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Medication Policy

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Author(s)	Registered manager
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Review Data

Initial Production

Name	Role/Department	RACI	Date
Registered manager	Registered Manager	RA	03.07.2017
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R = Responsible for document production; **A** = Accountable; **C** = Consulted; **I** = Informed

Change History

Version	Date	Details of Change	Author
2.0	03.07.2017	Re-write and re-structure of original policy in line with most recent legislative updates.	Registered manager

Emergency Contact Details

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CQC Fundamental Standards

Regulation Number	Regulation Details
Regulation 12: Safe Care and Treatment	The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

Key Lines of Enquiry

KLOE	How this applies to Medication Policy
Safe	This Medication policy is an aspect of 'Safe' because Living Carers Ltd recognises that the correct and effective administration of medication is essential for the safety and wellbeing of its Clients.

Related Documents

This policy should be read in conjunction with our:

1. **Safeguarding Policy**
2. **Consent Policy**
3. **Mental Capacity Policy**

Policy Aims

To set the standards, for safe practice in the management and administration of medications, for staff employed by Living Carers Ltd.

The aims of this policy are to ensure that:

- Client needs are safeguarded.
- Accountabilities for the management of medicines are clear.

Policy Statement

Most people receiving care in their own homes are prescribed some form of medication at some time as part of their treatment by their doctor or nurse. **Many Clients are able to administer their medication safely themselves and require no help.**

However, others will require assistance, **ranging from simple reminders and help with packaging through to actual administration of medication.**

In some cases, **this might include the administration of "controlled" drugs**, which requires care workers to know how they are being **safely stored and administered** in the home setting.

Living Carers Ltd recognises that **the correct and effective administration of medication is essential for the safety and wellbeing of its Clients**. Clients must therefore receive **the help identified in their plan of care** for the administration of medication only by trained and competent staff.

MAR Charting

"*MAR charts are the formal record of administration of medicine within the care setting and may be required to be used as evidence in clinical investigations and court cases. It is therefore important that they are clear, accurate and up to date.*" - Royal Pharmaceutical Society of Great Britain

A good MAR chart should include information to assist with the The six "R's" of medication administration.

- Right patient
- Right drug
- Right dose
- Right formulation
- Right route
- Right to refuse

What does the law say?

From April 2015, the Health, and Social Care Act 2008 (Regulated Activities) Regulations 2014 has replaced the Essential Standards with new Fundamental Standards.
Regulation 12, Safe Care and Treatment, includes a requirement for the "proper and safe" management of medicines and for sufficient medicines to be made available to meet Clients' needs and ensure their safety.
Guidance accompanying the regulations states that, where a Living Carers Ltd supports the management of medication:

- **the provider must provide medication management, in a safe way**
- **care and treatment assessments, planning and delivery (including those related to medication and when Clients start to use the service, are admitted, discharged/transferred, or move between services):**
  - **should be based on risk assessments that balance Clients' needs and safety with their rights and preferences**
  - **should include arrangements to respond appropriately and in a timely manner to Clients' changing needs**
  - **where appropriate, should be carried out in accordance with the Mental Capacity Act 2005**
  -
- **medication reviews should be part of Clients' care and treatment assessments, plans or pathways and are completed and reviewed regularly in relation to changes in medication**
- **the provider should comply with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare Products Regulatory Agency (MHRA) and via the Central Alerting System (CAS)**
- **arrangements should be in place to ensure Living Carers Ltd can take appropriate action in the event of a clinical/medical emergency**
- **the administration of medications should be timely to ensure that Clients are not placed at risk, particularly as a result of any non-compliance by the Client**
- **any arrangements for giving medicines covertly, where this is thought to be in the Clients' best interests, should be in accordance with the Mental Capacity Act 2005**
- **staff responsible for medicines management and administration should be suitably trained and competent. They should work only within the scope of their qualifications, competence, skills and experience (including when administering medication). This is particularly important when the Client has been prescribed "controlled drugs" the administration of which we have agreed to have a role, as determined by the care plan.**

Autonomy and Independence

Living Carers Ltd works on the principle that:

every Client has the right to manage and administer their own medication if they wish to.

