

|  |  |
| --- | --- |
| **Review Sheet** | |
| Last Reviewed Last Amended Next Planned Review in 12 months, or  17 Dec '19 17 Dec '19 sooner as required. | |
| Business impact | Changes are important, but urgent implementation is not required, incorporate into your existing workflow.  **MEDIUM IMPACT** |
| Reason for this review | Scheduled review |
| Were changes made? | Yes |
| Summary: | Content reviewed to ensure that it is in line with best practice guidelines. References have also been reviewed and updated, with further current ones added. |
| Relevant legislation: | * The Care Act 2014 * Care Quality Commission (Registration) Regulations 2009 * The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 * Human Rights Act 1998 * Medical Act 1983 * Medicines Act 1968 * Mental Capacity Act 2005 * Mental Capacity Act Code of Practice * Misuse of Drugs Act 1971 * Data Protection Act 2018 |
| Underpinning knowledge - What have we used to ensure that the policy is current: | * Author: Royal Pharmaceutical Society, (2018), *Professional guidance on the safe and secure handling of medicines*. [Online] Available from: [https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure- handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of- medicines](https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines) [Accessed: 17/12/2019] * Author: Royal Pharmaceutical Society, (2018), *Professional Guidance on the Administration of Medicines in Healthcare Settings*. [Online] Available from: [https://www.rpharms.com/Portals/0/RPS%20document%20library/Open% 20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of% 20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567) [Accessed: 17/12/2019] * Author: NICE, (2017), *Managing medicines for adults receiving social care in the community*. [Online] Available from: <https://www.nice.org.uk/guidance/ng67>[Accessed: 17/12/2019] * Author: NICE, (2015), *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [NG5]*. [Online] Available from: [https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#self-management- plans](https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#self-management-plans) [Accessed: 17/12/2019] * Author: NICE, (2015), *Medicines management in care homes Quality standard [QS85]*. [Online] Available from: <https://www.nice.org.uk/guidance/qs85>[Accessed: 17/12/2019] * Author: CQC, (2018), *Safe management of medicines*. [Online] Available from: [https://www.cqc.org.uk/guidance-providers/learning-safety-incidents/issue-5-safe- management-medicines](https://www.cqc.org.uk/guidance-providers/learning-safety-incidents/issue-5-safe-management-medicines) [Accessed: 17/12/2019] |
| Suggested action: | * Share ‘Key Facts’ with all staff * Ensure relevant staff are aware of the content of the whole policy |



**1. Purpose**

* 1. To ensure compliance with the Administration of Medicines Policy and Procedure at Holbeach Hospital & Nursing Home. This policy must be read alongside all associated medication policies and any local policies and procedures.
  2. To ensure that all staff involved in any aspect of medication administration understand the importance of accurate recording to prevent medication errors arising.
  3. To support Holbeach Hospital & Nursing Home in meeting the following Key Lines of Enquiry:

# Key Question Key Lines of Enquiry

|  |  |
| --- | --- |
| EFFECTIVE | E1: Are people’s needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence- based guidance to achieve effective outcomes? |
| SAFE | S4: How does the provider ensure the proper and safe use of medicines? |
| WELL-LED | W2: Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed? |
| WELL-LED | W3: How are the people who use the service, the public and staff engaged and involved? |
| WELL-LED | W4: How does the service continuously learn, improve, innovate and ensure sustainability? |

* 1. To meet the legal requirements of the regulated activities that Holbeach Hospital & Nursing Home is registered to provide:
     + The Care Act 2014
     + Care Quality Commission (Registration) Regulations 2009
     + The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
     + Human Rights Act 1998
     + Medical Act 1983
     + Medicines Act 1968
     + Mental Capacity Act 2005
     + Mental Capacity Act Code of Practice
     + Misuse of Drugs Act 1971
     + Data Protection Act 2018



**2. Scope**

* 1. The following roles may be affected by this policy:
     + Registered Manager
     + Other management
     + Nurse
     + Care staff
  2. The following Service Users may be affected by this policy:
     + Service Users
  3. The following stakeholders may be affected by this policy:
     + Family
     + Commissioners
     + External health professionals
     + NHS



**3. Objectives**

**3.1** To ensure that all Service Users at Holbeach Hospital & Nursing Home, including those who self- manage their medication, receive their medicines as intended (including controlled drugs and ‘as required’ medicines) and that this is recorded appropriately.



