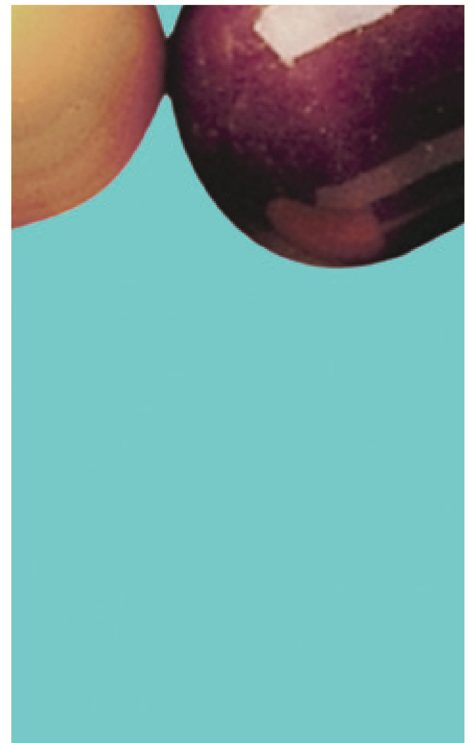
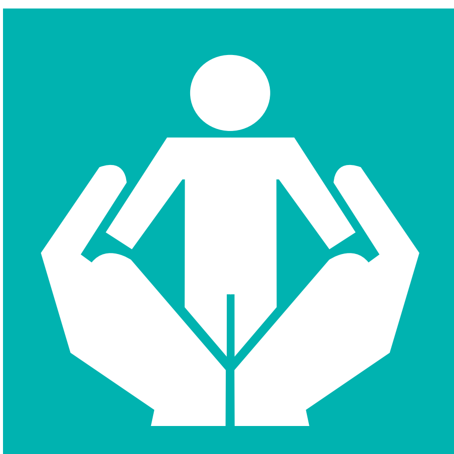

The Strategy and Good Practice Guide for the Safe Handling, Management and Administration of Medication in Health and Social Care within the Community

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The work of the North East Regional Development of Skills Group in developing a training strategy and a guide of good practice has been valuable in ensuring this document was produced and updated to meet the care sector's needs.

City & Guilds

Darlington Borough Council

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1. INTRODUCTION ///////////////////////////

This strategy and good practice guidance has been developed through joint working between health and social care organisations. It is intended for use by all those working in health and social care within the community.

1.1 Aims

The aims of the strategy and guidance are to:

- provide a system of administration and management for medicines that focuses on the needs of patients or service users, their families and carers, and re flects the quality standards that are outlined in the National Service Framework for Older People, Care Quality Commission (CQC) Professional Guidance for the Administration and Management of Medicines and the National Minimum Care Standards
- assist in the standardisation of medication policies within care provision across the North-East of England
- promote and maintain independence by advising on the safe management of medicines
- develop a strategic approach across all agencies for the provision of appropriately structured programmes of education and learning in the safe handling, management and administration of medication.
- ensure that patients or service users who need assistance with medicines are identified through the use of risk assessments
- promote safe recording

2.1 National Policy

The White Paper 'Our Health, Our Care, Our Say' (Department of Health, 2006) set a new direction for the whole health and social care system. It aims to:

- change the way these services are provided in communities and make them as flexible as possible
- provide a more personal service that is tailored to the specific health or social care needs of individuals
- give patients and service users more control over the treatment they receive
- give the most appropriate treatment or care for an individual's needs

It further states that

"Public, private, voluntary and charitable organisations will need to work in partnership to put the interests of the public first, ensure health and social care staff receive the right training and make good health and social care services an essential part of local communities."

(DoH, 2006)

As can be seen there is not a national position on medication management, however this policy is designed to address the issue.

2.2 Link with the Single Assessment Process

A medication risk assessment is part of the Single Assessment Process. One of the key principles is the promotion and maintenance of independence wherever possible.

2.3 Legal background

North East Regional Development of Skills Group recommends that training is undertaken prior to any administration of medication.

An individual may administer a prescription only medicine (POM) or controlled drug to another person with their consent as long as it is prescribed for that person and given in accordance with the instructions of the prescriber (Medicines Act, 1968). However, when medication is given by invasive techniques, such as an injection, then specialist education and training is required. Medicines prescribed for a person are that person's property and may not be used by any other person.

Doses of prescribed medicines should not be varied without the prescriber's consent. The only times these legislative requirements vary are when the service user lacks mental capacity. When these incidents arise then decisions should only be made by the 'appropriate person' who acts in the service user's best interests. All medication administered in these circumstances will be undertaken within the Level 3 Complete Medication Management processes.

2.4 Medication in Care Settings

In 2006, the then Commission for Social Care Inspection (CSCI) published a report 'Time to Care', which was an overview of home care services for older people in England, identifying areas for improvement. These included the need to improve practices relating to the handling of medication and processes for the recruitment and supervision of staff. Performance in these areas has continued to improve since this report was published

and the medication and supervision standards have seen the largest improvement of all the standards in recent years. However, whilst this improvement is encouraging, these remain amongst the standards where home care agencies perform least well. A link to this document is provided below:

http://www.cqc.org.uk/_db/_documents/SOSC08%20Report%2008_Web.pdf

CSCI also produced a report in 2006 entitled 'Handled with Care', looking specifically at care homes. This report concluded that insufficient progress had been made in improving the number of care homes meeting medication standards. Nine recommendations were made in this report relevant to care providers, local authorities, primary care trusts, and Healthcare Commission and training providers. Performance relating to National Minimum Standards (NMS) on medication handling has increased by 22% since 2003 and by 7% since 2007, following on from the report. However, a third of homes were still not meeting these requirements in 2008. A link to this document is provided below:

http://www.cqc.org.uk/_db/_documents/SOSC08%20Report%2008_Web.pdf

In 2010 the Care Quality Commission published Guidance about compliance and essential standards of quality and safety. Outcome 9 covers the Management of Medicines across all care settings. A link to this document is provided below:

http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf

Any care home registered to provide nursing care must ensure that the registered nurses they employ act in according to standards published by the Nursing and Midwifery Council (NMC). It also includes the process for delegating the task of administering medication. A link to this document is provided below:

http://www.nmc-uk.org Documents/Standards/

2.5 Access to Training for Health and Social Care Members of Staff

Until Skills for Care published the Knowledge and Skills Set in 2005, there was no national agreement as to what a training programme for medication should include. As a result, accreditation has not been consistent and learning and development programmes are variable. Many are distance learning and do not assess competence as part of the programme.