We provide support and aid to enable safe self-administration wherever possible. Living Carers Ltd believes that encouraging self-medication promotes the independence and autonomy of Clients and will enhance their dignity and privacy.

However, some Clients may not wish to manage their own medication and others may be unable to even if they wish.

The choices made by Clients — e.g. to administer and manage their own medication — are always respected by staff and recorded in the plan of care.

No assumption is made that a Client cannot self-administer their medication purely based on their condition or mental capacity.

As such, the following procedure should be adhered to:

- **At the initial assessment, all medication taken and when, how, where, and how much of each one should be listed. It should be explicitly stated under what circumstances care staff are permitted to assist with medication.**
- **Clients who are suspected to be lacking capacity are assessed in line with the "best interest" principles of the Mental Capacity Act 2005. Where a Client can be enabled to self-medicate with additional support, or where they can self-administer parts of their medication, such support is provided.**

- **Staff provide appropriate support to any Client who wishes and is able to take all or some of their own medication, providing this is in the care plan**

- **Medication is only ever administered to a Client based on their explicit consent or agreement to take the medication except where "best interests" decisions have been taken as a result of a person's mental incapacity.**

- **All new Clients will have their health and social care needs fully assessed and any need for help with the collection or administration of medication identified.**

- **Any request for support from staff identified within a care plan is discussed with managers or nurse consultants before being implemented to ensure that the role being requested is appropriate and can be performed safely and competently.**

- **No staff member should proceed with the administration of medication (tablets, liquids or creams) unless they have the explicit agreement of a nurse consultant or manager and this has been entered in the plan of care.**

- **Any staff member who is unsure of what to do regarding medication in any given situation should contact their nurse consultant or manager immediately. In all cases where help with medication is required the explicit consent of the Client is required.**

- **When a staff member does assist with medication, this needs to be recorded in the daily notes immediately**

Medication Reconciliation (Listing of Medicines)

Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.

In order to ensure that Living Carers Ltd contributes fully and effectively to its Clients' safe taking of their medicines, Living Carers Ltd will carry out the following "medicines reconciliation" procedures in co-operation with the other professionals and services involved.
Living Carers Ltd will **always** ensure that it has the following information prior to any involvement, and keeps it up to date. This information will be particularly important where Clients have been prescribed "controlled drugs" and where the Client has been unable to give their consent to the taking of their medicines, resulting in "best interest" decisions being taken about the prescribing, supplying, storing and taking of their medication.

The following information is always required:

1. Person's details, including full name, date of birth, NHS number, address, and weight (where appropriate in relation to their medication needs).
2. GP's details, including previous and current GP, where a change of GP has taken place.
3. Details of other relevant contacts who might affect their medication, as defined by the Client and/or their family, members or carers (for example, their consultant, regular pharmacist, specialist nurse).
4. Checks of known allergies and reactions to medicines or ingredients, and the type of reaction experienced.

5.
A list of medicines the person is currently taking, including name, strength, form, dose, timing and frequency, and what it is taken for.

6.
Information about recent changes to their medication, including medicines started, stopped or dosage changed, and reason for change.

7.
Date and time the last dose of any “when required” medicine was taken, or of any medicine given less often than once a day (weekly or monthly medicines).

8.
Other information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine.

9.
Checks on what information has been given to the Client and/or family members or carers about their medication.

10.
Details of any professional responsible for coordinating the safe taking of the person’s medication (which might be the Client, carer and/or

Levels of Support with Medication

Living Carers Ltd recognises three main levels of support that can be provided for Clients who have identified needs in handling their medication.

Support recorded should be documented in the daily notes and the care manager should be updated of changes to the care plan.