**4. Policy**

* 1. The Medication/Medicine Administration Record (MAR) is the formal record of the administration of medicines. It is required for all Service Users receiving support with medicines administration.
  2. Holbeach Hospital & Nursing Home recognises that it is important that MARs are clear, accurate and up-to-date to reduce any risk of error. They may be required as evidence in clinical investigations and court cases.
  3. Where Service Users are self-managing their own medication, it must be recorded in the Care Plan and a risk assessment must be undertaken. Medication balances for those Service Users self-managing their medication must be checked on a monthly basis, to ensure that the Service User is taking their medicines and that they have a sufficient supply.
  4. MARs are required for Service Users who are fully self-managing their own medication.
  5. Holbeach Hospital & Nursing Home understands that a MAR is not a prescription.
  6. All medication administered, intentionally withheld, or refused by the Service User must be recorded and signatures or initials must be legible. If medication is intentionally withheld or refused, the reason must be documented using the allocated codes.
  7. The signature of the person administering the medication must be linked to a specific medicine. This is to facilitate audits at a later date and to ensure that the records are clear.
  8. MARs must:
* Be legible, with clear details, written in indelible and permanent ink
* Include items which are still being currently prescribed and administered
* Include all externally applied medicines to be administered by staff
  1. There is no legal barrier to using a hand-written MAR but there is the potential for error when charts are regularly re-written by staff. Transcribed MAR charts need to signed by two nurses before medication is given as directed by the chart.
  2. The record of medicines taken will always be made available to the GP when they visit the Service User.
  3. It is a legal requirement for records of Holbeach Hospital & Nursing Home to be retained within Holbeach Hospital & Nursing Home, even when the Service User has left. Records relating to medication must be retained in the same way as Care Plan records and as detailed in the Archiving, Disposal and Storage Policy and Procedure at Holbeach Hospital & Nursing Home, which must be adhered to.
  4. A MAR is a confidential medical record and should therefore not be kept where everyone can see it.
  5. The MAR must provide an accurate account of the medicines being administered to the Service User by the staff. It must document all prescribed medicines, including externally applied medicines.
  6. Where topical administration is required, a body map must be used.



**5. Procedure**

* 1. The Medication Administration Record (MAR) for an individual Service User will include the name of the Service User, their date of birth, any known allergies to medicines or their ingredients and (if none, then this fact must also be recorded), the name of the drug, the dose, time to be given, and any special requirements, e.g. with food only. Weight available in care plan if required.
  2. The Medication Administration Record (MAR) must record:
* Which medications are prescribed for the person
* The quantity of new stock placed in the medicines trolley.
* The time they must be given
* The dose of the medication
* Any special administration requirements
* The signature can be matched to the name and designation of the person making the record using the signatory list found in every care plan.
* Copies of emails, texts and transcriptions of phone messages must be kept with medication chart for two weeks and stored with the Care Plan following that period.
* If more than one chart is in use, reference to the other charts, e.g. ‘chart 1 of 2'
* "When required" (PRN) medication as a cross reference to the PRN medication care plan.

An up-to-date photograph of the Service User will be attached to the MAR and medication folder to aid identification.

# MAR Recording Procedure

* Record what you do, when you do it. As medicines are

administered, verbal reminders or physical assistance is provided it must be recorded immediately and signed for by the person providing the medication support

* Record any medications not taken, with the reason using allocated code.
* Correct mistakes with a single line through the text, accompanied by a signature and date and time. Never use correction fluid
* Record medicines given by other professionals, such as a visiting health professional
* Records will be clear, complete, legible, written in black ink, dated and signed to say who has made the record
* Prescribed doses for Service Users on the MAR must be unambiguous to ensure correct dosage administration
* Medication with variable doses must be clearly recorded on the MAR with the actual dose given
* Any medication that has been discontinued on the MAR must clearly state the 'date', and 'name' of the nurse and the name of the initiator of the change ( E.G. GP), who had the interaction with the prescriber
* Medication changes, e.g. changes to dose or timings, must be recorded as a new entry in the MAR, with the previous entry discontinued on the MAR
* Hand-written medication administration records will only be produced in exceptional circumstances and created by a nurse with the appropriate medicines administration training. The hand-written record will be checked and verified by a second nurse with the same training before first use
* Codes for use in the event that the medication is not given can be found at the front of each medication folder.
  1. If the prescriber’s instruction is “take one or two” or “take 5ml or 10ml” please note clearly the amount that is given and sign
  2. Verbal Orders
     + Holbeach Hospital & Nursing Home must have a written prescription, signed by the prescriber, before the medicines can be given
     + In exceptional circumstances, a prescriber may give a verbal order to give medicines. However, they must authorise the change (by email or fax) before any new dose is administered
     + This must be followed up by the issuing of a prescription, as soon as possible, usually within 24 hours of the verbal instruction