Therefore, there is no guarantee that following an accredited training course will automatically produce competent health and social care workers. Good practice would be to follow up formal training with in-house supervision and competence assessment. Competence assessments should be repeated regularly. Employees will also need to be trained 'in-house' during induction and with regular updates, to ensure that they are fully aware of the medicine policy within their organisation. A useful document published in 2005 by the Association for Real Change on this subject is: 'Managing Medication in Learning Disability Social Care Settings – A guide and training framework for social care organisations'. A link to this document is provided below:

http://www.arcuk.org.uk/silo/files/76.pdf

The Care Quality Commission (CQC) in 2009 published professional advice called The Administration of Medication in Care. A link to this document is provided below:

http://www.cqc.org.uk/_.../20081119_Administration_of_medicines_in_care_homes_225-07_200911241944.doc

A guidance booklet entitled The Handling of Medicines in Social Care from the Royal Pharmaceutical Society (2007) set out:

- key principles that underpin the safe and appropriate handling of medicines
- how these apply in specific services, including residential care homes, secure accommodation, foster care and domiciliary care
- practical procedures and methods for handling medicines that represent good professional practice and cover all social care settings
- general aspects of medicines management relating to specific care services
- policies, systems, procedures and devices for consideration when implementing measures for handling medicines
- a glossary and reference source, including legislation and guidance from professional organisations

A link to this document is provided below:

:http://www.rpsgb.org/pdfs/handlingmedsocialcare.pdf

3. RECOMMENDATIONS ////////////////

3 Recommendations

This document provides an example of good practice in the administration and management of medicines in care settings.

The recommendations in Section 6, Education, Learning and Development of the enclosed Good Practice parts of this document are transferable to the continuous professional development of carers working in a wide range of health and social care settings.

However there may be a requirement to alter the procedural activities to enable the recommendations to be met within alternative settings. For example local authorities - may approve or adapt it for their domiciliary care services and through their contracting processes to ensure that independent providers that they contract work to the same policy framework.

However, whereas it is acceptable to adapt the policies to suit individual settings/circumstances, however, the education, learning and development recommended standards cannot be compromised.

4. GOOD PRACTICE

4: Good Practice

The Good Practice is to:

1. ensure the best interests of the patient or service user are paramount. The interests of the team or organisation should not determine any decision to administer medicines
2. embed the importance of risk assessment in identifying appropriate support for patients or service users. Carers MUST NOT offer any assistance with medication unless a risk assessment has been carried out, the level of support required is clearly documented and a care plan is in place and accessible within the patient or service user's home. A sample risk assessment, which can be used by health or social care members of staff, is attached at Appendix B (See also Section 5)
3. ensure the provision and availability of appropriate learning for those staff who assist patient or service users with the safe administration of medication
4. embed the importance of patient or service user consent and full understanding of the assistance given to them for the safe administration of their medication. Where the patient or service user is incapable of giving consent, alternative consent must be documented in the patient or service user care plan, together with the names of persons involved in the decision. If consent is refused, assistance with medicines cannot be given. The refusal should be reported to the care manager, GP and documented. In no circumstances should a medicine be given to a patient or service user without their knowledge i.e. covertly (e.g. crushed or hidden in food) or administered against their wishes
5. give care that is in accordance with the Health and Safety at Work Act 1974 which imposes a general duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare of employees and others which includes patient or service users and any others who may be affected by the activities. This duty extends to all aspects of the provision of care, including the storage, administration and disposal of medicines
6. promote independence whenever possible
7. promote good practice in the safe administration of medication:

   a. Carers **MUST ONLY** administer medication from the original container supplied by the pharmacist and not from any container filled by any other person

   b. Carers **MUST NOT** carry out any invasive, clinical or nursing procedures (refer to section 10, Types of Support) and are not expected to make judgements on medication where directions are not explicit e.g. 'take as required'. NB 'two tablets four times a day when required for pain' would be acceptable because a dose is clearly state
8. report any concerns about a patient or service user and their medication to the senior carer who will seek appropriate advice
9. ensure that the risk assessment, care plan, medication profile and a medicines administration record Chart (MAR Chart) is accessible in the patient or service user's home (Appendix 1,2,4)
10. ensure a 12 month review of the risk assessment and care plan in conjunction with all relevant parties plus at any time there is a change in the patient or service user's circumstances or if the carers report any problems
11. ensure the safe transfer of patient or service users and their medication from one provision to another utilising effective communication between the care managers, medical staff and community pharmacists

5. TYPES OF SUPPORT WITH PRESCRIBED MEDICINE

Support will only be offered after:

- a risk assessment has been carried out
- a level of support has been agreed
- a care plan has been developed
- the patient or service user has consented to this assistance
- a patient or service user care plan, medication profile (and MAR Chart where appropriate) which also details a medication log (Appendix 6) are to be accessible within the patient or service user's home.

Carers must be competent to provide the level of assistance required and must follow the standard operating procedure at appendix 3.

If assistance at any level is being provided, records must be kept of all medicines received or sent for destruction. An entry will be signed and dated on the back of the medication profile (Appendix 5) when prescriptions are requested and when medicines are received from the community pharmacy. Any medicines returned to the community pharmacy for disposal should also be recorded in similar fashion. Three different levels of support have been identified. These are consistent with current Care Quality Commission (CQC) guidance and are not linked to qualification levels.

These are:

- Level 1 Assisted self-medication
- Level 2 Supervised or physically assisted self-medication
- Level 3 Complete medication management

Table 1 details the different levels of support in their practical application.

Specialist Tasks

Specialist tasks may be added to care packages for patient or service users receiving support at Level 2 or 3. The assistance to be given should be recorded in the Care Plan.

To carry out specialist tasks carers must:

- have completed the full education and learning requirements (Appendix 8) of Level 3 of this document
- have been assessed and signed off as competent to undertake the specialist task by the relevant health professional. (Copy to be held on staff file)
- agree and feel competent to do so.

A community nurse should request tasks in this category and retains clinical responsibility and oversight. Specialist tasks may include:

- Application of eye drops / eye ointments / ear drops (without compliance aids)
- Simple dressings
- Prevention of pressure sores
- Changing and disposal of stoma appliance / incontinence appliances
- Assistance with prescribed hosiery
- Assistance with nebuliser
- Suppositories
- Enemas
- Pessaries
- Any other product for intra-vaginal or rectal use
- Injections.