Level 1

Providing general support

This includes:

1. **requesting repeat prescriptions from the GP**
2. **collecting medicines from the pharmacy**
3. **disposing of unwanted medicines safely, e.g. by returning them to the supplying pharmacy or GP practice**
4. **providing an occasional reminder or prompt to an adult to take their medicines**
5. **manipulating a container, e.g. opening a bottle or popping tablets out of a blister pack at the request of the person and when the care worker has not been required to select the medication.**

The policy is always to:

provide general support only with the consent of the Client concerned

identify the exact nature of the support in the needs assessment

include what has been agreed in the Client's plan of care

record all support provided on the care plan

make regular checks that the support provided is as agreed and meeting the person's needs

review the arrangement regularly as part of the reviewing of the whole plan of care.

Level 2

Assistance with administration of medication

Any need for medication to be administered by staff is identified at the care assessment stage and recorded in the Client's plan. The Client must agree to have the care worker administer the medication and the consent is also documented. If the person is unable to communicate informed consent, the prescriber must indicate formally that the treatment is in the best interest of the individual and comply with the requirements of the Mental Capacity Act.

Medication is only ever administered by a designated, appropriately trained member of staff.

The policy is always to:

check that the medication is written in the Client Plan

know the therapeutic use of the medication administered, its normal dose, side-effects, precautions and the contra-indications of its use; this is particularly important where the Client is taking a "controlled drug" for which strict protocols should be developed in line with individual circumstances

make certain of the identity of the Client to whom the medication is being given

check that the prescription or the label on the medication is clear and unambiguous and relates to the Client in person
check the expiry date

check that the Client is not allergic to the medication
keep clear and accurate signed records of all medication administered, withheld or refused.

ensure that where a Client is taking a "controlled drug" they follow the protocol agreed in the person's care plan (for example, to witness and record in a case of self-medication, or to ensure that the drugs are administered in the presence of at least one other person if involved in the actual administration).

A medication record sheet is kept in the home of any Client receiving help with medication as part of their care plan.

Any mistake or error in administering drugs must be reported to a parent (in the case of a child), line manager, supervisor or responsible medical practitioner without delay.
Staff must never in any circumstances administer medication that has not been prescribed, give medication to a Client against their wishes, give medication that has been prescribed to another person, or alter in any way the timing or dosage of medications.
If a care worker does not feel competent to administer the medication they should voice their concerns to their line manager. It is important that only staff who are appropriately trained and agree to perform the role administer medication.

Level 3

Administering medication by specialised techniques

In exceptional circumstances and following an assessment by a healthcare professional, a Living Carers Ltd worker may be asked to administer medication by a specialised technique including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection
- Administration through a Percutaneous Endoscopic Gastronomy (PEG)

If the task is to be delegated to the domiciliary care worker, the healthcare professional must train the care worker and be satisfied they are competent to carry out the task.

The company's procedures must include that care workers can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so.

This organisation will consider the request only in the following circumstances:

- Where an inappropriate admission to care would have to be considered.
- Where the ability to maintain the Client at home is undermined by a lack of appropriate funding which allows community nursing support.
- Where the Client is in the later stages of end of life management and has made clear their wishes to remain at home.

In the above circumstances this company will strive to maintain the Client with true regard to their wishes, whilst seeking to ensure that the Client will be cared for in an appropriate manner by the staff fully trained and competent to do so.

If the decision is taken that the task to be delegated to the care worker the HEALTHCARE PROFESSIONAL must train the worker(s) and be satisfied they are competent to carry out the task, this must be recorded on the Level 3 Training Record and signed off by the HEALTHCARE PROFESSIONAL involved in the training. Any additional support appropriate to the circumstances must be available by the Health Services involved.

Care workers who feel that they are not competent to assist with the administration of medication by specialised techniques can refuse to assist,

Any authorisation of Level 3 support must be authorised by the Manager and a level 3 training record must be completed by and in place after training by the appropriate health professional.

Health-Related Activities

In the interests of the Client, care workers may from time to time be asked to assist in health related activities which can include:

- Massage techniques
- Exercise regimes
- Mobility related assistance
- Monitoring and recording of particular conditions (diabetes, epilepsy etc.)

This area of activity must be clearly assessed and recorded during the care assessment. Specialist training must be undertaken and staff must be competent and confident in their own abilities to undertake the tasks required. The appropriate Health Professional must

"sign off" the training and the competency of the care worker and the information should be recorded on the level 3 staff training record. Health related activities will be undertaken only with the express agreement of the manager, the appropriate care assessment has been completed and it is recorded in the care plan. Reviews should take place and care plans updated as required.

