques. These will require training and sign off from the district nurse or health professional.</td>
<td></td>
</tr>
</tbody>
</table>
Name of Assessor/Supervisor (print) ________________________________________________________________

Signature of Assessor __________________________________________________ Date:________________________

Statement of Service User/Agreed representative
I confirm that I have given all necessary information to support the planning of any help with my medicines.
I agree to the support being offered.

Signed (Service User) __________________________________________________ Date:________________________

Representatives name ________________________________________________________________________________

Relationship to Service User __________________________________________________ Date:________________________

### Category 3 Healthcare Tasks

Refer to district nurse/relevant health professional if assistance with any of these specialist tasks may be required.
Level C tasks require a mandatory discussion with the health professional to clarify any additional training and sign off required prior to commencement of task.

| Assistance may also be required with the following specialist tasks (Please circle) |
| • Assisting customers with nutrition using PEG feeding |
| • Assisting customers with simple wound dressing |
| • Assisting customers with stoma management |
| • Assisting customers with supra public catheters |
| • Assisting customers who have dysphagia |
| • Application of medicated creams – prescribed medicated creams, ointments, lotions for external use **where skin integrity is compromised** |
| • Assisting customers with insulin |
| • Assisting customers with specialist medication including buccal midazolam and rectal diazepam |
Category 1:
General Support

Summary of Tasks and Guidance for Support Workers

Definition:
General support is given when the Service User directs their support i.e. the Service User is able to take overall responsibility for their own medication and consents to the specific support being arranged but needs some assistance due to their physical ability.

Tasks:
- Requesting repeat prescriptions from the GP.
- Collecting medicines from the community pharmacy and or dispensing GP Practice.
- Disposing of unwanted medicines safely.
- Safe storage of medicines.
- Manipulation of a container, e.g. opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the Service User. NB. Support Workers are not required to select the medication but may have to measure a dosage under direction of the Service User.
- Assist with home oxygen at the request of the Service User by turning the oxygen supply on or off and assisting with the provided mask or cannula. (Cumbria Care Support Workers are only allowed to assist people with adjusting their mask as directed by the Service User. Any other requests for assistance must be considered on a case by case basis and the relevant training and support obtained from the health professional.)
- Assist with inhalers/nebulisers/spacers at the request of the Service User. (Requests for assistance must be considered on a case by case basis and the relevant training and support obtained from the health professional.)
- Regular verbal reminders from Support Workers to the Service User to take their medication. A risk assessment must be completed by the Adult Social Care Practitioner identifying why the reminder is required and the implications if the person being prompted persistently demonstrates confusion around whether or not they have taken their meds. The referral for support must identify if the support is simply a verbal reminder to the Service User or if the Support Worker is to watch and monitor that the Service User has taken the medication.

‘Prompting’ Service Users to take their medication should be considered as a temporary measure and a persistent need for reminders may indicate that the Service User does not have the ability to take responsibility for their own medicines. The Supervisor should arrange a review with the Service User’s Social Worker after a maximum of six weeks.
Support Workers CAN/MUST:

- Monitor level of independence/capability is maintained and inform the Supervisor of any relevant change.
- Ensure written consent from the Service User is in the file.
- Inform the Supervisor of requests for further help than is documented in the support plan.
- Remind Service User to take their medication.
- Read out instructions etc. on packaging or the Patient Information Leaflet for Service Users (if requested by the Service User).
- Manipulate packaging (original containers or pharmacy filled compliance aids only) under direction and in full view of Service User.
- Assist in ordering/collection of medication as directed by Service User.
- Medication, if requested by the Service User who has mental capacity, can be placed into Service Users mouth/ear/eye/nose. *(This will normally come under Category 2. There may be rare occasions, when it is appropriate to support the service user in this way, for example if the service user is ill).*
- Must document all assistance given in the Communication Sheet.
- Report mistakes to the Supervisor immediately.
- Only undertake tasks that they feel adequately competent to undertake and to discuss any further training needs with their manager.

Support Workers WILL NOT:

- Assist in any way that is not documented in the Support Plan and if written consent has not been obtained.
- Assist with medications out of sight of the service user.
- Prompt, pass or assist the Service User with loose pills from non-original containers.
- Pass to the Service User loose pills from containers or medication compliance aids filled by the Service User or relatives. This is secondary dispensing under the Poisons Act of 1972.
- Fill compliance aids.
- Offer advice or recommendations regarding medication.
- Take direction from Service User’s family or friends regarding medications/ordering/collection etc.
- Crush tablets or open capsules.
Procedure for General Support

Support Workers must follow this procedure when required to assist Service Users with medication. This will be stated in the Reablement/Support Plan as Category 1 support.

Assisting with Medication:
1. Introduce yourself to the Service User
2. Check the Reablement/Support Plan for instructions on medication
3. Discuss with the Service User their medication requirements
4. Taking directions from, and in the full view of the Service User, give assistance to the Service User as requested by them
5. Ensure that the Service User is able to remain in control of their own medication
6. The exact assistance given on each visit should be documented in the Communication Sheet. There is no requirement for a Medication Support Record or a MAR chart.
7. If the Service User wishes to take their medication different from how it is prescribed, inform the Service User that you are unable to assist due to the risk of possible side effects. The Support Worker should report immediately to the Supervisor who should contact the Service User’s Pharmacist or GP for advice.

Support and monitoring with Medication:
1. Introduce yourself to the Service User
2. Check the Reablement/Support Plan for instructions on medication
3. Remind the Service User to take their medications and observe that they carry this out.
4. The exact assistance given on each visit, including the time, should be documented on the Communication Sheet. The Medication Support Record should also be completed by entering your initial, or appropriate code, into the appropriate box.

It is important to remember that the ability of the Service User may change and that the Support Worker is often the only person who will be aware of these changes. If you identify any changes in the ability of a Service User to manage his/her own medicines, this should be reported to your Supervisor as soon as possible.
# Medication Support Record

## Cumbria Care Medication Support Record

<table>
<thead>
<tr>
<th>NAME:</th>
<th>D.O.B</th>
<th>START DATE OF MSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td></td>
<td>ALLERGIES/ADVISORY INFO:</td>
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<tr>
<td>DOCTOR:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Profile</th>
<th>Time/ Dose</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
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</table>

**Committed:**

**Route:**

<table>
<thead>
<tr>
<th>Medication Profile</th>
<th>Time/ Dose</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
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</table>

**Committed:**

**Route:** Location of medication.

**Completed by Staff Signature:**

**Date:**

<table>
<thead>
<tr>
<th>R = Refused</th>
<th>N = Nausea/Vomiting</th>
<th>H = Hospital</th>
<th>A = Absent</th>
<th>G = Given by other</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/C = Discontinued</td>
<td>D = Destroyed</td>
<td>S = Self Administered</td>
<td>W = Wasted</td>
<td>M = Monitor</td>
</tr>
<tr>
<td>V = verbal prompt</td>
<td>P = Physical Assistance</td>
<td></td>
<td>O = Other</td>
<td></td>
</tr>
</tbody>
</table>
## Medication Support Record

<table>
<thead>
<tr>
<th>DATE:</th>
<th>COMMENT/ISSUE</th>
<th>SIGNATURE</th>
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</table>
Category 2: Medication Administration

Summary of Tasks and Guidance for Support Workers

Definition:

Support with the administering of medicine is given where a person is unable to take responsibility for their own medication due to impaired cognitive awareness or physical limitations. Support Workers will be required to physically select and give medication to the Service User, including placing medication into the Service User’s mouth and applying medicated cream or ointment to the skin.

Tasks:

• Physically selecting the required medication and giving it to the Service User (this may include physically placing meds into persons’ mouth and measuring dosage).
• Administration of routine eye/ear/nose drops, eye ointments includes post cataract procedures but excludes post-surgery and complex care regimes.
• Application of prescribed skin treatments including creams, powders, and lotions (excludes post-surgery and complex care regimes).
• Application of a transdermal patch.
• Assistance with medication to Service Users to administer their medication. The Support Worker may physically assist Service Users to:
  – take oral medicine by putting medication in Service User’s mouth,
  – apply medicated cream/ointment to the skin.

Reablement Support

As part of a reablement episode and an assessment period, there may be occasions when the Service User requires support to administer medication from a blister pack (made up by a pharmacist only), in order to gain confidence in trying to achieve independence. This should be detailed on the risk assessment and a physical description of each tablet should be stored with the MAR chart, in order to assess which tablets have been administered. A MAR chart should still be requested from the dispensing pharmacist and completed in full by the support worker if they have administered the medication.

This should always be a short term intervention and should be used as a last resort when all other avenues have been explored.
**Support Workers CAN/MUST:**

- Monitor level of independence/capability is maintained and inform the Supervisor of any relevant change
- Ensure written consent from the Service User is in the file
- Inform the Supervisor of requests for further support that is not documented in the Reablement/Support Plan
- Only administer medication from the packaging/container that is dispensed and labelled by a Pharmacist.
- Administer medication using MAR chart as per policy and procedure
- Must document administration given on a Pharmacy printed MAR chart and record any other information on the Communication Sheet.
- Ensure safe storage of medication
- Seek advice from the Supervisor where the Service User refuses medication
- Place refused medication already removed from original container into an envelope marked with details of the refusal and the Service User’s authorisation via their signature and return to the pharmacy and return to the pharmacy using the Medication Disposal Form.
- Report mistakes to the Supervisor immediately
- Only undertake tasks that they feel adequately competent to undertake and to discuss any further training needs with their manager

**Support Workers WILL NOT:**

- Assist in any way that is not clearly documented in the Reablement/Support Plan and without written consent
- Administer medication from family filled compliance aids or fill compliance aids themselves
- Give any medication that is not recorded on the Medication Administration Record (MAR) chart including ‘over the counter’ or ‘homely remedies’
- Amend or alter the MAR chart in any way
- Offer advice or recommendations regarding medication
- Force or coerce the Service User to take medication
- Crush tablets or open capsules
- Give medicines covertly
- Replace refused medication into its original container
- Leave out medicines for the service user to take later
Medication Administration: Signature Record Sheet

To be completed by any member of staff, or informal carer, who administers medication, or is involved with the completion of a MAR sheet. The sheet should be kept in the front of the Service User file.

Service User _______________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Sign Name</th>
<th>Initials</th>
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</table>
Procedure for the Safe Administration of Medication

Support Workers must follow this procedure when required to administer medication to Service Users who are not able to manage their medication themselves. This will be stated in the Reablement/Support Plan as **Category Two** support.

It is essential that the administration of all medication, lotions and creams should be recorded on a Service User’s medication administration record (MAR) so that at any given time it can be identified what medication has been taken.

Medication will be dispensed in its original packaging unless the risk assessment from Adult Social Care identifies otherwise. The patient information leaflet that is in the medicine pack contains information about the medicine and how it works as well as possible side effects so should always be kept with the medication packaging.