# Discontinued Items

* + - Draw a vertical line through any recording boxes left on the day the medicine is discontinued and then clearly transcribe the reason why it has been discontinued, e.g. “course complete”, “discontinued by Dr Jones, Geriatrician”, “see entry in professional visits/care plan dated dd/mm/yy”
    - If the prescriber gives a verbal instruction to stop the item, then ask them to back this up in writing or follow the local procedure at Holbeach Hospital & Nursing Home for verbal instructions
    - Ensure that these entries are dated and identify the staff member who made the change.

# Change of Dose

* Discontinue the original instruction and write a new one
* Do not amend the dose on the original entry and continue using the same record
* Ask the prescriber to confirm this in writing or follow the procedure of Holbeach Hospital & Nursing Home for verbal instructions
* When there has been a change of dose (particularly if the dose is increased), it is likely that the prescriber will need to write a new prescription so that additional stock can be supplied
* If the prescriber gives a verbal instruction to change the dose, then ask them to back this up in writing

# Change of Times or Frequency of Administration

* Discontinue the original instruction and write a new one
* If the original prescription says “One dose three times a day” and the Service User now wants to go to bed earlier than they used to, the dose can be brought forward to fit in with their new routine, but ensuring that there is adequate elapsed time between doses.
* There must not be multiple entries at 22:00 recorded as “not taken” because the person was asleep. The time of administration must be brought forward
* If the frequency is being changed, then ask the prescriber to confirm this in writing or follow the procedure for verbal instructions at Holbeach Hospital & Nursing Home

# Change to “When Required” or for Regular Administration

* Discontinue the original instruction and write a new one
* Do not score out or change a time on the original entry and continue using the same record
* Ask the prescriber to confirm this in writing or follow the procedure of Holbeach Hospital & Nursing Home for verbal instructions

# Instructions on Dispensing Labels

* + - The MAR is the document which will be kept for a period of time as the record of what medication has been given
    - These records may be needed as evidence in any scrutiny inspection, complaint investigation or legal proceedings

# Reviewing MARs

* + - 10% of the MARs are audited by Deputy Manager each month are reviewed and any themes and trends are discussed at Holbeach Hospital & Nursing Home quality meetings. Corrective action is taken intermediately.
    - The Care Plan must be checked for the duration of treatments to ensure that medicines are not continued inappropriately

# Service Users who Self-Manage their Medication

When discussing medicines with Service Users who have chronic or long-term conditions, Holbeach Hospital & Nursing Home will use an individualised, documented self-management plan to support Service Users who want to be involved in managing their medicines. The following must be discussed:

* + - The Service User's knowledge and skills needed to use the plan, using a risk assessment if needed
    - The benefits and risks of using the plan
    - The Service User's values and preferences
    - How to use the plan
    - Any support, signposting or monitoring the Service User needs Record the discussion in the Service User's Care Plan as appropriate.

When developing an individualised, documented self-management plan, provide it in an accessible format

for the Service User and include

* + - The plan's start and review dates
    - The condition(s) being managed
    - A description of medicines being taken under the plan (including the timing)
    - A list of the medicines that may be self-administered under the plan and their permitted frequency of use, including any strength or dose restrictions and how long a medicine may be taken for
    - Known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced (see the NICE guideline on [drug allergy](https://www.nice.org.uk/guidance/cg183))
    - Arrangements for the person to report suspected or known adverse reactions to medicines
    - Circumstances in which the person should refer to, or seek advice from, a health professional
    - The individual responsibilities of the health professional and the Service User
    - Any other instructions the Service User needs to safely and effectively self-manage their medicines Review the self-management plan to ensure that the person does not have problems using it.