All staff should be able to refuse to undertake tasks which they themselves feel they are not competent to do.

Supply and Storage of Medication

Following the care needs assessment and completion of the Medication Plan of Care with full pharmacy details, the care worker will obtain the supply of medication. Only medicines which have been obtained:

- On a prescription written by a registered prescriber will be obtained on behalf of the Client
- Any "over the counter" medicines which the Client has requested can be purchased and recorded in the MAR chart when administered e.g. Gaviscon if prior authorisation has been given from Living Carers Ltd or seek advice from a GP or nurse practitioner.

Medicines will usually be dispensed by the community pharmacist in an appropriate container or medication aid appropriately labelled with:

- The Clients name
- The name of the Medicine(s)
- The time to be administered
- The dosage
- Any special instructions (after food etc.)

Prescribed medicines which are not labelled as above should not be left in the Client's home but returned to the dispensing pharmacy and recorded on the appropriate form.

Where a Client is receiving medication from a medication aid e.g. dossette, nomad etc. there may be additional medication which is dispensed in individual bottles or boxes. For example short courses of antibiotics, liquid medication or where the medication is not stable enough to be dispensed in an aid. The same checks apply to the labelling of these medicines and the care worker must contact the office before administering such medication.

- All medicines prescribed or non-prescribed must be stored in conditions which maintain their potency and in accordance with the manufacturers advice. This should be clearly documented on the box/label.

- After use the care worker should return the remaining medication to the storage place.

Administration of Oral Medication

Following the assessment of need and completion of the Medication Plan of Care the care worker will assist with the administration of medicines. Wherever possible this should be administered by the care worker from a blister pack, nomad or dossette. In exceptional circumstances e.g. a short course of antibiotics, individual boxes or bottles may be used.

Care workers should only administer oral medication when they have been assessed as competent to carry out the task after appropriate training. If they are in any doubt regarding the medicine(s) or the physical or mental health of the Client, they should not assist but contact the office or on call immediately for further advice.

Before administering they should check:

- The Clients name
- Dosage Instructions
- The MAR Chart to ensure no other carer/professional has already administered

Identify the appropriate medicine container(s), checking the labels match the record including:

- The Clients name is on the container
- The medication
- The dosage
- The time to be administered

Prior to administration of a medicine the care worker should:

- Explain the procedure to the Client
- Wash their hands
- If they know they have a strong allergy or reaction to a particular medicine they should ensure gloves are worn prior to the handling of the medicine

If the instruction on the MAR does not coincide with the label on the container except. Please seek advice from Living Carers Ltd or a GP. Where the medicine to be given is Warfarin, when the instructions will be clearly written on the card or in the Clients Warfarin record book, no dose should be given until written instructions have been received from the dispensing pharmacist, medical practitioner or the community nurse or prescriber.

Care workers need to ensure every encouragement is given to Clients who initially refuse medication.

UNDER NO CIRCUMSTANCES SHOULD STAFF CO-ERCE OR COMPEL A CLIENT TO ACCEPT ANY KIND OF TREATMENT OR MEDICATION.

Key Question: What if the Client refuses to take their medication.

If a Client refuses the prescribed medication:

- Record on the MAR the Client has refused the medication
- Inform the office or on call at the earliest opportunity
- Document in daily record

Immediately after assisting the Client with administration of medication:

- Complete and sign the MAR
- Record any comments relating to the medication administered including any observations requested.
- Return the medication to where it is stored

Neither the medication (s) nor the MAR should be removed from the Client's home unless asked to do so by the office.

If the MAR is not available the medication must not be administered and the care worker should contact the office or on call immediately and record the reason for not giving the medication in the attendance record in the Client's home.

Medication Errors

Protection of Employees and Clients

From time to time errors can occur in the prescribing dispensing or administration of medicines the majority of these errors do not harm the individual, however on rare occasions they can have serious consequences. It is important that errors are recorded and the cause investigated so that we can learn from the incident and prevent a similar error happening again.