Some medicines are taken every other day, weekly or monthly and not daily. It is very important not to get these mixed up. Support Workers should only administer medication from a container or packaging that has been dispensed and labelled by a pharmacist accompanied by a MAR.

You should **only** carry out this procedure if you have received training and been assessed as competent by your manager.

### Administration of Medication

**REMEMBER!**

**DO NOT** administer medicines from unlabelled containers

**ALL** Category Two tasks must be recorded in the Service Users’ MAR Chart

**NEVER** tamper with the instructions on the MAR chart.

**ONLY** use a MAR chart that has had the medication details added by a responsible professional (this may be a pharmacist, registered manager or other responsible person of a social care service, a doctor or nurse)

**ALWAYS** contact your manager should a new medicine appear that is not accounted for anywhere on the chart

If you miss a dose, **DON’T** give a double dose next time. Record the missed dose in the Service User’s MAR and report it to your Supervisor straight away so they can seek advice from the pharmacist or GP.

If you are in doubt about anything, **DON’T** administer and seek advice from your Supervisor.
The **RIGHT** person should get the **RIGHT** medicine at the **RIGHT** time by the **RIGHT** dose, the **RIGHT** route and have the **RIGHT** to refuse

1. Prior to any assistance being provided, the Support Worker must:
   - Check that the Reablement/Support Plan identifies assistance with medication has been agreed by the Service User
   - Check the Service User name on the label of the medicine is correct
   - Check the medicine, strength and dose on the label matches those detailed on the MAR chart
   - Check the use by date on the packet/bottle/container
   - Check the MAR and Communication Sheet to make sure that no other person has already assisted the Service User with their medication

2. The Support Worker should then wash and thoroughly dry their hands and gather any utensil that may be required, e.g. medicine spoon, measure and drink

3. With good administration techniques, it is not necessary to wear gloves to administer oral medication (unless the risk assessment has identified otherwise). Gloves should be worn to apply medication or creams to the skin of a service user. A new pair of gloves should be worn if different creams are being applied at the same time.

4. Check for any special instruction on the dispensing label (e.g. not to be given with milk or to be taken after food, etc.) and take appropriate action.

5. Medicines should be handled as little as possible. When/if removing a tablet or capsule from a medication box/foil strip, then this is best achieved by pushing out over a small plate (in full view of the Service User), from which the Service User may then pick up and self administer if able. Medications should be administered one at a time and the MAR chart completed immediately.

6. Ensure that the Service User is either in a standing position or is sitting upright. **Do NOT** attempt to administer medication for someone who is lying down.

7. Medicines should be swallowed with plenty of water (unless otherwise detailed). Ideally, this should be a full glass of water.

8. Replace all lids and packaging and store medicines safely and correctly, i.e. eye drops in the fridge.

9. The Support Worker should again wash their hands and any utensils used.

10. Assistance with, or Service Users refusal must be recorded on to the MAR immediately, and follow the refusal procedure.

11. Where physical assistance is provided with skin applications, protective barrier gloves must always be worn. The gloves must be removed when this task is completed and hands washed thoroughly before undertaking any other task.

Please see **Section 3: Good Practice Guidelines** on administering medication for a step-by-step guide.
Procedure for Controlled Drugs

Controlled drugs are prescribed medicines that are usually used to treat severe pain, induce anaesthesia or treat drug dependence and they have additional safety precautions and requirements. Some people abuse controlled drugs by taking them when there is no clinical reason to do so. Controlled drugs are therefore subject to additional controls under the Misuse of Drugs Act 2001.

Controlled drugs should be administered in the same way as other medicines, in accordance with the Administration of Medicines Procedure.

One member of staff can administer Controlled Drugs. Two support workers are not required.

It is good practice for records to be kept of the balance of each medicine. At each administration, the Support Worker must first record the current balance, in brackets, on the MAR chart in the initial/code box, before administering any dose. The MAR chart should then be completed in the usual way. The balance should then be checked against the amount in the pack or bottle and also against the previous balance check. Any discrepancies should be reported to the Supervisor.

Common Controlled Drugs

<table>
<thead>
<tr>
<th>Schedule 2</th>
<th>Schedule 3</th>
<th>Schedule 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Drug</td>
<td>Brand Names</td>
<td>Controlled Drug</td>
</tr>
<tr>
<td>Morphine</td>
<td>MST</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Sevredol</td>
<td>Midazolam</td>
<td>Hypnovel</td>
</tr>
<tr>
<td>Oramorph Concentrated oral solution 100mg/5ml*</td>
<td>Temazepam</td>
<td></td>
</tr>
<tr>
<td>MXL</td>
<td>Pentazocine tablets</td>
<td>Fortral</td>
</tr>
<tr>
<td>Cyclimorph</td>
<td>Phenobarbitone</td>
<td></td>
</tr>
</tbody>
</table>

Dexamphetamine | Dexedrine
Diamorphine
Pethidine
Methadone | Physeptone
Methylphenidate | Ritalin
Fentanyl | Durogesic
Pentazocine injection | Fortral

The misuse of drugs regulations (2001) divide controlled drugs into five schedules according to their therapeutic usefulness and misuse potential.
Administering Anticoagulant Medication (e.g. Warfarin)

Warfarin is a medicine given to thin the blood to avoid the risk of stroke or thrombosis. People who take Warfarin have regular blood tests which determine the dosage of medication to be taken. The Service User will usually have a supply of Warfarin in different strengths which enables the correct dose to be selected.

Each Service User’s individual circumstances will need to be considered to ensure the safety of the Service User and that all involved parties (GP surgery, Pharmacist, Cumbria Care and the Service User) understand their key responsibilities.

Upon receiving a referral for supporting a Service User with administering Warfarin, the Supervisor should arrange a meeting with the health professional to establish a system for ensuring the Support Worker can safely administer the correct dosage of medication to that individual Service User.

The procedure:

1. On referral to Cumbria Care, the Supervisor should inform and discuss the referral with the District Coordinator to agree the steps to take.

2. The Supervisor should arrange a meeting with the health professional responsible for the Service User’s care (possibly a district nurse or the Medicines Manager at the GP surgery).

3. The aim of the meeting is to establish a system to ensure Cumbria Care receives information on the changes to the Service User’s medication and that an updated MAR chart is provided to enable the Support Worker to administer the medication safely. A risk assessment will need to be provided by the responsible health professional.

4. The Community Pharmacy will dispense Warfarin as per prescription. If the prescription is dispensed during the month and there is a change of dose, a new MAR chart must be updated and provided to Cumbria Care by a health professional with clear directions on the dose of Warfarin to be administered to enable the Support Worker to take on the task.

5. The Supervisor will need to arrange training on the system for all the Support Workers involved in each individual Service User’s care and update the Reablement/Support Plan accordingly.

6. In general, Support Workers should administer Warfarin in accordance with the MAR chart instructions and by checking the dosage with the Service User. The Support Worker must ask the Service User for information on the current dosage and should enter the dose administered on the recording panel of the MAR along with their initials.

7. Extreme care must be taken in selecting the correct Warfarin dosage and advice sought from the Supervisor immediately if the Support Worker has any doubts. The Supervisor should contact the dispensing Pharmacist or GP for advice.
Administering ‘As and When Required’ (PRN) Medication

Service Users take this sort of medication when they feel they need it. (PRN stands for ‘pro re nata’ which means ‘when required’). The Service User may not need the medication at every dosage time but they should still be asked if they need to take it.

Support Workers may be asked to help the Service User take the medication but the Service User will make the decision about when it is needed.

Information about the frequency and maximum dosage should be on the medication label on the medication container and also on the MAR.

The Support Worker should always record on the MAR chart that a Service User has taken a PRN medicine. The PRN medication record form should also be completed which includes the dose and time. This means that Support Workers visiting later know what the Service User has taken.

Some PRN medicines are for use in an emergency, when the Service User might be unable to request them. For example, an EpiPen is a self-injectable device that contains epinephrine which is used by people who have a history of life-threatening allergic reactions (anaphylaxis) to things like bee stings, peanuts or seafood, or are at increased risk for a severe allergic reaction. You will be given special training if you are likely to be required to administer PRN medicines under these circumstances. The particular situations where this might be necessary will be clearly described in the Support Plan.

The procedure:

1. The Supervisor should obtain clear instructions on the use of PRN during the initial visit to the Service User by completing the PRN protocol and reference this in the support plan.

2. Support Workers should:
   - Contact the Supervisor if this information is not available.
   - Always check the time of the previous dose in order to ensure that it is within the minimum time interval specified by the prescriber.
   - Check the service user has not taken the medicine themselves or been given it by an informal carer since the last documented dose. The Service User should be asked if they have taken the medicine and the MAR chart should also be checked.
   - Ask the Service User if they need to take their PRN medication. The MAR chart should be completed accordingly. If the Service User does not wish to take their PRN medication, the MAR chart should be marked with the code for ‘not required.’
   - Record the date the dose was administered on the MAR chart and the time (using 24 hour clock) and reason for administration of the medicine PRN recording form.
• Support Worker’s should inform the Supervisor, who should contact the Service User’s doctor, if
  – The service user wishes to take PRN medication more frequently than prescribed
  – Consumption increases markedly
  – They have reason to believe the medication is not effective for the Service User.

3. If PRN medicines are used infrequently, it is important for the Support Worker to check before administering:

  • That it was originally prescribed for the purpose for which it is now required.
  • That the service user is not taking any new medication that might interact with or duplicate it. If in doubt, check with the doctor or pharmacist.
  • That it has not been replaced by a different PRN or regular medicine more recently prescribed.
  • That the supply is still in date, bearing in mind that some medicines have a shortened expiry date once opened. Check the medication pack for details. If in doubt, refer to pharmacist for advice.
PRN Medication Recording Form

Service User Name:
Service User Address:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Given</th>
<th>Reason Given</th>
<th>Medication Name and Dose</th>
<th>Support Worker/ Family Member Signature</th>
</tr>
</thead>
</table>
Arranging a MAR chart from the community pharmacy and/or dispensing GP Practice

When a Service User requires support from Cumbria Care with the administration of medication, then a MAR chart needs to be in place.

During the medication risk assessment, the Supervisor should ask the Service User which Pharmacist they wish to use. The Supervisor should then notify the Pharmacist or dispensing GP surgery that Cumbria Care are supporting the Service User with the administration of medication and request a printed MAR chart.

Not all Pharmacists provide a MAR chart. If the Pharmacist is unable to provide a MAR chart, the Service User should be offered a choice of alternative Pharmacists in the area that do provide this service.

In exceptional circumstances, the Supervisor may need to put together a MAR chart to enable the Service User to take their medication. The MAR should be produced following safe production guidelines.

Arrangements for the collection or delivery of the MAR chart should be made with the Pharmacist as well as the ongoing arrangements.