TABLE 1: Levels of Support

	Level 1	Level 2	Level 3*	Record on MAR chart
Patient or service user directs carers and takes responsibility for their medicines	✔	✔	✔	
The patient or service user is selecting which medicine is needed and its dose, but needs physical assistance to prepare to take or use the medication.		✔	✔	
The patient or service user is not taking responsibility for the medicines to be taken			✔	
Help with ordering and collecting prescriptions	✔	✔	✔	
Verbal reminder to take medication	✔	✔	✔	
Help with reading labels or patient information leaflet	✔	✔	✔	
Advising on safe storage of medicines	✔	✔	✔	
Observing and reporting to the Senior Care Worker any changes in patient or service user's ability to manage their medicines	✔	✔	✔	
Opening containers with direction from the patient or service user	X	✔	✔	✔
Pouring liquid doses with direction from the patient or service user	X	✔	✔	✔
Preparing inhaler/spacer devices with direction from the patient or service user	X	✔	✔	✔
Preparing a compliance device for eye drops with direction from the patient or service user	X	✔	✔	✔
Applying topical preparations e.g. a cream or ointment with direction from the patient or service user	X	✔	✔	✔
Selecting and administering the appropriate medicine by opening the container, handing the prepared dose to the patient or service user and ensuring that it is taken correctly in accordance with a standard operating procedure (SOP) (Appendix C)	X	X	✔	✔
Assisting with opening monitored dose devices (Medidos, Dosette or similar) filled by family or friends	X	X	X	
Any invasive, clinical or nursing procedures	X	X	X	
Specialist tasks without specialist training	X	X	X	

✔ allowed   Blank not appropriate   **X** not allowed

* These are not qualification levels

6. EDUCATION LEARNING //////////////// AND DEVELOPMENT //////////////////////

6.1 CQC Guidance on Training

CQC guidance states that the care agency is responsible for:

- evidence that training is appropriate and carried out by a suitably competent trainer with current experience of handling medicines
- establishing a formal means to assess whether the care worker is competent to assist with medicines

6.2 National Minimum Standards

6.2.1 Care Homes for Older People - National Minimum Standards (2003) stated:

The registered person ensures that there is a policy and staff adhere to procedures, for the receipt, recording, storage, handling, administration and disposal of medicines, and patient or service users are able to take responsibility for their own medication if they wish, within a risk management framework.

In residential care homes, all medicines, including Controlled Drugs, (except those for self-administration) are administered by designated and appropriately trained staff. The administration of Controlled Drugs is witnessed by another designated, appropriately trained member of staff.

The training for care staff must be accredited and must include:

- basic knowledge of how medicines are used and how to recognise and deal with problems in use
- the principles behind all aspects of the home's policy on medicines handling and records

6.2.2 Domiciliary Care - National Minimum Standards (2003) stated:

The registered person ensures there is a clear, written policy and procedure which is adhered to by staff and which identifies parameters and circumstances for assisting with medication and health related tasks and identifies the limits to assistance and tasks which may not be undertaken without specialist training.

The policy should include procedures if required for obtaining prescriptions and dispensed medicines and for recording the information.

Staff only provide assistance with taking medication or administer medication or undertake other health related tasks, when it is within their competence and they have received any necessary specialist training and it is:

- with the informed consent of the patient or service user or their relatives or representative
- clearly requested on the care plan by a named assessor
- with agreement of the care or support workers' line manager

This document sets out a model of good practice to meet all of the criteria laid out above. Assistance in sourcing training may be provided by Skills for Care and Skills for Health.

Good practice in providing assistance at any level with medicines is that care workers should:

- be fully aware of this document as part of their induction and ongoing training
- have completed a suitable training course approved by their employer

and

- have undergone a formal assessment of their competency and knowledge. (Appendix 8)

//////////////////////// 7. KNOWLEDGE AND //COMPETENCE A CARER REQUIRES

The minimum level of knowledge and competence a Carer will require to provide Medication Support at each Level

The minimum standard of knowledge and skills recommended for each level of support identified in section 10 above is:

	Level 1 Assisted self-medication	Level 2 Supervised or physically assisted self-medication	Level 3 Complete medicines management
Literacy and numeracy assessment (and support if required)	✔	✔	✔
Knowledge of:			
Legislation and Regulation	✔	✔	✔
Policy and Procedure	✔	✔	✔
Roles, responsibilities and boundaries	✔	✔	✔
Risk Assessment	✔	✔	✔
Promoting Independence	✔	✔	✔
Medication Administration Records (MAR Chart)	✔	✔	✔
Storage of medication	✔	✔	✔
Disposal of medication	✔	✔	✔
Types of medicines and routes of administration		✔	✔
Safe Practice in administration of medicines		✔	✔
Preparation of medicines		✔	✔
Evidence competence:			
Hold or be working towards (within 18 months) an NVQ Level 2 unit - Assist in the Administration of Medication	✔		
Fulfilling the Skills for Care Refreshed Common Induction Standards	✔		
Achieved a sufficient level of competence at National Test Level 1 literacy and numeracy and working towards L2 (within 18 months)	✔	✔	✔
Hold or be working towards (within 18 months) a Level 2 or 3 NVQ/QCF Diploma in Health and Social Care	✔	✔	
Hold or be working towards (within 18 months) NVQ 375 Safe Administration of Medication or the QCF unit Support the Use of Medication in a Social Care Setting HSC3047		✔	
Hold a Level 2 or 3 NVQ/QCF Diploma in Health and Social Care which includes NVQ 375 Safe Administration of Medication or the QCF unit Support the Use of Medication in a Social Care Setting HSC3047	✔	✔	✔

8, 9,10 & 11. MEDICATION ////////////////

8: Supervision and Management of Carers working with Medication

It would also be good practice that Supervisor/Registered Manager should have achieved an NVQ level 4 Registered Manager's Award, NVQ Level 4 Leadership and Management in Care Services or a QCF Level 5 Diploma in Leadership for Health and Social Care and Children and Young People's Services.

Monitoring of practice should also be an inclusive part of the supervision and appraisal process and appropriate observations of practice should take place at least once a year post qualification for all staff.