Carers must immediately report any error or incident in the handling or administration of medicines. This report should be made to the manager or person in charge as appropriate in order that senior managers are able to take decisions regarding Outcome 20, Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The error report form is to be completed and include near misses.

All policies, procedures and training must be implemented in a way that supports Staff in the work place. These are also intended to reduce the risk of medication error and the associated risks to residents or staff.

No member of staff should administer medication until suitably trained to do so.

Employees have the responsibility to:

- **Ensure that medication is presented and administered from clearly labelled appropriate container with pharmacist label.**
- **Complete the MAR sheet accurately**
- **Record any instance of noncompliance, where this becomes habitual this should be reported to a manager**
- **Concentrate on the important task at hand of administering medication to the exclusion of all duties and distractions**
- **Report any instance of a medication error immediately by seeking medical advice via the residents GP or NHS direct.**
- **Report the error to the office or out of hours immediately and include the advice given by the GP or NHS direct.**
- **Complete an accident/incident report form and return the form to the office.**

An error is a learning exercise and it is important that within a medication management system, errors are reported so that all can learn from the incident. It is imperative that when dealing with medicines you are focussed and concentrating on the task at hand. Near misses are recorded so that they can be used as empirical evidence within medication training sessions.

Drug Errors

Drug errors are regarded as potentially serious events and staff are reminded of the NMC standards of Administration of Medicine Guidelines.

All drug errors will be investigated and the following will be considered:

a) The experience of staff with regard to any previous incidences/errors

b) The events which participated the error, with the clinical effect upon the Client

If any of the following events take place they will be classified as errors:

a) Drugs are given that are not prescribed

b) Drugs are given at a time other than that prescribed

c) Drugs are given via a route other than prescribed

d) There is an error or omission in recording

f) There is an omission of a prescribed drug (other than a specifically recorded omission)

Procedure

a) The Carer informs the Manager who informs Doctor about the incident and records it on the appropriate form

b) The Doctor will decide on any medical attention

c) The Manager and Doctor will investigate the incident, and then an appropriate course of action will be decided

Management of Errors or Incidents in the Administration of Medicines (Taken from NMC Standards)

In a number of Annual reports the Council has recorded its concern that practitioners who have made mistakes under pressure of work, and have been honest and open about their mistakes to their senior staff. appear to have been made the subject of disciplinary action in a way which seems likely to discourage the reporting of incidents and therefore to be to the potential detriment of Clients and of standards. When considering allegations of misconduct arising out of errors in the administration of medicines the Council's Professional Conduct Committee takes great care to distinguish between those cases where the error was the result of reckless practice and was concealed, and those, which resulted from serious pressure of work and where there was immediate, honest disclosure in the Client's interest. The Council recognises the prerogative of managers to take local disciplinary action where it is considered appropriate, but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described.

The Council's position is that all errors and incidents require a thorough and careful investigation which takes full account of the circumstances and context of the event and the position of the practitioner involved. Events of this kind call equally for sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed.

Application of Creams, Lotions or Ointment

Following assessment and appropriate recording in the Medication Plan of Care, care workers will assist with the application of creams lotions and ointments. Care workers will apply prescribed creams, dusting powders, lotions or ointments when they:

- Have received appropriate training
- Have been assessed as competent to carry out the task by an appropriate professional

If a care worker is in any doubt regarding the products, physical or mental health of the Client they should not apply the product but contact the office or on call immediately.

Care workers can apply the products when they are not prescribed:

- As part of the Client's personal hygiene regime e.g. moisturisers face creams etc.
- To assist with the rehydration of skin, for example aqueous cream used to wash and E45 etc.

Care workers can apply the prescribed products except when:

- The area of skin to be treated is broken
- The product contains topical corticosteroids, and is not listed as a prescribed item
- There is or appears to be inflammation or infection present, unless the product is being used to treat inflammation or infection.