It is important that the same Community Pharmacy is used so that the Service User’s records will be kept up to date.

Supervisors should only instruct Support Workers to start support with medication administration once the MAR chart is in place.

It is good to build up a working relationship with the local Pharmacist so you have access to advice on medication. Pharmacists are the experts in medicines, they know how medicines work in the body and they understand the practical problems too. You will be able to contact the Pharmacist directly when you need advice about medicines, as well as to obtain a MAR chart.

Top Tip! Ensure that you have the contact numbers for your local pharmacy readily available together with a named person to contact

What to do if there are any queries with the MAR chart

Support Workers should contact the Supervisor if there are any queries to do with the MAR chart:

1. The Supervisor should contact the Pharmacist (or dispensing GP surgery) who has provided the MAR chart with any queries regarding the instructions on the chart.
2. The Supervisor should then follow the advice given by the Pharmacist /GP dispensing surgery and advise the Support Workers accordingly.
3. The Supervisor/Support Worker should update the Service User’s records with the action taken.
Changes to a Service User’s Medication

Changes to a Service User’s medication may occur at any time, (for example the GP or prescribing nurse may have visited during the night) and may involve changes to the medication, dosage, strength time of administration or routes.

Support Workers should not administer any change of medication without the written authority of the GP or prescribing health professional. During a life threatening situation, support workers may take verbal instruction from a health professional.

If changes are made, the following should be available / provided:

a) If a new medication is prescribed and written on the MAR, the Support Worker should contact the Supervisor to tell them about the changes.

b) If the GP or prescribing health professional makes a change to the dose or the strength of the medication, the MAR must clearly show the changes and this must be dated and signed by the person changing this record.

c) If it is not possible for the GP or prescribing health professional to record these changes on the MAR then a signed FAX, email or letter must be received from the GP or Health Professional clearly stating the instruction to support this change.

d) The Supervisor should then produce a Cumbria Care MAR chart for the Support Worker to administer the medication. The first support worker in at the service users house will check the MAR chart against the medication and alert the Supervisor of any discrepancies.

e) In an urgent or emergency situation, for example during the night and when a MAR chart is not available, the Support Worker should contact Cumbria Health on Call (CHOC) for advice. The Support Worker should proceed as advised by CHOC. The detail of the situation and the actions should be written on the Communication sheet and the Supervisor informed at the earliest opportunity.
Safe Storage of Medication in the Service User’s Home

All medication prescribed for a Service User is the property of that Service User and the safe storage of medicines is the responsibility of the Service User. Cumbria Care can assist the Service User with ensuring safe storage.

Medication must be stored in accordance with the instructions on the dispensing label or manufacturing instructions. They should be kept away from heat, light and damp sources and out of the reach of children and pets.

Consideration must also be given to medicines with special storage conditions, for example, those kept in the fridge. The general security of the medication also needs to be considered.

Medicines should be stored in the container supplied by the pharmacy or dispensing surgery. This will be correctly labelled and suitable to keep the medicine in good condition.

The method of storing the medication will have initially been discussed by the Social Worker with the Service User and detailed in the medication risk assessment (MM form).

The procedure:

1. The Supervisor should consider the medication storage detail provided by the Social Worker and discuss this in detail with the Service User as part of the Medication Risk Assessment.

2. The Supervisor should encourage the Service User to keep their medicines and MAR chart together and in the same safe place, ideally in a box that is out of the way of children or in a drawer or cupboard. MAR charts can be kept in the Service User’s file if more convenient. The storage details should be written in the Support Plan.

3. Support Workers should follow the storage instructions in the Support Plan.

4. If it becomes clear that specified storage conditions have not been adhered to, the Support Worker should report this to the Supervisor who should seek advice from the pharmacy or dispensing surgery regarding the medicines suitability for use. The outcome of the advice from the pharmacist should be discussed with the Support Worker who can then take appropriate action.

5. All actions should be recorded by the Supervisor in the Service User’s file.

6. Support Workers are not permitted to remove medication from its original packaging for later administration by a third party such as another Support Worker or family member.

7. If medication is required to be administered at a different setting, for example a day service or a visit to family, the medication should be sent in the original container received from the pharmacy. If this happens on a regular basis, the Supervisor should contact the pharmacy to see if it is possible to obtain a separate supply of medication for the Service User to take to the alternative setting.
8. Support Workers must not administer medication that has been removed from the packaging and stored in a different container by another person.

9. If the Support Worker has any concerns about the storage of medicines, you should raise your concerns with the Supervisor who can then contact the Pharmacist, the Service User’s family or GP.

10. If the Medicines Risk Assessment identifies that the Service User is at risk of overdose, a safe storage strategy must be considered in collaboration with others involved in the care of the Service User and recorded in the Adult Social Care MM referral and the Support Plan. Any sign of taking additional doses or of tampering with the container must be reported to the Adult Social Care Practitioner and GP or Pharmacist and recorded in the Service User’s communication sheets and where applicable, the MAR sheet.

IF YOU HAVE ANY CONCERNS ABOUT STORAGE
If Support Workers have any concerns, for example, if children visit and medication is not out of reach, the Supervisor should be informed and alternative arrangements agreed with the Service User.
What to do when a Service User refuses their medication

Where a Service User refuses any medication, this should be respected as it is the Service User’s right to refuse their medication. The Support Worker must never administer medicines covertly or force a service user to take medication but encouragement can be given.

If the Service User is refusing a medicine, it is useful to ask them why they do not wish to take it as the health of the Service User may be affected if medication is not taken. This may need to be discussed with their GP.

The procedure:

1. If the Service User refuses the medication, the Support Worker should record this on the MAR chart using the appropriate code indicated at the bottom of the chart (this may be different for each Pharmacy).

2. Ask the Service User respectfully why they are refusing their medication. Write a note in the Communication Sheet explaining why the person has refused their medication (there may be different reasons for different medicines).

3. If medication has not been removed from the original container, then leave in place. If there is a subsequent risk that medication may be administered incorrectly, remove and follow the procedure for disposing of unwanted medicines safely.

4. If medication has been removed from the original container, but refused by the Service User, then place in a separate container such as a pot or envelope, label, seal, and keep in the same place as the other medication. Be careful that it does not get mixed up. Return the medication to the Community Pharmacist for disposal. (Some pharmacists, Boots for example, will provide containers and labels for this).

5. The Support Worker should then report this to the Supervisor who should then contact the Community Pharmacist or Service User’s GP as soon as is practical for advice.

6. The Supervisor should record the advice given by the Community Pharmacist or GP in the Service User’s notes on the system. The advice should be shared with the Support Worker as appropriate.

7. All changes in the Service User’s condition, including refusal of regular medication should always be reported by the Support Worker to the Supervisor. The Supervisor should then discuss this with the Service User’s GP.
What to do when a Service User who lacks mental capacity refuses their medication

In certain circumstances, covert administration may need to be considered to prevent a person missing out on essential treatment.

This might include cases where the Service User lacks mental capacity (for example, some people with dementia).

A multi professional team (including the Service User's GP and Adult Social Care) and relatives of the Service User should assess whether the Service User has adequate mental capacity to understand if taking the medicines is in their best interests and that the medicine is essential to the Service User’s health and well-being.

The views of everyone involved in the Service User’s care should be considered before the decision to administer medication covertly is approved. All decisions will need to be taken in accordance with the Mental Capacity Act.

The decision taken should respect any previous instructions given by the Service User and be recorded in the risk assessment and support plan with a date for review as capacity can sometimes fluctuate.

The stability of medication may be altered by administering in a covert way, e.g. crushed into food and this should be checked with the Community Pharmacist.

The procedure:

1. The Adult Social Care referral (MM form) will identify new Service Users who lack mental capacity.

2. For ongoing cases where Cumbria Care have been supporting the Service User with medication, Cumbria Care should attend the Best Interest meeting which will be organised by Adult Social Care. Risk assessments would need to be in place and instructions followed as determined at the multi-disciplinary meeting.

3. The Supervisor should ensure that written direction/instruction from the GP is obtained and kept on the Service User’s file before updating the Support Plan and instructing the Support Worker accordingly.

REMEMBER: Support Workers should NEVER administer medication covertly to any Service User UNLESS you have been directed in writing by your Supervisor following an assessment by a multi professional panel.
Procedure for Requesting Repeat Prescriptions

Cumbria Care may take responsibility for ensuring that the Service User always has a supply of medicines for ongoing treatment by arranging repeat prescriptions and the collection or delivery of the medication. If required, this will be requested and detailed on the Medicine Management Form (MM). Prescribed medication should always be available for when the Service User needs them.

The procedure:

1. Referrals for reablement/home care support with medication may require Cumbria Care to arrange repeat prescriptions. The Supervisor should discuss with the Service User arrangements for obtaining their prescription to determine if assistance is required.

2. If the Service User does require support, then the Supervisor should discuss with the Service User the details of the GP surgery where the prescription should be collected from and detail the ordering and collection arrangements in the reablement/support plan.

3. The Supervisor should contact the GP surgery to discuss arrangements. Where possible, arrangements should be made with the GP surgery for the prescription to be sent direct to the pharmacist.

4. The Supervisor should ensure the arrangements for obtaining repeat prescriptions are detailed in the Repeat Prescription Log, a copy of which should be kept in the office along with a copy in the Service User’s Reablement/Support Plan, at the Service User’s home along with the arrangements for collecting medicines from the pharmacist. The Supervisor should ensure the prescriptions are obtained in accordance with the plan.

5. Support Workers should record all actions taken on the communication sheet.

Delayed or interrupted treatment could make a Service User ill or delay their recovery.

Delayed treatment with antibiotics could mean that an infection gets worse.
A missed dose of a pain-killer could lead to increased pain and decreased mobility.

Inform your Supervisor if you are concerned about medication running out.
<table>
<thead>
<tr>
<th>Date Prescription Ordered</th>
<th>Date Received</th>
<th>Signature</th>
<th>Comments</th>
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Include dates of ordering and receipt and any changes or problems.
Procedure for Collecting Medicines from the Community Pharmacy and/or Dispensing GP Practice

The preferred option is for family or friends to collect medicines from the Pharmacy/GP surgery or for the Pharmacy to deliver the medicines to the Service User where this is offered. Where this is not possible, Cumbria Care may be able to assist.

The procedure:

1. Referrals for reablement/home care support that include an element of medication support may require Support Workers to collect medicines. The Supervisor should discuss with the Service User arrangements for obtaining their medicines to determine if any assistance is required.

2. If the Service User does require support, then the Supervisor should discuss with the Service User the details of the Pharmacist/GP surgery where the medicines should be collected from and detail the collection and delivery arrangements in the Reablement/Support Plan.

3. The Supervisor should then carry out a risk assessment for the Support Worker to collect medicines on behalf of the Service User. If appropriate, the Supervisor may then ask the Support Worker to collect the medication. This should be clearly noted in the Reablement/Support.