9: Medication Risk Assessment

In keeping with the aim of promoting and maintaining independence, it should not be assumed that help with medicines is automatically required when care is in place.

Suitably competent individuals should carry out medication Risk/Needs Assessment. It is expected that Social Workers, Care Managers or healthcare staff could carry out the assessment.

The Medication Risk Assessment should identify the support needs of the patient or service user. Reference must be made to the relevant health professional (GP, Community Nurse or Community Pharmacist) where further information is needed, or concerns arise and always if Level 3 support is being considered.

The patient or service user must provide consent for the support being offered and the Rrisk assessment, medication profile and care plan must be accessible in the patient or service user's home.

Where a patient or service user is unable to provide consent due to a lack of mental capacity then a functional capacity test needs to be undertaken in accordance with organisational policy and procedures and the requirements of the Mental Capacity Act 2005. Subsequent actions regarding the administration of medication must be undertaken with adherence to acting in that person's best interests (see also the Mental Capacity Act Code of Practice Chapter 5). Any subsequent support should always be at Level 3.

See Appendix B for Medication Risk Assessment

10: Supply, Storage and Disposal of Medicines

10.1 Supply

Medicines should normally be provided by a community pharmacist selected by the patient or service user. Wherever possible, the same community pharmacist should be used. It is good practice to inform the community pharmacist (with patient or service user consent) that support with medicines is being provided.

Community pharmacists are ideally placed to offer advice when a patient or service user is struggling to manage their medicines. Problems such as swallowing difficulties, complex timings, unclear instructions, inability to access containers or read labels, for example, can all be referred to the patient or service user's community pharmacist.

It is desirable that all medicines are supplied in the pharmacist's original container, complete with label and patient information leaflet, rather than in monitored dose packs. There may be situations where a patient or service user who is self-medicating would benefit from using a blister pack or monitored dose system. Advice should be sought from the patient or service user's community pharmacist, who will determine the most appropriate method of supply.

All labels should include explicit directions - for example 'take as required/ as before' or 'take as required for pain' would not be sufficient information to allow assistance to be provided. (See Appendix F 'Problems and Solutions' for further guidance)

- No alterations should be made to the dispensing label provided by the pharmacist under any circumstances.
- Medicines should not be decanted into other containers or put out for the patient or service user to take at a later time.
- Medicines should not be separated from their label or patient/service user information leaflet.

Family or friends may choose to fill a monitored dose device for a patient or service user (Medidos, Dosette or similar). Assistance will be limited to level 1 support if this is the case.

10.2 Storage

Medicines must be stored where they are readily accessible to carers. They should be kept away from excessive heat, humidity and light sources. They must be out of the reach of children.

Medicines which need to be stored in a refrigerator should preferably be stored in a sealed plastic box, separate from other foodstuffs at a temperature between 2 and 8 degrees centigrade.

Medicines must be stored in the original packaging and not separated from the label or patient information leaflet

When a child is the sole or main carer, medicines must be accessible to them as necessary, but care must still be taken to keep medicines away from other children who may visit the home.

The hiding of medicines from a patient or service user will only occur where the risk assessment indicate that this is needed to protect the health and safety of the patient or service user. The Care Manager must ensure that information on how to access medicines is available to all relevant personnel.

10.3 Disposal

The patient or service user and their relatives/carers should be encouraged to return any unwanted or out of date medicines to their community pharmacist.

Medicines remain the property of the patient and cannot be removed without consent.

In exceptional circumstances (and with the specific permission of their line manager) care staff may return medicines to a community pharmacist for disposal on behalf of a patient or service user. Consent must be given by the patient or service user and a record must be made on the medication profile stating what has been removed and to which community pharmacy.

11: Over the Counter (OTC) Medicines (including herbal and homeopathic remedies)

Carers should remind patients or service users to check with their community pharmacist before taking or using OTC treatments, in order to avoid potential adverse effects or interaction with existing prescribed treatment.

Carers must not offer any advice on non-prescribed medicines or remedies.

Carers must not purchase or assist with OTC medicines unless suitability has been confirmed with a named and appropriate healthcare professional (pharmacist or GP), and the product is being taken in accordance with manufacturer's instructions. A record of such confirmation should be made on the medication profile and reference to it on the observation record.

Carers should seek advice from the care manager if they are concerned that a patient or service user is using OTC medicines inappropriately or excessively.

12. RESPONSIBILITIES

12.1 Patient or service user

The level of responsibility assumed by an individual patient or service user will depend on their ability to control this aspect of their lives. Those who are able to assume a greater amount of control and independence will require less assistance than people with reduced physical or cognitive abilities.

The risk assessment will identify the level of assistance required to support independent living. If assistance with medication is required then the patient or service user must provide care staff with access to the prescription medicines and other information which should be detailed in the medication profile and care plan to enable them to carry out the duties safely.

12.2 Unpaid Carers

It would normally be expected that any unpaid carer would provide assistance with medication required by the patient or service user.

However, unpaid carers often need a break or cannot be available. In these circumstances, it may be necessary for care staff to provide the service during the carer's absence. Any short term assistance can only be provided in accordance with this document.

For the duration of the absence, the unpaid carer must provide the care staff with access to the prescription, medicines and other information which should be detailed in the medication profile and care plan to enable them to carry out the duties identified safely.

All prescription medicines must be provided contained within the original pharmacy-filled container. This may be a monitored dose system or any other suitable container. (Where medicines are placed in compliance aids or other containers by unpaid carers or professionals other than the supplying pharmacist, care staff may only provide level 1 support. No physical assistance may be offered.)

12.3 Paid Health and Social Care Workers

Following a risk assessment, with the consent of the patient or service user, the level of assistance required will be detailed within the care plan.

It is the responsibility of the care staff to follow the care plan and to report any concerns to their line manager.

Health and social care staff should only assist with medication where they are competent to do so. (as detailed in section 7)

12.4 Commissioner of Care Package

- Carries out medication risk assessment.
- Identifies the appropriate level of support and records this in the care plan.
- Obtains and records patient or service user's consent.
- Liaises with health professionals as appropriate to confirm medication requirements, special storage, administration details, etc.
- Ensures that all records of the above are retained.

The Commissioner continues to hold responsibility for ensuring that reviews are conducted whenever there is a significant change in the patient or service user's circumstances. Where there is no change reviews must take place every 12 months.