When the product to be applied is recorded on the medication record, the care worker must, from the medication record, check:

- The Client's name
- Application instructions
- That no other carer or professional has already administered the product

Identify the appropriate container(s), checking that the label(s) match the record including:

- The name on the product is that of the Client
- Storage instructions
- The product
- The instructions on use
- The time/s to be applied

Prior to administration of a medicine the care worker should:

- Explain the procedure to the Client
- Wash their hands
- Put on a pair of gloves

If the instructions on the administration record do not coincide with the label on the product container, it should not be applied until written instructions have been received from the community pharmacist, medical practitioner or the community nurse. Staff should ensure that they give every encouragement and opportunity to Clients' who might initially refuse application of the product. Under no circumstances should staff compel a Client to accept any kind of treatment.

If the Client refuses the prescribed product:

- Record on the administration record that the Client has refused the application of the product
- Inform the office or on call at the earliest opportunity.

Immediately after assisting the Client with the administration of product the care worker will:

- Remove and dispose of gloves
- Wash their hands thoroughly
- Complete and sign the MAR chart
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored

Neither the product nor the MAR should be removed from the Client's home unless instructed to do so by the office or on call.

If the medication records are unavailable the prescribed product must not be administered and the care worker should inform the office or on call immediately and record the reason for the product not being administered in the Client's attendance record.

Instillation of Eye Drops and Ointments

Following from the assessment of need and appropriate recording in the Medication Plan of Care, the care worker will assist with the instillation of eye drops and ointments. Wherever possible the eye drops should be administered by the care worker using a device or aid. Care workers will only administer eye drops or ointments:

- When they have received appropriate training and assessed as competent to carry out the task.
- At the appropriate time according to the prescribers instructions

Is a care worker is in any doubt regarding the eye drops or ointments or the physical or mental health of the Client, they should not assist with the instillation of the eye drops or ointment but contact the home care manager, community nurse or the office on call immediately.

From the MAR, check

- The Client's name
- Dosage instructions
- That no other carer/professional has already administered the eye drops or ointment

Identify the appropriate container(s), checking that the label(s) match the recording including:

- How the drops or ointment should be stored
- The name on the drops or ointment is that of the Client
- The label states clearly which eye the product is to be used for
- The dosage
- The time to be administered

Prior to administration of any eye drops or ointments the care worker should:

- Explain the procedure to the Client
- Wash their hands
- If they know they have a strong allergy to any of the medicines they should put on gloves prior to handling the medicine.

If the instructions on the MAR do not coincide with the label on the drops/ointment container, none should be instilled until written instructions have been received from the prescriber.

When the care worker has collected the equipment and laid it on a suitable surface near the Client where there is a good light source, they should explain the procedure to the Client.

The care worker should then check the following

- Which eye the drops/ointment are prescribed for
- The date the bottle was first opened
- Expiry date on the label

Once the care worker has washed their hands they should:

- Assist the Client into a comfortable position with the head well supported and titled back
- Remove the lid/s from the drops or ointment
- Hold the Clients lower eyelid down by pressing gently with a clean folded paper tissue
- Ask the Client to look up immediately prior to the instillation of the drops/ointment

Eye Drops

- Eye drops should be stored in the fridge in order for them to remain below a certain temperature
- The dropper should be held approximately 2.5cms from the Client's eye if they are being instilled without the use of an aid
- Gently squeeze the bottle
- Ask the Client to close their eye, keeping the tissue in place for one to two minutes. Wipe away any excess from the Client's face.

When two different preparations in the form of eye drops, are required at the same time of day. Dilution and overflow may occur when one immediately follows the other e.g. pilocarpine and timolol in glaucoma. Therefore an interval of 5 minutes should be left between the instillation of each preparation.

Immediately after completing the instillation of the eye drops the care worker should:

- Wash their hands thoroughly

- Complete and sign the MAR
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored

Eye Ointment

- Before applying the ointment, pull down the lower eye lid
- Squeeze approximately 2.5cms of the ointment inside the lower lid from the nasal corner outwards
- Ask the Client to close their eye, remove the excess ointment with the tissue
- Advise the Client that blurring of vision will occur for a few minutes

Immediately after completing the instillation of the eye ointment, the Care worker should:

- Wash their hands thoroughly
- Complete and sign the administration record
- Record any comments relating to the product applied including any observations
- Return the product to where it is stored – make sure to check storage instructions.