4. The Support Worker should collect the medicines as detailed in the Reablement/Support Plan from the Pharmacy or GP surgery and deliver directly to the Service User’s home. Support Workers should transport medication out of direct view and not store medication in the office or their car.

5. Support Workers collecting Controlled Drugs from the Pharmacy/GP surgery may be required to show their Cumbria County Council I.D badge as proof of identity and to sign the back of the prescription.

6. If payment is required for a prescription, Support Workers should follow appropriate procedures.

7. Support Workers should record all actions taken in the Communications Sheet.
Procedure for Disposing of Unwanted Medicines Safely

The preferred option is for family or friends to return unwanted medicines to the Pharmacy. Where this is not possible, the Service User may require support with disposing of unwanted medicines and these must be returned to a Community Pharmacist for safe disposal.

Support Workers must not put unwanted medicines in with the household rubbish or put them down the sink or toilet. Children could take the medicine from the bin and medicines that have been flushed down a toilet could end up in the drinking water system or harm the environment.

The procedure:

1. Referrals for reablement/home care home that include an element of medication support may require Support Workers to dispose of unwanted medication. Regular disposal of medication should not be required, however, Supervisors may arrange for medication to be disposed of weekly, i.e. on a Monday.

2. If the Service User does require support, then the Supervisor should detail the arrangements in the Reablement/Support Plan. Medication should be placed in an envelope, sealed and labelled. (Labels are available from most pharmacists).

3. Before a Support Worker can remove any medicine from the Service User’s home, the Service User must be in agreement and sign the Medicine Disposal Form.

4. The Support Worker should return the unwanted medicines to the Pharmacy and ask the Pharmacist to sign the Medication Disposal Form.

5. The signed Medication Disposal Form should be retained by the Support Worker and given to the Supervisor who will store it in the Service User’s records in the office.

If a Service User dies, the Supervisor must inform the family that all medication must be retained for at least seven days in case the Coroner’s Office requires them.
Medication Disposal Form

Your consent for us to destroy your unwanted or discontinued medicines

I authorise that you can take the following medicines to the local pharmacy or GP dispensing practice for destruction.

<table>
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<th>Medicine Name</th>
<th>Quantity</th>
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Service User signature: Date:

If you are unable to sign this form, please get someone to do it on your behalf.

Signature of representative: Date:

Name of Cumbria Care staff member returning the medication: Date:

FOR PHARMACY USE ONLY

I (Pharmacist’s name) confirm the medicines listed above have been handed over for destruction.

Signature: Date:

Pharmacist’s address:
Over the Counter and Homely Medications  
(including herbal and homeopathic remedies)

Service Users may wish to use over the counter medication, for example painkillers or skin creams for minor ailments and it is their choice whether to buy remedies and take them.

If a Service User is considering taking an over the counter/homely medicine, then the Service User should be advised to check with their pharmacist or GP, in case it interacts with medicine they are already taking.

If Support Workers have any concerns about a Service User purchasing and taking medication inappropriately, this must be discussed with the Service User and Supervisor and a review arranged if necessary.

Support Workers must not purchase or assist the Service User with over the counter/homely medication unless suitability has been confirmed with the Service User’s Pharmacist or GP and the product is being taken in accordance with the manufacturers instructions. A record of such confirmation should be made on the Support Plan.

Care staff must not give any assistance with the administration of these medicines. An exception may be made at service user request, under very exceptional circumstances, following discussion between the supervisor and the service user’s GP or the pharmacist to ensure there are no contraindication’s.

If the Service User requests support with purchasing or administering over the counter/homely medication, then follow this procedure.

The procedure:

1. The Support Worker should inform the Service User that they are unable to purchase over the counter/homely medication until they have discussed it with their Supervisor who will in turn discuss it with the Service User’s Pharmacist and/or GP.

2. The Support Worker should make a note of the Service User’s request (including the type of medication and why they require it) and discuss with the Supervisor.

3. The Supervisor should discuss the request with the Service User’s Pharmacist. The Pharmacist will advise if it is suitable for the Service User to take the medication. (The Pharmacist will advise if the input of the GP is required).

4. The Supervisor should make a record of the advice received from the Pharmacist/GP in the Service User’s records and update the Support Plan as required.

5. The Supervisor should write to the GP for consent if administration is required using the GP consent form.

6. The Supervisor should inform the Support Worker of the outcome and then update the Medication Risk Assessment (if support is required) and update the Support Plan as required. If any creams are to be administered, a Topical Medicines Application Record should be produced by the Supervisor as a visual guide for the Support Worker to follow. The Supervisor should also produce a MAR chart for the Support Worker to record their administration.

7. The Supervisor or Support Worker should advise the Service User of the outcome accordingly. Normal procedures should be followed for purchasing items on behalf of the Service User.

REMEMBER: Support Workers should not offer any advice to Service Users about over the counter or homely medicines
Non-Prescription Medication - GP Consent Form

Dear Doctor

Cumbria care operates a limited non prescription medication policy as follows:

- Paracetamol 500mg x 2, 6 hourly
- Simple Linctus 10mls, 4 hourly
- Mist Mag Trisil 10 mls, 4 hourly Sample List amended for each
- Dioralyte 1 sachet, 4 hourly individual
- Sennokot 1-2 tablets, daily
- Aspirin 300mgs

We request your permission to administer these medicines at our discretion when necessary to your patient listed below. No more than 2 consecutive doses will be given to your patient without further advice being sought from yourself.

Name of patient: Date of birth:

Yours sincerely

Service / Home manager

I do ☐ / do not ☐ * authorise the administration of the above non-prescription medication as described.

Doctors name

Doctor’s signature

Date

*Please add cross as appropriate
Family and Friends Administering Medication

The referral from Adult Social Care will identify if informal carers (e.g. relatives, friends or neighbours) are supporting the Service User, at times, with medication. This support can help promote a Service User’s independence.

The Supervisor should check during the risk assessment that family and friends are not involved in administering medication.

If family or friends are identified as administering medication (alongside the formal support from Cumbria Care), then the Supervisor should ask the informal carers if they are willing to complete the MAR. It should be explained to them that this is very helpful as it will provide a comprehensive record of all medication that has been administered to that Service User.

If family are willing to complete the MAR, their signatures need to be readily identifiable as family members. The Supervisor should ask the informal carers to put their sample signatures on the Signature Record Sheet accompanied by a brief description of who they are (e.g. daughter).

The Supervisor should ask the informal carers that if a circumstance arises where it is necessary for them to administer medication to the Service User, that it is helpful if they can contact the Cumbria Care office to inform them, as well as signing the MAR chart. It should be explained that this will ensure the Service User receives the correct amount of medication.

This also applies to any health care professional that is administering medication, so that the record is all in one place.
Category 3: Administering Medication by Specialised Techniques

Summary of Tasks and Guidance for Support Workers

These would only be requested following full risk assessment supported by clinical supervision and training from a Health Care Professional. Referrals for support with Category 3 Tasks will be rare.

Tasks:
- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure).
- Insulin by injection including testing of blood sugars.
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)

Support Workers CAN/MUST:
- These would only be requested following full risk assessment supported by clinical supervision and training from the healthcare professional
- Have received training, been assessed as competent, and the delegation of the task has been ‘signed off’ from a Healthcare Professional to be included in the Support Delivery Plan.
- Only undertake tasks that they feel adequately competent to undertake

Support Workers WILL NOT:
- Must not carry out any invasive, clinical or nursing procedures unless they have been assessed as competent to do so by Cumbria Care and a Health Care Professional.
Procedure for Administering Medication by Specialised Techniques

There may be occasions when Support Workers are asked to give medicines that registered nurses normally administer. This is helpful in many situations and avoids Service User’s having to wait for a nurse or paramedic to attend. Referrals for support with Category 3 tasks will always require training and clinical supervision from a Health Care professional, usually the District Nurse, for every individual Service User.

If you are asked to assist with these tasks, you will be given specialist training and you will be supervised by a District Nurse.

The procedure:

1. Referrals for support with Category 3 tasks will be detailed on the Medicines Management (MM) form from Adult Social Care.

2. The Supervisor should contact the District Nurse to arrange training for all the Support Workers who will be involved in the Service User’s care. The District Nurse will undertake the training, usually at the Service User’s house.

3. The Supervisor should ensure the District Nurse signs off each Support Worker as being competent at carrying out the task before individual Support Workers can undertake that particular task. The Health Professional Sign Off sheet should be used.

4. The competency form should be signed by the District Nurse for each Service User and added to the Service User’s support plan by the Supervisor.

5. Support Workers who do not achieve the competency needed to carry out the task should not be assigned to support the Service User with that particular task.

6. The Service User’s consent must be given for Support Workers to carry out the treatment.
Procedure for Undertaking Health Care Tasks

Referrals for health care tasks will be made by Adult Social Care using the Medicines Management (MM) form. Cumbria Care can proceed with organising Level A tasks as part of the Support Plan.

**Summary of Level A Tasks** *(Health professional sign off is NOT required)*

- Assisting customers with the management of continence e.g. catheter bag change and empty
- Assisting customers with dementia, those who are confused or displaying challenging behaviour
- Helping to prevent falls
- Infection control
- Assisting customers with nutrition, hydration and reducing the risk of malnutrition and dehydration
- Assisting customers with, and where needed administration of, prescribed medication including eye drops (including post cataract surgery), ear drops, nose drops, inhalers, patch based medicine, emollient and barrier products
- Application of creams including prescribed medicated creams, ointments, lotions for external use (where skin is unbroken)
- Assisting customers who are dying in achieving a peaceful and dignified death
- Assisting customers with skin care and preventing pressure sores
- Assisting customers with equipment to use oxygen
- Assisting customers who use nebulisers/spacers/inhaler

Level B and Level C tasks require sign off from a health professional as confirmation of delegation of the task to Cumbria Care. ‘Sign off’ is defined as confirmation of delegation of the task by a health professional to the provider. The sign off confirms the health professional is satisfied that the provider is competent to carry out the task at that time.