12.5 Provider of Care Package

It is the responsibility of the Provider to ensure:

- They use this Strategy and Model of Good Practice to ensure that appropriate policies are in place.
- That the service provided is monitored and reviewed.
- Incidents and 'near-misses' are recorded appropriately and used as a learning tool to improve the service.
- That training for carers is provided.
- That records of continuous professional development are kept.
- The agreed and documented level of assistance is provided to patient or service users on a day-to-day basis by competent staff
- The care plan is reviewed and maintained as appropriate

12.6 Service Managers and Corporate Responsibilities

Where problems arise which cannot be resolved locally, these must be referred to appropriate national bodies. Beyond this, further appropriate specialist support must be sought. In this way a body of knowledge can be generated about problematic issues relating to medication. It is a corporate responsibility to collate and communicate these issues consistently to all relevant personnel.

12.7 General Practitioners

General Practitioners (GPs) have a responsibility of care for all of their listed patients to provide general health and medical care or refer for specialist health care or social care. In looking after an individual's health and wellbeing, the GP or other non-medical prescriber will prescribe medication to their patient to prevent, treat or relieve medical conditions.

It should be noted that individual patient or service users might also receive medication prescribed by specialists and which might have been supplied to them in hospital.

Within primary care, other professionals may be involved in prescribing for patient or service users – suitably qualified nurses or pharmacists are able to prescribe.

13. DOCUMENTATION //////////////////////

The risk assessment must be signed and dated and the level of assistance agreed and consented to by the patient or service user must be clearly stated.

The care plan records the level of assistance required by each patient or service user, their usual community pharmacist, where the medicines are stored and any necessary details about ordering and collecting medicines.

The medication profile lists usual medicines and doses including any OTC medicines which are cleared as suitable by an appropriate health professional.

A Medication Administration Record Chart (MAR Chart) follows the patient or service user's when level 2 or 3 assistance is being given. All assistance with medication must be recorded at the time it is provided.

MAR Charts are preferably pre-printed on request by the community pharmacist at the time of dispensing. However it is the providers' responsibility to produce a MAR Chart and keep record of all medicines administered to the patient or service user. If the pharmacist cannot do this, the chart should be written out by a senior carer and double checked and signed by another appropriate member of staff. For this reason, the MAR Chart should not be used as the only source of information. It is essentially a record of what HAS been given, not what SHOULD be given. It is the paid health and social care worker's responsibility to check the dispensing labels in addition, to ascertain the correct dose.

Paid health and social care workers must not record assistance with medicines administered by others, including other agencies. However, the care manager / co-ordinator should encourage others to use the same medication administration record chart to enable a complete record of medicines taken to be made.

Any concerns that doses are being given by others and not recorded, must be reported to the Care Manager

The completed MAR Chart should be stored in the patient or service user information pack for a period of one month then transferred to the patient or service users file maintained by the care provider in their main office.

//////// 14. MEDICATION ERRORS AND /// MEDICATION RELATED INCIDENTS

There are several ways in which errors can be made when medicines are administered. It is important to recognise that occasionally a member of staff or carer (whether professionally qualified or not) will make an error. organisations should have systems in place which are designed to minimise the occurrence of errors.

There is rarely one single reason for an error being made – the circumstances should be examined thoroughly (using other health and social care professionals for advice/ information if necessary). Errors can often be traced back to systems failures. It is also important to collect information about mistakes and 'near misses' so that recurring problems are identified and acted on. Learning from errors and 'near-misses' is a key outcome.

The Social Care Institute for Excellence has published a report entitled 'Managing Risk and Minimising Mistakes in Services to Children and Families'. This report (link below), although relating to children's services and not specifically about medicines, is relevant to other social care situations in terms of building a culture within an organisation which promotes incident reporting and learning from errors.

http://www.scie.org.uk/publications/reports/report06.pdf

14.1 Responsibilities of carers

Some errors may appear trivial, but it is not easy or appropriate for carers to judge the potential impact on a patient or service user.

Therefore, all mistakes in assisting with medicines must be reported to the line manager or on-call manager immediately (e.g. wrong dose, wrong medicine, wrong person or dose missed accidentally) so that appropriate action can be taken to avoid further potential harm to the patient or service user. This action will routinely involve immediately seeking advice from the patient or service user's GP or pharmacist. (If the line manager is not available advice should be sought from the patient or service user's GP or appropriate health professional directly by the paid health and social care worker)

The error should also be recorded on the MAR chart in the patient or service user's home

An incident reporting form should be completed appropriate to the employing organisation.

All actions taken and advice received should be documented.

If carers suspect misuse or misappropriation of medication (by patient or service user, care staff or relatives) this should be reported immediately to their line manager and an incident form completed.

14.2 Responsibilities of Employers

Employers must be aware of their responsibility to report medication-related incidents to the appropriate bodies, and also to take appropriate action if there is a possibility of criminal actions. This will include being aware of adult protection procedures as well as responsibilities under the appropriate regulations to report incidents to the Care Quality Commission. Responsibilities are to:

- Ensure that all carers and their line managers are aware of:

  a. the procedure to be followed if an error is made

  b. the need to complete an incident form

  c. the importance of timely and accurate documentation of all actions taken and advice received

- Ensure that a report is made to the local office of the CQC within 24 hours under the health and Social Care Act 2008

- Ensure that incident forms are reviewed on a regular basis to identify recurring themes and to inform any policy review.

- Investigate thoroughly and fairly any errors or near misses reported, to ensure that systems failures are not masked by an over-emphasis on blame for an individual.

APPENDIX A

Glossary of Terms

Administration Record Chart (MAR Chart)
Records all assistance with medicines with dates and times and records refusals or omissions (with reasons)

Care Manager
Applies to the lead professional involved in the case. This can be a Social Worker, Community Psychiatric Nurse or Community Nurse, Occupational Therapist, Physiotherapist

Care Plan
The care plan is developed by the care manager and is a written statement of the assessed needs of the patient or service user.

Carer
The Carer will provide direct personal or social care to patient or service users.

Commissioner
The responsible professional for the commissioning of medication support as part of a care package

Container
For example: a bottle, manufacturer's original pack, a blister pack, a monitored dose device or any other container that the pharmacist deems suitable. A pharmacist must supply medicines within childproof containers unless requested not to do so by the patient /patient or service user.