Instillation of Ear Drops

Following from the assessment of need and appropriate recording in the Medication plan of care, the care worker will assist with the instillation of eardrops. Care workers will only administer ear drops when they:

- Are appropriately trained and assessed as competent to complete the task

From the MAR, check:

- The Client's name
- Dosage instructions
- That no other carer or professional has already administered the eardrops.

Identify the appropriate container(s), checking that the label(s) match the recording including:

- The name on the drops is that of the Client

- The label states clearly which ear the product is to be used for
- The dosage
- The time to be administered

If a care worker is in any doubt regarding the ear drops, the physical or mental health of the Client they should not assist with the instillation of the ear drops but contact the office or on call immediately.

Once the care worker has explained the procedure to the Client and washed their hands, they should:

- Assist the Client into a lying or seated position and explain the procedure
- Assist the Client to a comfortable position with the head well supported and tilted to one side if possible
- Remove the lid/s from the dear drops
- Gently pull the top of the ear (pinna) outwards and upwards in order to straighten the outer ear canal
- Gently squeeze the bottle instilling the prescribed number of drops into the ear
- Ensuring they are comfortable, leave the Client with head to one side for a few minutes

Immediately after completing the instillation of the eardrops the care worker should:

- Wash their hands thoroughly
- Complete and sign the MAR
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored – check the storage information.
- Assist the Client to sit up and adopt their choice of position and location

Application of Compression Hosiery

Following the assessment of need and appropriate recording in the Medication plan of care, care workers will assist in the application of compression hosiery. When they have received appropriate training and been assessed as competent by the appropriate professional. Care workers must not assist with the application of compression hosiery without the proper instruction from the office.

To ensure maximum effect compression hosiery should be applied before the Client gets out of bed and removed last thing at night. Compression hosiery is prescribed to individuals to:

- Prevent deep vein thrombosis, a complication of mobility
- To prevent occurrence or re occurrence of leg ulcers
- To manage oedema (swelling) as a result of disease or injury e.g. for Clients with heart failure whose legs swell or following treatment for burns

Before removal or application of the hosiery the care worker should explain the procedure.

The care worker should check the medication plan of Care for specific instructions about the times of removal/application and any special instruction related to the type of hosiery used.

Hosiery Removal

- The care worker should remove all jewellery they are wearing on their hands to avoid ladders and unintentional injury
- Gently but firmly grip the top edge of the hosiery and pull it away from the body towards the end of the limb
- If at any time the Client complains of pain, the care worker should stop and check no skin damage is occurring before they resume the procedure. If skin damage occurs contact the Client's surgery immediately for advice.

When the hosiery has been removed the care worker should gently wash and dry the Client's skin using warm water and soap. Skin covered by hosiery can become very dry. If this is the case and a cream has been prescribed then this should be applied. If the skin is very dry but no cream has been prescribed the Clients surgery should be contacted to seek advice.

If the hosiery is to be reapplied immediately following skin cleansing it is advisable to apply a light dusting of powder to the skin to aid application. If an application aid has been provided this should be used according to the manufacturer's instruction.

Application of Hosiery

- The care worker should ensure the hosiery is clean and wrinkle free with no tears or frays
- The care worker should explain the procedure to the Client
- Run your hand inside the stocking down to the heel and pinch the heel with finger and thumb.
- Turn the stocking inside out leaving the foot part tucked in
- Pull the foot part gently over the Client's toes and ease over the foot taking care to check the toes and heel are correctly positioned and wrinkle free
- Gather up remaining stocking and take it over the foot and lower leg. Working in sections from the ankle pull the stocking up the leg in short folds of about 2 inches at a time without forcing and keeping it wrinkle free.
- When the stocking is fully extended on the leg, take the top back down to the calf hold the top stocking up the leg again to ensure it remains in place
- If applying thigh length hosiery secure with a suspender belt.