**Summary of Level B Tasks**

- Eye drops including post-surgery, variable dosage and multiple eye drops where combination or order of drops is important
- Application of support stockings where skin is intact and hosiery has been prescribed including recovery from leg ulcers and where there is a risk of deep vein thrombosis and pulmonary embolism
- Use of patch based medicine including controlled drug pain relief like Fentanyl

**Procedure for Level B tasks:**
The Supervisor should contact the relevant health professional for each referral to discuss the need for any further training needs and for the health professional to ‘sign off’ the Level B tasks. The discussion must be documented in the Service User’s file and written ‘sign off’ obtained.
**Summary of Level C Tasks:**

- Assisting customers with nutrition using PEG feeding
- Assisting customers with simple wound dressing
- Assisting customers with stoma management
- Assisting customers with supra public catheters
- Assisting customers who have dysphagia
- Application of medicated creams – prescribed medicated creams, ointments, lotions for external use where skin integrity is compromised
- Assisting customers with insulin
- Assisting customers with specialist medication including buccal midazolam and rectal diazepam

**Procedure for Level C tasks:**

Prior to commencement of Level C tasks, the Supervisor should contact the relevant health professional to identify and arrange training on the task (for each individual Service User) for Support Workers. The health professional is responsible for providing this training. The health professional could:

a. train all Cumbria Care staff who will carry out the task or
b. train a Cumbria Care Supervisor or Medication Trainer who they are satisfied will cascade the training to all Cumbria Care staff who will carry out the task

The Supervisor must obtain ‘sign off’ from the health professional before Cumbria Care can commence support with Level C tasks. Evidence of sign off could be:

a. A record of the discussion between the health professional and the Supervisor. This should be recorded by the Supervisor in the Service User’s Support Plan
b. It is preferred for the health professional to ‘sign off’ the support by making a physical signature in the Support Plan or on the ‘sign off’ form.

c. Sign off could be in other forms such as a fax, email or other paperwork signed and provided by the health professional.
Training and Competency for Health Care Tasks
Health Professional sign off form

Service User Name:  

Service User Address:  

Support Worker confirmation of training:
I confirm that I have received training from ........................................... To enable me to carry out the tasks detailed below. I understand that this training applies only to the care required for the service user detailed above.

<table>
<thead>
<tr>
<th>Name of Support Worker (print names)</th>
<th>Support Worker Signature</th>
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</tbody>
</table>

Health Professional certification
I confirm that the above named support worker (s) have received appropriate training from me to carry out the following tasks on my behalf and are deemed to be competent to carry out these tasks under my supervision for the client named above.

Details of Health Tasks:
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................

Signed by:............................................  Print Name:..............................................................

Job Title:............................................  Organisation:.................................  Date:.........................
Medication Incidents

There are several ways in which errors can be made when medicines are administered such as incorrect administration, omitted doses, duplicated doses, administration of discontinued medication and medication being lost or stolen, amongst other reasons.

Some errors may appear trivial but all mistakes in assisting with medicines must be reported to your line manager or on call service immediately so that appropriate action can be taken to avoid harm to the Service User. This also applies to errors that care staff identify, but have not made themselves, for example errors made by pharmacists and other care staff.

What to do if you make a mistake – Support Worker

1. Remain calm and acknowledge that an incident has occurred
2. Identify the nature of the incident. For example, has the wrong tablet been given, has the medication been dropped on the floor
3. Immediate advice should be sought from the Pharmacist or GP. If this occurs out of hours, then Cumbria Health On Call (CHOC) should be contacted or:
4. Call your Supervisor to seek further advice
5. Call an ambulance if the Service User is in distress or showing signs of being unwell
6. Observe the Service User for any changes in behaviour or well-being as a result of the incident and report these to your Supervisor
7. Record the incident in the communication sheet and MAR chart
8. Complete a Medication Incident Record Form and provide this report to your Supervisor
9. Reassure the Service User and do not leave the Service User until instructed to do so by your Supervisor

Actions for the Supervisor

1. Identify the nature of the incident
2. Contact the Pharmacist or GP for information and instructions
3. Follow advice provided by the Pharmacist or GP (include advice in the Medication Incident report)
4. In accordance with the Pharmacist or GP instructions, instruct the Support Worker to observe the Service User for changes in behaviour or well-being as a result of the incident and report these to the GP as advised
5. Instruct the Support Worker to call an ambulance if the Service User is in distress or showing signs of being unwell
6. Advise the Support Worker when they can leave the Service User
7. Assist the Support Worker to complete a Medication Incident Report
8. Advise the Service User’s family member/carer/significant other of the medication incident
9. Ring to check on the Service User later in the day/next day (if appropriate)
10. The Medication Incident report should be sent to the District Coordinator in the first instance.

The District Coordinator will carry out an investigation of the specific incident with the emphasis on the process associated with the incident. The District Coordinator will then complete the Medication Error Report form (MER). The results of this will be passed to the Operations Manager for feedback on action to take.

An action plan will be developed to prevent re-occurrence of the incident and to share the decided actions.

Any incidents will be regarded as a learning process and will be shared with all staff as part of training sessions and newsletters to raise awareness of safety issues.

Where the medication error has resulted in harm or potential harm, a referral should be made to the Local Adult Social Care Team, the Safeguarding Team and CQC.
Problems are more likely to occur when:

- Service Users have long lists of prescribed medicines
- Some medicines are taken regularly and some are taken only when required for specific reasons, e.g. for pain relief
- The dose of a medicine is not constant but depends on the results of blood tests, e.g. Warfarin
- Service Users have hoarded medicines that the doctor has told them to stop taking
- People are confused about what they should be taking
- When a new medicine is introduced
- When the dosage is changed
- There are frequent changes to medicines

If you are ever unsure about anything, please ask your Supervisor
## Medication Incident Report

<table>
<thead>
<tr>
<th>Details of Service User Affected by Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service User Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date incident occurred:</td>
</tr>
<tr>
<td>Details of staff involved:</td>
</tr>
<tr>
<td>Report completed by:</td>
</tr>
<tr>
<td>Please describe the incident:</td>
</tr>
</tbody>
</table>

Why do you think it happened?

Did it involve GP, District Nurse or Pharmacist? If so, how?

What actions (if any) were implemented to minimise the impact on the Service User?

If harm occurred, describe the injury:
Describe any actions taken to prevent a reoccurrence

In your view, what were the underlying causes or events which, if rectified, may prevent another incident?

<table>
<thead>
<tr>
<th>Date Pharmacist/GP informed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the advice from the Pharmacist/GP?</td>
</tr>
</tbody>
</table>

**Details of medication involved in the incident**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>correct/intended</th>
<th>Incorrect (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose/strength</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td></td>
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</tr>
</tbody>
</table>

Support Worker Name__________________________________________________

Signature ____________________________________________________________

Supervisor Name______________________________________________________

Signature ____________________________________________________________

Date sent to District Coordinator _____________________________________
# Medication Error - Managers Report to Operations Managers

## PART A – ERROR REPORT CHECKLIST

<p>| Date of Error: | |
| Full Name of the Service User: | |
| Service / Establishment: | |
| Medication details: (Name of drug, quantity, admin time, route). | |
| <strong>What is the drug for?</strong> (e.g. water tablet, antibiotics for infection) | |
| Person making this report &amp; position: | |
| Person responsible for the error &amp; position: | |
| Date person responsible for error was trained: | |
| When were they last observed as competent? | |
| <strong>Nature of error:</strong> (please tick appropriate boxes and provide further information) | |
| Missed Dose | |
| Wrong Dose | |
| Missed Signature | |
| Given at wrong time | |
| Given to wrong person | |
| Procedure Error | |
| Meds signed for but not given | |
| Stock Discrepancy | |
| Controlled drugs | |
| Other (please provide more details) | |
| Reported to GP (Name of GP, who reported it to the GP, time and date) | |
| Action / Advice recommended by GP – give details: | |
| <strong>Outcome for Service User</strong> (e.g. any observable side effects or distress?) | |
| <strong>Medical intervention required / Controlled drug?</strong> (E.g. attend hospital, see GP etc). | |
| Delete as necessary | |
| Yes – go to (a) below | |
| No – go to (b) below | |
| <strong>Registered Services only</strong> – For registered services, if the error has resulted in the need for medical intervention or has involved a controlled drug, inform the Care Quality Commission (CQC) by completing a | |
| Record the date the notification was sent below and attach a copy to this report. | |</p>
<table>
<thead>
<tr>
<th>Part A – Error Report Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Notification form. Report to the Head of Service, Ops Manager and others as appropriate</strong></td>
</tr>
<tr>
<td><strong>(b) Date and time Manager was informed:</strong></td>
</tr>
<tr>
<td><strong>Date, time and name of the Ops Manager informed:</strong> <em>(N.B. it should be reported to the Operations manager within 7 days of the error)</em></td>
</tr>
<tr>
<td><strong>Date, time and names of SU / Carer / NOK / parent informed:</strong> <em>(If appropriate)</em></td>
</tr>
<tr>
<td><strong>Date, time and name of Social Worker informed:</strong> <em>(If appropriate)</em></td>
</tr>
<tr>
<td><strong>Date and time Service User informed:</strong> <em>(If appropriate)</em></td>
</tr>
<tr>
<td><strong>Medication Error Report Checklist and Action Plan forwarded to the Operations Manager</strong> <em>(Must be within 7 days of date of error)</em></td>
</tr>
</tbody>
</table>

By whom: Date:
Medication Error - Managers Report to Operations Managers

PART B – INCIDENT REPORT AND ACTION PLAN

Medication Error Date:

Establishment: Person responsible for the error:

1) In accordance with the Administration, Control & Disposal of Medication Policy describe the procedure that has been breached, resulting in this error.

2) What happened to cause this breach / medication error?

3) Has this person been involved in any medication errors / breaches of medication policy within the past 12 months: Yes / No
   (If yes, please indicate what actions were taken and any sanctions applied):

4) Recommendation / action as a result of this error, with associated timescales and any review dates:
   (Detail what you have / will put in place e.g. prompt sheet training, 1:1 coaching on policy and procedure, supervision etc).

5) Has the person researched the potential consequences of this medication error, written a paragraph on what they found, and brought it to supervision to be discussed and recorded? If so, on what date? And was there any learning that could be shared?

6) As the manager, what is your conclusion in relation to this error?

Signed: Date:

Print Name:
MANAGER / DISTRICT CO-ORDINATOR (Delete as appropriate)

A COPY OF PARTS A IS TO BE PLACED ON THE SERVICE USER FILE

A COPY OF PARTS A & B IS TO BE PLACED ON THE EMPLOYEE FILE
Frequently Asked Questions

Service User Factors

What should I do if the Service User is unwell, distressed or not their usual self?
The Support Worker must contact their Supervisor for advice, with the agreement of the service user (provided they are able to give permission). The Supervisor should assess the situation and decide on whether to contact the pharmacist or the GP. Guidance must be sought as to whether due medication should be offered to the service user.

Concerns about the service user

Any doubt or concern about Service Users taking or refusing to take their medication, any changes of condition or any possible side effects must be reported to the Supervisor. The Supervisor should assess the situation and seek guidance from the pharmacist or GP in the first instance. The Social Worker may need to be contacted.

Refusal to take medication

It is an individual’s choice not to take medication which must be respected. Medicines must not be disguised or hidden in food in order to force a service user to take them against their wishes. They must not be coerced or forced in any way but some degree of encouragement can be given.

All refusals must be recorded on the MAR chart. All refusals must be reported to the Supervisor who must communicate the problem to the GP and request advice regarding the action to be taken if the service user continues to refuse the medicine.

The Supervisor should record this communication in the Service User’s records.