Covert
Covert medication refers to medication that is hidden in food or beverages. The covert administration of medication is the practice of hiding medication in food or beverages so that it will be undetected by the person receiving the medication. Pills may be crushed or medication in liquid form may be used.

Domiciliary Care Co-ordinator
The DCC or Team Leader is responsible for the day to day running of the service and will liaise with the Care Manager, Home Care Manager, Pharmacists, GP, etc.

Drug
The terms 'drug', 'medicine' and 'medication' are used interchangeably.

Expert Witness
An Expert Witness is a colleague/supervisor/manager who is professional qualified and competent to provide a carer with a statement of competence of their meeting of National Occupational Standards for the administration and management of medicines.

Home Care Manager
This is the Line Manager for Domiciliary Care Co-ordinators, Team Leaders. Senior Care Assistants, Supervisors, Care Assistants, Support Workers and Health Care Assistants

Invasive procedure
Any clinical procedure which punctures the skin surface (e.g. injections) or which requires administration to or within intimate areas of the body (e.g. vaginal pessaries)

Medicines
Used for all patient or service users receiving level 2 or 3 support,

Medication Log
Records name, signature and initials of any person completing the MAR Chart, together with an incident log to record dates of ordering, receipt, disposal of medicines, any advice sought etc

Medication Profile
Records usual medication with dose, frequency, dates of discontinuation, arrangements for repeat prescriptions, and any agreed OTC medicines

Non medicine form
Usually apparatus or appliances available on NHS prescriptions, for example, support stockings, nebulisers or stoma bags.

NVQ/QCF Assessor
An NVQ Assessor is an associate level teacher who will be trained to assess competence of carers in line with National Occupational Standards for the administration and management of medicines. An Assessor will also be occupationally to undertake such assessments.

Observation Record
This is the recording document used by people providing the care to record actions taken, observations and concerns

Paid Carer
A person under the employment of Local Authority Social Services, a Private Independent Sector Company or employed by the patient or service user, who is engaged to provide care services to one or more patient or service users.

Senior Care Assistant
The SCA or supervisor is the first contact for Home Care Workers in the community but still provides direct care to patient or service users.

Unpaid Carer
A partner, spouse, family member, friend or neighbour of the patient or service user who provides care for that individual

APPENDIX B

MEDICATION RISK AND CONSENT ASSESSMENT FORM

Service User Name.. **Social Services Computer Number** ....

Address .... **Date of Birth** ....

POSSIBLE RISK		IF NO	OUTCOME/ACTIONS TAKEN
Is the patient or service user able to order and collect prescriptions if needed?	Yes/No	• Can family /informal carers collect? • Does community pharmacy delive • Consider level 1 support if no other option	
Can patient or 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 patient or 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 patient or service user or informal carers to return unwanted medicines to the pharmacy • Advise patient or 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 patient or service user. Disposal should only be arranged by SU themselves or informal carers.
Does patient or service user know and understand what medicines they should be taking?	Yes/No	• Advise patient or 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 level 3 support	
Is patient or service user aware of date, day, time?	Yes/No	• Is help available from informal carers? • Consider safety / storage issues • Consider level 3 support • Inform all relevant parties if storage out of patient or service user's reach is planned.	If level 3 support is being considered, liaise with GP or community nurse
Does the patient or service user always want to take their medication?	Yes/No	• Explore reasons – Encourage patient or service user to discuss with GP, or Community Nurse. (or assessor to liaise on patient or service user's behalf as appropriate) • Inform GP or Community Nurse if patient or service user considered as being at risk.	It is the patient's right to refuse treatment, but this should be based on an informed choice as far as possible.
Does the patient or service user usually remember to take his/her medication at the right time?	Yes/No	• Can informal carers help? • Can community pharmacist offer reminder chart? • Seek advice from pharmacist/GP, community nurse or community matron.	
Can patient or service user read the labels on medicines?	Yes/No	• Can an informal carer help? • Seek advice from community pharmacist – may be able to produce larger print labels or consider alternative packaging • Consider level 1 support if no other options	
Can patient or service user remove tabs/caps from the container him/herself?	Yes/No	• Can an informal carer help? • Can community pharmacist supply alternative packaging, or aids to open? • Consider level 2 or 3 support	
Is the patient or service user able to swallow their tablets / capsules?	Yes/No	• Can community pharmacist advise alternative options? • Seek advice from GP	Refer to GP / Community Nurse if swallowing problems give rise to concern.
Can patient or service user pick up a bottle and pour out a dose of liquid medicine accurately?		• Can an informal carer help? • Can community pharmacist supply a device to assist? • Consider level 2 or level 3 support if no other option	
If applicable, does patient or service user describe any problems using unhalers?		• Seek advice from community nurse or pharmacist • Consider level 2 support if physically unable to manage, even with device to assist	
If applicable, does patient or service user describe any problems instilling eye drops?		• Can an informal carer help? • Can community pharmacist advise on a device to assist patient or service user? • Request assistance as a 'Specialist task' if unable to manage even with assistive device	

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.

APPENDIX B CONT. //////////////////////////

OUTCOME OF ASSESSMENT	
Outcome	Details of the assessed level of support required
NO SUPPORT REQUIRED	
INFORMAL CARER CAN ASSIST	
SUPPORT TO BE PROVIDED BY FORMAL CARERS	
LEVEL 1 Patient or service user needs help ordering and collecting their medicines, reading the labels, reminders on safe storage, occasional verbal reminder to take tablets.	
LEVEL 2 As Level 1 and also: Patient or service user is responsible and able to manage their own medication but needs help to open containers etc due to physical disability or frailty	
LEVEL 3 Patient or service user unable to take responsibility for their medicines. Tasks from ordering or collecting prescriptions to some direct administration of medicines may be required. **Note: involve GP or community nurse before proceeding with Level 3 arrangements.**	

Name of Assessor (Print) ....

Signature of Assessor ....

Date ....

Statement of Patient/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 (Patient/Service User) ....

To be completed by a Patient/Service's representative where they are unable to do so

Representative's name ....

Relationship to Service User ....

Date ....

Specialist Tasks (Only to be undertaken by Carers who have had appropriate training and completed a competency assessment)

Assistance may also be required with the following specialist tasks (Please circle):

Application of eye drops / eye ointments/ ear drops
Simple dressings
Prevention of pressure sores
Changing and disposal of stoma appliance / incontinence appliances
Assistance with prescribed hosiery
Assistance with nebuliser
Suppositories
Enemas
Pessaries
Any other product for intra-vaginal or rectal use
Injections
Other – Please detail:

Refer to Community Nurse/Matron (Care Manager) if assistance with any of these specialist tasks is required.