If the Client experiences pain at any time the care worker should cease the application and check if any skin damage has occurred. If this is the case contact the Client's surgery for further advice and remove the hosiery.

Hosiery should be washed at 40 degrees and hung to dry (UNDER NO CIRCUMSTANCES SHOULD THEY BE IRONED)

Clients should always wear hosiery on both legs

Hosiery should be replaced every three months or earlier if they become damaged or worn.

Monitoring of Medication

Staff should always be aware of the nature of the medication being taken by individual Clients and should report any change in condition that might be due to medication or side-effects immediately to a child's parent, their line manager or supervisor, or to the GP or community pharmacist.

Living Carers Ltd will work closely with community pharmacy services and with Clients' GPs to ensure that they are provided with adequate support and a seamless and integrated service relating to their medication needs.

Key Question: How should unwanted medication be disposed of?

Where Living Carers Ltd is responsible, unwanted or surplus medication is recorded and then returned to the community pharmacist for disposal and a receipt obtained. Controlled drugs are disposed of in line with local procedures, which might involve contacting a licensed waste disposal service. Living Carers Ltd will seek pharmaceutical advice in order to follow the correct procedures.

Covert Administration of Medication

Disguising medication in the absence of informed consent may be regarded as deception and should never be seen as a routine procedure.

A clear distinction should always be made between those Clients who have the capacity to refuse medication and whose refusal should be respected, and those who lack capacity. Among those who lack the capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication, (such as unconscious Clients) and others who would be aware if they were not deceived into thinking otherwise.

In these circumstances, the Registered Manager must convene a meeting of all the involved professionals, carers and family to assess the care needs of the individual and how best these can be met. No-one can give consent to treatment on behalf of another adult but generally doctors, nurses and therapists are allowed to provide treatment which they believe to be in the best interest of the Client, taking into account not just their physical health but their general well-being and beliefs.

Covert administration of medication should only be undertaken with written instructions from a health care professional

The decision to administer medication covertly must be recorded on the care plan and the details of any covert administration recorded on the Client's medication chart. This must be reviewed on at least a monthly basis.

The stability of medication may be altered by administering it in a covert way, e.g. in food, and so the Service should check this with the pharmacist.

Storage of Oxygen

If a Client is prescribed oxygen the individual should have an assessment completed, should discuss storage and administration with the pharmacist who supplies the oxygen. Oxygen cylinders should be stored safely under cover and not subject to extreme temperatures. This should be in a dry, clean well-ventilated area away from highly flammable liquids, combustibles and sources of heat and ignition. A statutory warning notice should be displayed in any room/area where oxygen is stored, stating;

"Compressed gas. Oxygen: No Smoking. No naked lights."

An oxygen concentrator may be supplied if the Client requires continuous oxygen, which the GP can arrange.
In the case of fire, following evacuation of the residents, it is the responsibility of the Registered Manager or delegated officer, to inform the fire brigade officer that oxygen cylinders are present and where they are located.

Training

All new staff receive training as part of their induction covering basic information about common medicines and how to recognise and deal with medication problems.

Additional training is provided by competent trainers to those fulfilling additional roles relating to the administration of medication. Living Carers will inform you of when your training updates are due.

Staff never undertake any duties or roles that they have not been trained to do or for which they do not feel competent.

Training records are kept of all training accessed. These will be periodically reviewed and staff are expected to attend any refresher training required.

Key Points to Take Away

- Every Client has the right to manage and administer their own medication if they wish to.
- Medication is only ever administered by a designated, appropriately trained member of staff.
- General support should only be provided with the consent of the Client concerned.
- Covert administration of medication should only be undertaken with written instructions from a health care professional.

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Policy Review

This policy will be reviewed by the Registered Manager at least annually to make any updates and amendments necessary to ensure the policy conforms to current legislation, reflects current practice and expectations.

Authorisation and Signature

This policy is the official and authorised version agreed by the Directors of Living Carers Ltd. All employees are expected to work in accordance with this policy and failure to comply with this policy could result in disciplinary action.

Registered Manager

04.12.2017