Possible side effects

People react differently to different medicines, so it is not possible or helpful to list anticipated side effects. However, should concern arise, Support Workers should note whether any new medicine or change of dose to existing medicine has occurred during the last few days. Inform the Supervisor who should discuss this with the GP, Pharmacist or Nurse promptly.

Service User consuming alcohol or using illicit drugs

It is an individual’s own decision to drink alcohol or use an illicit substance. Support Workers would not be held liable for accidents that occur in the Service User’s home as a result of alcohol or illicit drug usage. Should a Service User request alcoholic drink with medication, this must be refused and reported to the Supervisor who should then inform the GP or Pharmacist.

Should a Service User be found to be intoxicated and under the effect of alcohol or illicit substances on arrival at their home, the Support Worker must refuse to assist with medicines. This action must be reported to the Supervisor immediately or as soon as possible who should then notify the GP or Pharmacist.

MAR Charts

Missing, incomplete or ambiguous, directions on the label
Support Workers are NOT PERMITTED to assist with these medications. They should inform their Supervisor immediately who should contact the supplying pharmacist/ GP dispenser urgently.

Can medication only be administered from a MAR chart?
Medication should always be administered from the label on the packet (which is the pharmacist’s instruction, based on the prescriber’s instructions).

The MAR is a record of administration, not an instruction to administer. So it’s not essential in order to comply with the law, but it is important to have an accurate, record of events, made at the time they happened in case of mistakes or mishaps.
It is essential to check the label against the MAR before administering, in case instructions have changed since the MAR was written.

**Can care staff update the instructions on a MAR chart?**

Cumbria Care staff are not permitted to update MAR charts provided by the Pharmacy. Only the Pharmacist or GP or prescriber can update a MAR chart.

In urgent situations (for example, if the GP has visited the Service User during the night and prescribed a new medicine or changed the dosage), Cumbria Care Supervisors can produce a Cumbria Care MAR (upon confirmation of the changes from the GP surgery) to enable the Support Worker to administer the medication.

**Who should any discrepancies between the label and the MAR chart be reported to?**

Support Workers should report to their Supervisor who should urgently contact the Community Pharmacist or GP to clarify and resolve the issue.

It should be recorded in the care notes together with a note of the action taken and who this was reported to, and the entry signed and dated

**What should I do if I make a mistake?**

First, ensure the safety of the Service User.

Staff should report any mistakes to their line manager, but **should not let this delay them in reporting the error to the patient’s GP first** in case they need to take any action.

The Support Worker should enter the details of the error on the MAR chart and in the Service User’s care record. The care record entry should include full details of:

- name of the person making the entry
- date, time and nature of the error
- action taken at the time
- name(s) of people contacted
- any advice received, and from whom
- any change in the health or behaviour the service user.

In addition to this, the Medication Incident reporting procedure must be followed.

**Whose responsibility is it to renew the MAR charts at the end of each month?**

Requests for MAR charts should be made to the Service User’s Pharmacist or dispensing GP surgery.

**When confirming medication has been taken should staff record their initials in the appropriate box or a tick?**

Support Workers should always use their initials to indicate that medication has been given. This is so that the Supervisor knows who to ask if there is a query.

**If staff only visit once a day to administer medication and family assist with morning and lunch medication, where should family record medicines taken?**

With the Service User’s permission:

- If family are willing to complete the MAR, which is very helpful, their signatures need to be readily identifiable as family members on the chart.
- They should put their sample signatures on the Signature Recording Sheet accompanied by a brief description of who they are (e.g. daughter).

**Administration of Medicines**

**Should gloves be worn when applying skin treatments?**

Yes, and hands should be washed both before and after applying the skin treatment. New gloves must be worn when applying each cream.

**Should gloves be worn when assisting with tablets?**

All tablets, capsules etc. should be given using a ‘no touch’ technique. Therefore it should not be necessary to wear gloves.

However, it is advisable to do so when administering cytotoxic or hormonal preparations.
**Missed Doses**
If a dose of medicine is missed or omitted this **MUST** be recorded on the MAR chart and reported to the Pharmacist or GP for advice before reporting to the Supervisor. The Medication Incident procedure should be followed.

If it becomes known that a dose was missed or omitted during the previous visit a double dose **MUST NOT** be given. The person identifying the error must record this and report it to the Supervisor.

**Are Support Workers allowed to prepare medication and leave it out for the Service User to take at a later time?**
No. Medicine should not be ‘prepared’ for a Service User to take later.

**Is it all right to put all of a Services User’s tablets into one pot and administer them all together?**
No. The Support Worker must be able to take responsibility and sign for each individual medicine administered. If the service user did not take one of the tablets for any reason, the carer would not be able to tell which one it was.

Therefore each medicine must individually be identified, checked against the label and MAR chart, removed from its packaging, administered and signed for, one by one.
Section 3:
Good Practice Guidelines

Guidelines for the Safe Administration of Medication

1. Introduce yourself to the Service User

2. Ensure the environment is free of distractions e.g. ask the Service User to turn the television off if this helps you to concentrate better

3. Check the Support Plan for instructions on medication

4. Explain to the Service User that you will need to check the medication to see if any is to be given prior to food.

5. Find a clean tidy area to open the medicines box/storage container etc.

6. Open the medicines box/storage container and take out the MAR chart. Ask the Service User if they have taken medication already and check the MAR chart to ensure that none of the medicines have already been given/signed for.

7. Check the date on the front of the MAR chart to make sure that it’s in current use, and that it is the only MAR chart in use. Use a new MAR chart with each new month's supply of medication.

8. If you have reason to believe medicines have been taken already STOP PROCEDURE and inform the Supervisor. Otherwise continue as follows:

9. Remove all medicines from the box/storage container, checking as you do that they all have the Service User’s name on them.

10. Assemble all of the equipment needed to administer the medication such as 5ml spoon, MAR chart, gloves etc.

11. Using the MAR chart in conjunction with the labels on the medication boxes, go through each to check that the name of the Service User, the name of the medicine and the instructions on the bottle/box are the same as those on the MAR chart – IF NOT DO NOT GIVE IT.

12. Check the label for any special instructions before administering the medicine e.g. does it need to be taken before or after food? Should the service user avoid alcoholic drink? Does the medicine need to be dissolved or mixed with water before taking? Should it be swallowed whole not chewed? Etc. Please ensure that these additional instructions are followed.

13. Some medicines should only be taken ‘when required’ to relieve symptoms e.g. pain killers, laxatives, sleeping tablets, inhalers, GTN spray for angina. The service user will need to be asked whether they need these medicines and they should not be given routinely. (If you are not sure what a ‘when required’ medicine is for, please consult the patient information leaflet inside the medicines container or contact the Community Pharmacist).
14. As you are doing the above, place the medicines as follows:

- Medication to be taken before food – place to one side of the lid (if medicines are stored in a box)
- Medication to be taken with or after food, place on the other side of the lid, along with any other to be taken at this time
- Medication that is not required at this call – place back inside the box out of the way
- Where there is more than one container of the same medicine, put spare containers back into the box and the pack to be used on the lid

If there is any medication that needs further clarification – for example, if it is not listed on the MAR chart, place this in the box and make an immediate written note to contact the Supervisor or Community Pharmacist for further information.

If you always do this the same way then if you become distracted for any reason it is easy to see where you have got to. Always use the MAR chart AND the medication boxes as your point of reference.

(If then for any reason you have missed something, it will be left outside of the box for you to clarify)

15. Wash and dry hands. With good administration techniques, it is not necessary to wear gloves to administer oral medication. Gloves should be worn to apply medication or creams to the skin of a service user.

16. Before administering, check any expiry dates highlighted on the label e.g. for eye drops and liquids. Also check when removing strip from the box that the name of the drug on the strip matches that on the container.

17. Check whether the medicine is to be given by mouth or by another route (e.g. to be inhaled, applied to the skin etc.) If oral, ensure the service user is standing or sitting as upright as possible, and give the medicine to the Service User with a drink of water. If applying a cream for a service user, ensure you are wearing plastic gloves.

18. Following the MAR chart AND the medication boxes, administer any medication that should be given before food, **one medicine at a time, and sign the MAR chart after each is administered.**

   a) Enter your initials clearly on the correct date and time to show you have seen the service-user take the medicine.
   b) If the dose is variable (e.g. one or two tablets to be taken) record the actual amount given and initial.
   c) If the medication is NOT GIVEN enter the relevant code in the box and enter the reason in the service-user’s care record. Report this to your manager immediately.

19. Continue to assist with other activities, such as personal care, and if more medicines are to be taken after food, ensure that service user has something to eat.

20. Wash and dry hands and put on gloves

21. Following the MAR chart **AND** the boxes administer any medication that should be given after food, **one medicine at a time, and sign the MAR chart after each is administered.** NB with ‘As required’ medicines, ask the service user whether they need these medicines as they should not be given routinely.
22. Once all medication has been administered check that no boxes/bottles are left over, wash and dry any utensils, and return everything to its original place ensuring the medication box is locked (if appropriate).

23. If you make, or detect a mistake relating to the actual medication, or have any urgent concerns, immediately call the Service User’s doctor for advice before notifying your manager during office hours. During out of office hours you should contact CHOC and inform the Out of Hours service.

IN AN EMERGENCY CONTACT THE SERVICE-USER’S DOCTOR

REMEMBER

• **DO NOT** administer medicines from unlabelled containers
• **ALL** Category Two tasks must be recorded in the Service Users’ MAR Chart
• **NEVER** tamper with the instructions on the MAR chart
• **ONLY** use a MAR chart that has had the medication details added by a responsible professional (this may be a pharmacist, registered manager or other responsible person of a social care service, a doctor or nurse)
• **ALWAYS** contact your manager should a new medicine appear that is not accounted for anywhere on the chart
• **If you are in doubt about anything, DON’T administer and seek advice from your Supervisor.**
ADMINISTERING PRESCRIBED EYE DROPS

Administering Prescribed Eye Drops
Explain and instruct the Service User on the proper use of the eye drops that are prescribed.

*Proper application of the prescribed eye drops is the most important thing a patient can do to relieve post-op discomfort and to prevent complications after surgery.*

- Administer eye drops exactly as instructed by the doctor.
- If more than one type of eye drop to be administered follow the instructions of the doctor.
- Wait for the recommended time between administering different types of eye drops.
- Wait for the recommended time between administering more than one drop of the same eye drop.
- Administer eye drops before eye gels/ointments.
- The eye drop needs to remain in contact with the eye for as long as possible.
To use eye drops, follow these steps:

- Wash hands thoroughly with soap and water. (5 moments of hand hygiene)
- Wear disposable gloves - if risk assessment indicates the need to do so.
- Check the dropper tip to make sure that it is not chipped or cracked.
- Avoid touching the dropper tip against the eye or anything else; eye drops and droppers must be kept clean.
- While tilting the Service User's head back, pull down the lower lid of the eye with your index finger to form a pocket.
- Hold the dropper (tip down) with the other hand, as close to the eye as possible without touching it.
- Brace the remaining fingers of that hand against the face.
- Ask the Service User to look up, gently squeeze the dropper so that a single drop falls into the pocket made by the lower eyelid. Remove your index finger from the lower eyelid.