APPENDIX C //////////////////////////////////

Standard Operating Procedure for level 3 support with medicines
(Administration without direction from service-user)

The Right patient should get the Right medicine at the Right time and by the Right method / route

1. Prior to any assistance being provided, the Carer must:

- check that the Care Plan identifies that assistance with medicines has been agreed, and note that level 3 assistance is requested
- check the patient or 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 medication profile
- check the use by date on the packet/ bottle/container
- check the MAR Chart and observation record to make sure that no other person has already assisted the patient or service user with their medication

2. The Carer should then wash and thoroughly dry their hands and any utensil that may be required, e.g. medicine spoon, measure and glass.
3. Put on protective gloves Hira suggests if medicines may be physically handles or when cream is to be applied.
4. Check for any special instructions on the dispensing label (e.g. not to be given with milk or antacids or to be taken after food, etc) and take appropriate action.
5. Medicines should be handled as little as possible. If removing a tablet or capsule from a bottle or foil (blister) strip, this is best achieved if tipped or pushed out over a small plate from which the patient or service user may then pick up and self–administer if able.
6. Ensure that the patient or service user is either in a standing position or is sitting upright. A Home Care Assistant should not attempt to assist with medication for someone who is in a prone position (lying down).
7. Medicines should be swallowed with plenty of water. Ideally, this should be a full glass of water.
8. Replace all lids and packaging and re store medicines safely
9. The Carer should again wash their hands and any utensils used.
10. Assistance with or patient or service users refusal must be recorded on to the Medication Administration Record chart immediately.
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 tas

APPENDIX D

MEDICATION ADMINISTRATION RECORD.. MONTH ....YEAR ....

Patient or service user Name .... Address .... Date of Birth ....

Instructions ....

.... Allergies ....

Medicine with strength		tick	T	1	T	2	T	3	T	4	T	5	T	6	T	7	T	8	T	9	T	10	T	11	T	12	T	13	T	14	T	15	T	16	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	1	T	2	T	3	T	4	T	5	T	6	T	7	T	8	T	9	T	10	T	11	T	12	T	13	T	14	T	15	T	16	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	1	T	2	T	3	T	4	T	5	T	6	T	7	T	8	T	9	T	10	T	11	T	12	T	13	T	14	T	15	T	16	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	1	T	2	T	3	T	4	T	5	T	6	T	7	T	8	T	9	T	10	T	11	T	12	T	13	T	14	T	15	T	16	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	

Please ensure that you record the time and your initials every time you assist with medication. If medication is commenced after the beginning of the month then a line should be drawn through the boxes to the date it starts. Similarly if it is discontinued draw a line through to the end of the month and record date discontinued. For identification purposes please write your name, signature and initial below. If relatives/ carers other agencies assist with medication please ask them to record on this sheet.

Codes X = Refused, A = Absent, S = Self, O = Other (record the reason on the visiting record)

APPENDIX D

MEDICATION ADMINISTRATION RECORD.. MONTH ....YEAR ....

Patient or service user Name ……………………….. .... Address …………………………......... Date of Birth ....

Instructions ....

……………………………………………………………………………………………. Allergies ....

Medicine with strength		tick	T	17	T	18	T	19	T	20	T	21	T	21	T	22	T	23	T	24	T	25	T	26	T	27	T	28	T	29	T	30	T	31	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	17	T	18	T	19	T	20	T	21	T	21	T	22	T	23	T	24	T	25	T	26	T	27	T	28	T	29	T	30	T	31	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	17	T	18	T	19	T	20	T	21	T	21	T	22	T	23	T	24	T	25	T	26	T	27	T	28	T	29	T	30	T	31	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	
Medicine with strength			T	17	T	18	T	19	T	20	T	21	T	21	T	22	T	23	T	24	T	25	T	26	T	27	T	28	T	29	T	30	T	31	Date
Dose	morn																																	discontinued
Notes	lunch																																	
Sig.	tea																																	
Sig.	bed																																	
Sig.	other																																	

Please ensure that you record the time and your initials every time you assist with medication. If medication is commenced after the beginning of the month then a line should be drawn through the boxes to the date it starts. Similarly if it is discontinued draw a line through to the end of the month and record date discontinued. For identification purposes please write your name, signature and initial below. If relatives/ carers other agencies assist with medication please ask them to record on this sheet.

Codes X = Refused, A = Absent, S = Self, O = Other (record the reason on the visiting record)

APPENDIX E

Medication Log

All carers who assist with medication should provide a sample signature and initials below:

Name	Signature	Initials	Name	Signature	Initials

Repeat Prescription Log

Include dates of ordering and receipt and any changes or problems.

Date	Incident	Signature

APPENDIX E CONT. ////////////////////////////

Medication Profile

Prescribed Medication	Dosage	Frequency	Additional Information	Patient or service user / Family signed consent	Date started	Date discontinued

Arrangements for repeat prescriptions

Community Pharmacist: ....

Tel No: ....

Form completed by:

Name: ....

Date: ....

Patient service user name

Address ....

Postcode ....

Date of birth ....

Computer number ....

GP Name ....

Contact number ....

APPENDIX F

Possible Problems and Solutions

Patient or service user unwell – should the patient or service user appear to be unwell on a visit, the Carer must contact the individual's GP and report this to the Care Manager. Guidance must be sought as to whether due medication should be offered to the patient or service user.

No directions on the label – refer to Care Manager who will refer to the pharmacist. Do not assist with the medication until this problem has been resolved.

"As required" medicines – assistance should not be offered if dose instructions are unclear. For example, "take as before" or "take as required for pain". Refer to supplying pharmacist to qualify this direction. (Note: pharmacists may need to contact GP in some cases) If the dose is "two tablets four hourly for pain when required" - with a maximum of 8 in 24 hours, the time at which assistance with a dose of this medicine is given must be recorded on to the MAR Chart, to ensure that future doses are not given until the necessary time period has elapsed.

No date of opening on eye drops – look at pharmacy label on the drops container to confirm if supplied more than 28 days ago. if less than 28 days, the drops are safe to use. If the date is more than 28 days ago an investigation is needed to establish the date of opening. If the date of opening cannot be established, it should be assumed to be the day of dispensing and discarded 28 days following that.