**6. Definitions**

# MAR

* + - Medication Administration Record

# PRN Medication

* + - "PRN” is a Latin term that stands for “pro re nata,” which means “as the thing is needed”

# Self-Administer

* + - Staff must assume that a Service User can take and look after their medicines themselves (self- administer) unless a risk assessment has indicated otherwise



**Key Facts - Professionals**

Professionals providing this service should be aware of the following:

* + - Holbeach Hospital & Nursing Home must make sure that Service Users receive their medicines as intended (including controlled drugs and ‘as required’ medicines), and that this is recorded appropriately
    - Nurses responsible for medication administration must ensure that the Service User has been assessed to ensure that the level of support needed by the Service User is agreed and recorded.
    - Service Users with communication difficulties must be given information about their medication in a way that they can understand
    - Holbeach Hospital & Nursing Home must carry out medication risk assessments to ensure that Service Users who wish to self-manage their medication can do so safely and can remain as independent as possible
    - Staff at Holbeach Hospital & Nursing Home will receive training on medication management and competency will be assessed in line with the training matrix at Holbeach Hospital & Nursing Home
    - The medication management training will include how to record medication administration at Holbeach Hospital & Nursing Home and the use of MARs at Holbeach Hospital & Nursing Home
    - A MAR is required when a Service User requires physical assistance or verbal reminders with medication



**Key Facts - People affected by the service**

People affected by this service should be aware of the following:

* + - You can tell staff at Holbeach Hospital & Nursing Home if you think if your medication is not correct
    - You will not require a MAR if you are self-managing your own medication without assistance
    - You have a right to expect that the staff administering your medication have the skills and competencies to support your needs



**Further Reading**

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

# CQC - Medicines - Information for adult social care services (These pages have replaced the adult social care medicines FAQs):

[https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-](https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-services) [services](https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-services)



**Outstanding Practice**

To be ‘ outstanding ’ in this policy area you could provide evidence that:

* + - The wide understanding of the policy is enabled by proactive use of the QCS App
    - Service Users receive their medicines on time and in a safe way
    - There are effective systems to assure quality and identify any potential improvements to the service. This means that Service Users benefit from a constantly improving service that they are at the heart of
    - Audits of MARs are undertaken monthly and corrective action is taken when required



**Forms**

The following forms are included as part of this policy:

|  |  |  |
| --- | --- | --- |
| **Title of form** | **When would the form be used?** | **Created by** |
| Body Map - CN12 | When topical medication is required or to indicate injection or transdermal patch locations. | QCS |
| Self-Administration of Medication Assessment - CN12 | When a Service User wishes to self-administer their own medication. | QCS |

|  |
| --- |
| Service User Name: |
| Use the below body map to indicate where topical medication, injections, or transdermal patches are located. |
|  |
| Notes: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Self-Administration of Medication (SAM) Questionnaire** | | **Response (Please circle)** | |
| 1. | Does the Service User have responsibility for administering their own medicines currently? | Yes | No |
| 2. | Does the Service User want to self-administer, and has a written agreement been obtained? | Yes | No |
| 3. | Does the Service User have any (temporary or permanent) impairment of their physical, emotional or cognitive state that may affect their ability to self-administer? | Yes | No |
| 4. | Is insulin included in the list of medicines that the Service User will self-administer? | Yes | No |
| 5. | Does the Service User have a history of drug abuse or alcoholism? | Yes | No |
| 6. | Is the Service User confused (particularly if any deficiency in short term memory) or is their judgement impaired? | Yes | No |
| 7. | Is their medicine regimen stable? (Frequent medicine or dose changes will make SAM difficult) | Yes | No |
| 8. | Does the Service User understand the following about their prescribed medication?   * The purpose of the medicine * The dosage and special instructions * The common possible side effects * What to do if a dose is missed | Yes | No |
| 9. | Does the Service User have any difficulty in reading the label on their medication packet? | Yes | No |
| 10. | Has the Service User been given an information leaflet about the self-administration of medicines? | Yes | No |
| 11. | Does the Service User understand the principles of safe storage of medicines, including their responsibility for the safekeeping of the medication and storage keys? | Yes | No |

|  |  |
| --- | --- |
| Name of Assessor: |  |
| Role of Assessor: |  |
| Date of Assessment: |  |