To use eye drops, follow these steps:

- Ask the Service User to close the eye for 2 to 3 minutes and tip their head down as though looking at the floor. Advise them not to blink or squeeze the eyelids.
- Place a finger on the tear duct and apply gentle pressure - or ask the Service User to do this.
- Wipe any excess liquid from their face with a tissue.
- If more than one drop is needed in the same eye, wait for the recommended time before instilling the next drop.
- Replace and tighten the cap on the dropper bottle. Do not wipe or rinse the dropper tip.
- Remove gloves (if wearing) and wash hands.
- Complete MAR chart.
Common symptoms of eye infections are:

- Pain, itching, or sensation of a foreign body in the eye
- Photosensitivity (aversion to bright light)
- Redness or small red lines in the white of the eye
- Discharge of yellow pus that may be crusty on waking up
- Tears

Contact GP or health care professional
APPLICATION OF
MEDICATED CREAMS
Where skin integrity is compromised

Why do we have skin?

- Skin is a dynamic, protective organ that grows, stretches, shrinks, creases, and wrinkles in response to a person's age, habits, weight fluctuations, and the environment. Skin serves many important functions including: protecting the body from environmental factors such as bacteria, fungus, viruses, allergens, water, and chemicals.
- regulating body temperature by sweating and adjusting blood flow to the skin
- synthesizing vitamin D
- helping the body sense touch, pain, temperature, pressure, and position
- providing some protection against the sun's harmful ultraviolet rays

Cumbria County Council

Serving the people of Cumbria
What Is Skin Integrity?

- Skin integrity means that the skin is healthy, undamaged and able to perform its basic functions.
- A skin integrity issue might mean that the skin is damaged, vulnerable to injury or unable to heal quickly.
- Skin is the largest organ in the body. It contributes 15% of the body’s weight and receives 1/3 of circulating blood.

Effects of Ageing on Skin
Five important actions for skin integrity management

1. Inspect skin daily with attention to skin folds, bony prominences and oral health.
2. THROW AWAY THE SOAP!
3. Moisturise regularly, and apply prescribed barrier creams to prevent skin excoriation (damage) from irritants such as urine, faeces or wound.
4. Pay constant attention to nutrition and hydration.
5. Involve and educate the Service User and carers in skin integrity management.

Skin tears are a preventable injury

- Careful positioning, turning, lifting and transferring, to avoid shear and friction forces and accidental injury
- Use slide sheets
- Pad bed rails and sharp corners
- Be especially careful with wheelchairs
- Advise Service User to keep fingernails and toenails short
- Care Workers must pay attention to their own fingernails, jewellery and name tags
Areas to consider when assessing for impaired skin integrity:

- Nutrition
- Incontinence
- Keep bedding clean and free from wrinkles
- Keep skin dry and clean
- Mobility /Activity
- Risk of pressure sores
- Pressure relieving cushion & mattress
- Other diseases
- Completing risk assessments
- Ongoing assessment
- Education of Service User and family
- Reporting concerns to a Health Professional
- Documentation

Some of the most common early signs of skin integrity issues include:

- A red or pink appearance on people who have light coloured skin
- An ashen, blue or purple appearance on people who have darker skin
- Pain in the area
- A firmer, softer, warmer or cooler feeling in the area compared to other parts of the body
- An area that doesn’t blanch (lose colour when pressed)
Applying medicated creams

- Wash hands, wear gloves.
- Follow directions given by the Health Professional, refer to body map (B2)
- The amount of cream that should be applied is commonly measured by fingertip units (FTUs).
- One FTU is the amount of cream or ointment that is squeezed out along an adult’s fingertip (that is, from the very end of the finger to the first crease in the finger).
- As a guide, one FTU is enough to cover an area twice the size of an adult hand.
- Apply cream only to the area it has been prescribed for.
- Record date of opening of external preparations on the MAR chart and the medication tube/bottle.

Care Workers must:

- Monitor the condition of the Service User’s skin daily
- Be able to identify when there is a risk of the skin breaking down
- Report changes/concerns to the appropriate Health Professional and their line manager
- Document clearly their findings
- Only apply prescribed medicated creams when skin integrity is compromised following direction from the Health Professional
- Understand how to complete nutrition charts
- Complete body maps (B2) as instructed
- Always follow standard infection control guidelines
ADMINISTERING PATCH BASED MEDICINE

Use of patch based medicines
**Liner** – Protects the patch during storage. The liner should be removed before use.

**Drug** – Drug solution is in direct contact with the release liner.

**Adhesive** – Holds the components of the patch together. It also helps keep the patch 'glued' to the skin.

**Membrane** – Controls the release of the drug from the patch.

**Backing** – Protects the overall patch during the application period.
Applying transdermal patch

Assess for:
- Skin irritation
- Rash
- Redness
- Swelling

Ask person if feel any:
- Burning
- Itching
- Pain
- Tenderness

REPORT AND SEEK ADVICE BEFORE APPLYING NEW PATCH

Useful advice...

- The service user may get slight redness, irritation or itching of the skin where a patch has been. If this doesn’t clear up, gets worse or a rash develops, consult a doctor.
- Avoid placing patches under tight clothing or elasticated waistbands.
- Cover the patch so it is not exposed to direct sunlight when sunbathing.
- Exercising or applying heat to patches may increase the amount of medicine absorbed into the body. This can increase the risk of side effects.
- If you accidentally put on too many patches, remove the extra one(s) as soon as possible and tell a doctor immediately.
Advice ....

- If you forget to put a patch on, apply it as soon as you remember. However, do not apply two patches at once to make up for the one you forgot.
- Never divide or cut a patch.
- Do not use patches past their expiry date.
- Store patches in a dry place at room temperature or according to the instruction on the medication.
- Don't keep patches in the bathroom as they may become damp or too hot.
- If the patch accidentally sticks to the skin of another person, remove it immediately and consult a doctor.

Advice...

- Always use the medicines according to the printed label on or inside the packaging and as directed by the doctor or pharmacist.
- Always keep medicines out of the reach of children.
- **Dispose of used patches carefully as they will still contain some active medicine.** Fold the patch so it sticks to itself and make sure it is disposed of well out of the reach of children and animals. This is particularly important for nicotine patches and patches containing strong opioid painkillers, as even used patches can still contain enough medicine to cause severe side effects or even be fatal to a child.
**Safe production of MAR charts**

The procedure for producing MAR charts should ensure that:

- The MAR chart is individual to the service user and reflects the items which are still being currently prescribed and administered.
- The MAR chart is clear, indelible, permanent and contains product name, strength, dose and frequency.
- The MAR chart is constructed on the basis of currently prescribed medicines together with information about repeat prescriptions for PRN medicines.
- The MAR chart includes all prescribed externally applied medicines to be administered by care staff.
- The MAR chart incorporates a method to ensure that any changes made after production are evident (dated, signed and indicates who has made the change).

An additional check will be made every time the Support Worker administers and cross references the information on the medication label with the MAR chart using the 6 R’s. Any discrepancies should be reported to the Supervisor.
# Cumbria Care Medication Administration Record (MAR)

**Key**

- **A**: Applied (creams)
- **S**: Service User administered
- **F**: Family administered
- **O**: S.U. Out HP
- **HP**: Health Professional administered
- **NR**: Not Required

<table>
<thead>
<tr>
<th>CUMBERLAND COUNTY COUNCIL</th>
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**NAME**

**ADDRESS**

**MEDICAL HISTORY**

**ALLERGIES**

**NAME OF DOCTOR**

**SURGERY NAME**

**WHERE ARE MEDS KEPT?**

**IF YES TOPOICAL MED APP RECORD IN SITU**

**CREAMS REQUIRED**

**START DATE**

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**Key:**

- **A**: Applied (creams)
- **S**: Service User administered
- **F**: Family administered
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- **HP**: Health Professional administered
- **NR**: Not Required

---

**Serving the people of Cumbria**
# Cumbria Care Medication Administration Record (MAR)

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**DAY STARTED**

**START DATE**

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**DAY STARTED**

**START DATE**

<table>
<thead>
<tr>
<th>DATE</th>
<th>COMMENTS SECTION – Please record any further information below</th>
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**Key**
- A = Applied (creams)
- S = Service User administrated
- F = Family administrated
- O = S.U. Out
- HP = Health Professional administrated

Completed by Staff Signature:
Topical Medicines Application Record

Record of Observations of Skin Integrity

Report any concerns to your Supervisor
**Latin Abbreviations**

The following is a list of commonly used Latin abbreviations that are sometimes included on prescriptions.

- **a. c.** = ante cibum (before food)
- **b. d.** = bis die (twice daily)
- **o. d.** = omni die (every day)
- **o. m.** = omni mane (every morning)
- **o. n.** = omni nocte (every night)
- **p. c.** = post cibum (after food)
- **p. r. n.** = pro re nate (when required)
- **q. d. s.** = quarter die sumendum (to be taken four times daily)
- **stat** = immediately
- **t. d. s.** = ter die sumendum (to be taken three times daily)
- **t.i.d.** = ter in die (three times daily)
### Competent Person Record - Domiciliary Care Category One

<table>
<thead>
<tr>
<th>Dates of policy training and 1st observation:</th>
<th>Support worker name</th>
<th>Observations</th>
<th>Annual Competency Checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with medication. If this is not available or there are any concerns report to supervisor</td>
<td></td>
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<tr>
<td>2. Seek the service users consent</td>
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<tr>
<td>3. Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times</td>
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<tr>
<td>4. If requested provide information, support and reassurance throughout</td>
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<tr>
<td>5. Support worker understands why a general support, prompt and assist is required</td>
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<tr>
<td>6. Check that the service user has not taken or any informal carer has administered any medication, including PRN, by checking PRN sheet and communication sheet</td>
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<tr>
<td>7. Routinely applies standard precautions for infection control and any other relevant health and safety measures</td>
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<tr>
<td>Competent Person Record - Domiciliary Care Category One</td>
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<tr>
<td>8. Remind service user to take their medication, and document appropriately on prompt sheet, and communication sheet.</td>
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<tr>
<td>9. Manipulates original packaging or pharmacy filled compliance aide under the full view and direction of the service user.</td>
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<tr>
<td>10. Record exact assistance on the communication sheet. Use PRN recording sheet if appropriate.</td>
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<tr>
<td>11. Monitor the service user's condition throughout, recognise any obvious adverse effects and takes the appropriate action without delay.</td>
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<tr>
<td>12. Safe storage of medication in line with the agreed medication risk assessment, taking into account any special storage instructions.</td>
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<tr>
<td>13. Reports or disposes of out of date and part-used or refused/wasted medication in accordance with the MM paperwork, legal and local requirements, and with the permission of the service user.</td>
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<tr>
<td>14. Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication.</td>
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<td>15. Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication.</td>
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<td>16. Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication.</td>
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<td>17. Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication.</td>
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<tr>
<td>18. Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication.</td>
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</table>
### Competent Person Record - Domiciliary Care Category One