Refusal to take medication – It is an individual's choice not to take medication. They cannot be coerced or forced in any way, but some degree of encouragement can be given. Refusal must be recorded on the MAR Chart. Regular or persistent refusals within any one week period must be recorded on the Care Plan and reported to the Care Manager who will communicate the problem to the GP.

Medicines must not be disguised nor hidden in food in order to force a patient or service user to take them against their wishes.

Missed doses – If a dose of medicine was missed or omitted during the previous visit, a double dose MUST NOT be given. This should be recorded on the MAR Chart that a dose has been missed and report to the Care Manager. Consult the supplying pharmacist for advice if necessary.

Stoma appliances – a Carer may assist with the disposal of bags and all items used by the patient or service user during cleansing and changing. If a patient or service user is experiencing problems, these should be reported to the Care Manager who will communicate the problem to the GP or Stoma Nurse. A Carer should not attempt to change a bag or deal with any other problems relating to the management of the stoma, unless specific training has been undertaken and the carer has been signed off as competent to do so (see specialist tasks under Level 3 assistance)

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, the Carer should note whether any new medicine or change of dose to existing medicine have occurred during the last few days. Inform the Care Manager who will discuss with the GP, pharmacist or Nurse as appropriate.

Patient or service user consuming alcohol or using illicit drugs – it is an individual's own decision to drink alcohol or use an illicit substance. Carers would not be held liable for accidents that occur in the patient or service user's home as a result of alcohol or illicit drug usage. Should a patient or service user request alcoholic drink with medication, this must be refused and reported to the Care Manager who will inform the GP or pharmacist.

Should a patient or service user be found to be intoxicated and under the effect of alcohol or illicit substance on arrival at their home, a Carer must refuse to assist with medicines. This action must be reported to the Care Manager immediately or as soon as possible.

Infection or Contamination – the risk assessment should have identified possible sources of infection or contamination, e.g., clinical waste. Cases of infections such as head lice, scabies or fleas must be reported to the Care Manager, who will seek expert advice.

The Care Manager must report infections e.g. MRSA, TB, Hepatitis or other hospital acquired infection to the Carer, to ensure that appropriate infection control precautions are undertaken.

If a patient or service user self injects medication (e.g. Insulin), the Carer should not handle the used equipment. If this is necessary due to risk to the patient or service user or others, protective barrier gloves must be worn. Contact with or handling of the needle must be avoided. The equipment must be discarded into sealed 'Sharps Boxes' and not into the household waste. Sharps boxes can now be prescribed.

(NOTE: Care should be taken only to discard disposable insulin pens / syringes, some insulin pens are designed for re-use with disposable cartridges. If in doubt you should check with the patient or service user, community nurse or community pharmacist.)

APPENDIX G //

Recommended Appropriate Learning and Development

The most appropriate formal accredited knowledge and competency assessment that includes all aspects of the level 2 and 3 competences (NOS level 3 standards) for those who administer medication is the QCF accredited unit HSC3047 - Support the Use of Medication in a Social Care Setting, a stand alone unit or it can be an option unit in the Diploma in Health and Social Care at level 2 or at level 3 or the NVQ 375 Safe Administration of Medication from the L3 NVQ Health and Social Care.

Carers who are working with people with Dementia may wish to complement the above unit with the Knowledge based unit DEM 305 - Understand the Administration of Medication to Individuals with Dementia Using a Person Centred Approach.

Assessment

Assessment should follow the assessment principles laid down by Skills for Care, Skills for Health and the Awarding Organisation. The assessors, teachers/ trainers/tutors and the expert witnesses should meet the requirements laid down by Skills for Care and Development, Skills for Health and Awarding Organisations

When assessing this unit particular attention should be paid to the guidelines published by the Royal Pharmaceutical Society of Great Britain entitled ‘The Handling of Medicines in Social Care’ (October 2007) and the procedure they identify should form the basis of good practice.

For further information please consult www.lluk.org/feworkforcereforms/ LLUK offer a free information and advice service. You can visit www.lluk.org/ias/

The IfL also offers help and advice to individual members and organisations. You can visit www.ifl.ac.uk

Quality Assurance

Internal quality assurance procedures should follow the guidelines laid down by the Awarding Organisation. The internal verifiers/internal quality assurers should meet the requirements laid down by Skills for Care and Development, Skills for Health and Awarding Organisations

This strategy and the accompanying document are based on standards and guidance current at the time of its review (Summer 2010). It will be reviewed once again in the light of updated guidance / standards.

APPENDIX H

Reference to Standards and Guidance

Current National Minimum Standards for Domiciliary Care

http://www.dh.gov.uk/assetRoot/04/01/86/71/04018671.pdf

Domiciliary Care Agencies Regulations 2002

http://www.opsi.gov.uk/si/si2002/20023214.htm

Current National Minimum Standards for Care Homes

http://www.dh.gov.uk/assetRoot/04/13/54/03/04135403.pdf

Care Homes Regulations 2001

http://www.opsi.gov.uk/si/si2001/20013965.htm

National Service Framework for Older People March 2001

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf

Legal requirements under Medicines Act and Misuse of Drugs Act 1971

Professional Guidelines/ Standards

The Administration of Medicines in Domiciliary Care (CQC Jan 2009)

http://www.cqc.org.uk/guidanceforprofessionals/adultsocialcare/guidance.cfm?widCall1=customWidgets.content_view_1&cit_id=2646

The Administration of Medicines in Care Homes (CQC Nov 2008)

http://www.cqc.org.uk/guidanceforprofessionals/adultsocialcare/guidance.cfm?widCall1=customWidgets.content_view_1&cit_id=2568.csci.org.uk/docs/admin_meds_care_home.doc

Assistance with Medication – good practice guidelines (Ceretas Jan 2006)

Administration of Medication UK Home Care Association (UKHCA) Feb 2008

http://www.ukhca.co.uk/members/pdfs/MedicationPolicyGuidance.pdf

Managing Medication in Learning Disability Social Care Settings – A guide and training framework for social care organisations' Association for Real Change (2006)

http://www.arcuk.org.uk/silo/files/76.pdf

The Handling of Medicines in Social Care – Royal Pharmaceutical Society (2007)

http://www.rpsgb.org/pdfs/handlingmedsocialcare.pdf

NOTES

NOTES

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