<table>
<thead>
<tr>
<th>Observation date</th>
<th>Comments/Actions</th>
<th>Signature of support worker/supervisor</th>
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</table>
## Competent Person Record - Domiciliary Care Category One

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>Dates of policy training and 1st observation:</td>
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</tr>
<tr>
<td>Date of theory / 1st observation sign off:</td>
<td>Observations</td>
<td>Annual Competency Checks</td>
</tr>
<tr>
<td>Support worker name</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>The support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with medication. If this is not available or there are any concerns report to supervisor</td>
<td></td>
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<tr>
<td>2</td>
<td>Seek the service user's consent</td>
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<tr>
<td>3</td>
<td>Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times</td>
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<tr>
<td>4</td>
<td>If requested provide information, support and reassurance throughout</td>
<td></td>
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<tr>
<td>5</td>
<td>Support worker understands why an administration is required</td>
<td></td>
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<tr>
<td>6</td>
<td>Check that the service user has not taken or any informal carer has administered any medication, including PRN, by checking the MAR chart, PRN sheet and communication sheet</td>
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<tr>
<td>7</td>
<td>Routinely applies standard precautions for infection control and any other relevant health and safety measures</td>
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<td>8</td>
<td>Safely administers medication following the written instructions and in line with legislation and local Policies, including PRN. Check the identity of the individual which is to receive the medication, and select, check and prepare the medication using the 6 “R”s with the MAR chart. Check expiry date if appropriately</td>
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<tr>
<td>9</td>
<td>Record administration on MAR chart and PRN recording form (if appropriate) immediately or enter the correct code as illustrated on current MAR chart</td>
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<tr>
<td>10</td>
<td>Monitor the service user’s condition throughout, recognise any obvious adverse effects and takes the appropriate action without delay.</td>
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<tr>
<td>11</td>
<td>Safe storage of medication in line with the agreed medication risk assessment, taking into account any special storage instructions.</td>
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<tr>
<td>12</td>
<td>Reports or disposes of out of date and part-used, refused/wasted medication in accordance with the MM paperwork, legal and local requirements, and with the permission of the service user</td>
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<tr>
<td>13</td>
<td>Understands the actions required to report any concerns, errors or incidents relating to medication</td>
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<td>14</td>
<td>Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication</td>
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<td>15</td>
<td>Support worker understand what to do in the event that a service users medication changes, or a new...</td>
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<td>16</td>
<td>Support worker understands the procedure around over the counter and Homely medication (including herbal and homeopathic remedies)</td>
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<td>17</td>
<td>Support worker signature and date</td>
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- medication appears on the MAR chart
## Competent Person Record - Domiciliary Care Category Two

<table>
<thead>
<tr>
<th>Observation date</th>
<th>Comments/Actions</th>
<th>Signature of support worker/supervisor</th>
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# Competent Person Record - Prescribed creams

<table>
<thead>
<tr>
<th>Dates of policy training and 1st observation sign-off:</th>
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<th>4:</th>
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<tbody>
<tr>
<td>Support worker name:</td>
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<table>
<thead>
<tr>
<th>Support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with medication. If this is not available or there are any concerns report to supervisor.</th>
<th>2</th>
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<tbody>
<tr>
<td>Seek the service users consent</td>
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<tr>
<td>Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times</td>
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<tr>
<td>If requested provide information, support and reassurance throughout</td>
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<tr>
<td>Support worker understands why an administration is required</td>
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<td>6</td>
</tr>
<tr>
<td>Check that the service user has not taken or any informal carer has administered any medication, including PRN, by checking the MAR chart, PRN sheet and communication sheet</td>
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<tr>
<td>Routinely applies standard precautions for infection control and any other relevant health and safety measures. Wears clean pair of gloves for each prescribed cream to be applied</td>
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**Dates of policy training and 1st observation sign-off:**

1. The support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with medication. If this is not available or there are any concerns report to supervisor.

2. Seek the service users consent

3. Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times

4. If requested provide information, support and reassurance throughout

5. Support worker understands why an administration is required

6. Check that the service user has not taken or any informal carer has administered any medication, including PRN, by checking the MAR chart, PRN sheet and communication sheet

7. Routinely applies standard precautions for infection control and any other relevant health and safety measures. Wears clean pair of gloves for each prescribed cream to be applied

**Support worker name:**

**Observations**

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<tr>
<td></td>
<td>Competent Person Record - Prescribed creams</td>
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<tr>
<td>8</td>
<td>Writes date of opening on box of newly opened cream. Check expiry date.</td>
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<tr>
<td>9</td>
<td>Applies cream down the limb in the direction of hair growth using sweeping motion, as directed using fingertip units.</td>
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<tr>
<td>10</td>
<td>If applying a steroid creams, applies cream thinly, if barrier cream use as per directions</td>
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<tr>
<td>11</td>
<td>Monitor the service user's condition throughout, recognise any obvious adverse effects and takes the appropriate action without delay.</td>
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<tr>
<td>12</td>
<td>Safely administers medication following the written instructions and in line with legislation and local Policies, including PRN. Check the identity of the individual which is to receive the medication, and select, check and prepare the medication using the 6 &quot;R&quot;s with the MAR chart.</td>
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<tr>
<td>13</td>
<td>Safe storage of medication in line with the agreed medication risk assessment, taking into account any special storage instructions.</td>
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<tr>
<td>14</td>
<td>Reports or disposes of out of date and part-used, refused/wasted medication in accordance with the MM paperwork, legal and local requirements, and with the permission of the service user</td>
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</table>
### Competent Person Record - Prescribed creams

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<tbody>
<tr>
<td>15</td>
<td>Understands the actions required to report any concerns, errors or incidents relating to medication</td>
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<tr>
<td>16</td>
<td>Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication</td>
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<tr>
<td>17</td>
<td>Record administration on MAR chart and PRN recording form (if appropriate) immediately or enter the correct code as illustrated on current MAR chart</td>
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<tr>
<td>18</td>
<td>Support worker signature and date</td>
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</tbody>
</table>
## Competent Person Record - Prescribed creams

<table>
<thead>
<tr>
<th>Observation date</th>
<th>Comments/Actions</th>
<th>Signature od support worker/supervisor</th>
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</table>
### Competent Person Record - Prescribed eye drops

<table>
<thead>
<tr>
<th>Dates of policy training and 1st observation:</th>
<th>1:</th>
<th>2:</th>
<th>3:</th>
<th>4:</th>
<th>5:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of theory / 1st observation sign off:</td>
<td>Observations</td>
<td>Annual Competency Checks</td>
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<tr>
<td>Support worker name</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>1 The support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with medication. If this is not available or there are any concerns report to supervisor</td>
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<tr>
<td>2 Seek the service users consent</td>
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<tr>
<td>3 Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times</td>
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<tr>
<td>4 If requested provide information, support and reassurance throughout</td>
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<tr>
<td>5 Support worker understands why an administration is required</td>
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<tr>
<td>6 Check that the service user has not taken or any informal carer has administered any medication, including PRN, by checking the MAR chart, PRN sheet and communication sheet</td>
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<tr>
<td>7 Routinely applies standard precautions for infection control and any other relevant health and safety measures</td>
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<tr>
<td>Step</td>
<td>Action</td>
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<td>Safely administers medication following the written instructions and in line with legislation and local Policies, including PRN. Check the identity of the individual which is to receive the medication, and select, check and prepare the medication using the 6 “R”s with the MAR chart. Check expiry date and date of opening</td>
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<tr>
<td>9</td>
<td>Takes top off the bottle top and checks that it is not cracked or chipped and puts it down somewhere clean to avoid contamination</td>
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<tr>
<td>10</td>
<td>Ensures the service user is upright. Tilts the service users head backwards and gently rolls down lower lid. Asks the service user to look upwards</td>
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<tr>
<td>11</td>
<td>Holds dropper above the eye and squeezes one drop inside lower lid. Let go of the eye lid and asks service user to keep eye closed and tilt head forward. Wipes away any liquid from service users cheek with clean tissue.</td>
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<tr>
<td>12</td>
<td>Repeats in the other eye if drops prescribed for both eyes. If using more than one drop, waits the recommended time before instilling second drop</td>
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<td>Monitor the service user’s condition throughout, recognise any obvious adverse effects and takes the appropriate action without delay.</td>
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<td>Support worker understands the correct procedure for refused medication or any other reason for service user not taking their medication</td>
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<td>Record administration on MAR chart and PRN recording form (if appropriate) immediately or enter the correct code as illustrated on current MAR chart</td>
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<td>Support worker signature and date</td>
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## Competent Person Record - Prescribed eye drops

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</table>
## Competent Person Record - Prescribed Stockings

<table>
<thead>
<tr>
<th>Dates of policy training and 1st observation sign-off:</th>
<th>1:</th>
<th>2:</th>
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<tbody>
<tr>
<td>Support worker name</td>
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<thead>
<tr>
<th>Observations</th>
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<tr>
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<tr>
<td>Support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with Health Care Task. If this is not available or there are any concerns report to supervisor.</td>
<td>1</td>
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<tr>
<td>Seek the service users consent</td>
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<td>Encourage the service user to be as independent as possible, maintaining privacy and dignity at all times.</td>
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<tr>
<td>Support worker can explain why assistance is required and why support stockings are worn.</td>
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<tr>
<td>Support worker checks the skin for integrity issues prior to application of prescribed stockings.</td>
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<tr>
<td>Routinely applies standard precautions for infection control and any other relevant health and safety measures.</td>
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<td>6</td>
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<tr>
<td>Support worker applies stockings competently.</td>
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The support worker should read through the support plan and associated paperwork prior to support commencing. To establish level of support required with Health Care Task. If this is not available or there are any concerns report to supervisor.
## Competent Person Record - Prescribed Stockings

<table>
<thead>
<tr>
<th>Support worker checks for wrinkles and ensures stockings fit correctly</th>
<th>Record exact assistance in the communication record</th>
<th>Monitor the service user’s condition throughout, recognise any obvious adverse effects and takes the appropriate action without delay.</th>
<th>Support worker can explain signs of skin integrity issues</th>
<th>Support worker understands what advice to give the service user who is wearing the support stockings</th>
<th>Understands the actions required to report any concerns regarding the use of prescribed support stockings</th>
<th>Support worker signature and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>1</td>
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<td>11</td>
<td>12</td>
<td>13</td>
<td>12</td>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Issue date</th>
<th>Amendment</th>
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