care inspectorate

# Review of medicine management procedures

## Guidance for care at home services


HAPPY TO TRANSLATE

# Template for Review of Medication Management Procedures in Care at Home Services

## 1. PURPOSE

There is a requirement for all care services that manage medicines to have policies and procedures in place which cover this.

We have produced this guidance for Care Inspectorate staff to help them review care at home medication policies/procedures.

**This template is NOT a draft medication procedure for Care at Home services.** However, it may be of help to care providers developing and reviewing medication policies/procedures.

This template is intended to provide general advice only on the legal requirements and best practice guidelines and does not preclude more stringent local controls being in place.

## 2. SCOPE

This document relates to registered care at home services only. It does not apply to care purchased from an unregistered source by individuals using direct payments.

Some specialist services are registered as a care at home services but operate more like a residential care home service in certain aspects. There may be some areas where this guidance is applicable but in general specific advice should be sought for these services.

This template covers key aspects of the management of medicines within the care at home service.

The left hand column describes the area of the Standard Operating Procedure (SOP) being addressed, with some general guidance if needed. The right hand column contains an indication or example of the basic type of information which should be covered in this section of any medication procedure.

Policies should be populated with the relevant local information, describing the activity and its procedures applicable for the care worker. In some cases this may be as the example but in other cases this may require more detailed information.

This document covers the following:

- General Responsibilities of Provider, Manager, Care workers, for example
- Framework of Support – Assessment of Capabilities, Levels of Support Offered, Definitions of Prompting, for example
- Recording Systems – Prompting/Assisting, Obtaining, Administration, Disposal, Electronic, Care Plans
- Storage – Medicines, Controlled Drugs
- Administration of Medicines – Tasks Care Staff Can and Cannot do, Involvement of Informal Carers, Multi-compartmental Compliance Aids, When Required Medicines, Controlled Drugs, Warfarin, Procedure for Giving Oral Medicines, Procedure for External Medicines, PEG/Swallowing Difficulties, Secondary Dispensing, Refusal of Medicines, OTC Medicines
- Disposal - Responsibilities and Paperwork
- Miscellaneous – Handling of Errors, Controlled Drugs Notifications, Staff Training, Adults with Incapacity and Consent, Covert Medication, Transfer to Another Care Setting
- Legislation, Health and Social Care Standards and Best Practice

- Appendix.

The term “care workers” in this document relates to care staff employed by the care service. The term “informal carers” relates to family members or friends of the supported person who may also be involved in caring for them.

## 3. BASIC HOUSEKEEPING OF PROCEDURE DOCUMENT

Any policy or procedure will have a system, such as the one below, to allow the reader to track the current version. Some procedures may also have a version control record.

| **Lead Author:**<br>**[Name of lead author]** | **Consultation Group:**<br>**[details of others consulted, for example]** | **Approved by:**<br>**[details of who approved if relevant, for example someone at corporate level in organisation]** |
|---|---|---|

| **Document Identifier:** | **SOP_Template_for_care at home medication**<br>**For example _v.2.0_YYYYYY** | **Supersedes:** | **v.1.4_XXXXXX** |
|---|---|---|---|
| **Date Approved:** | | **Review Date:** | |

## 4. GENERAL RESPONSIBILITIES

A good procedure should clarify the relevant responsibilities of all staff involved in the care.

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| a) Provider of the care service | List Responsibilities, for example<br>• ensure enough trained staff to meet the needs of the service. |
| b) Manager of the care service | List Responsibilities, for example<br>• organising staff training<br>• staff supervision and assessment of staff competency. |
| c) Care Worker Line Manager | List Responsibilities, for example<br>• organising staff visit rotas<br>• dealing with medicine errors<br>• organising assessments of service user medication capabilities or liaising with GP/Pharmacist/Nurse on other matters of care. |

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| d) Care workers | List Responsibilities, for example<br>• only carry out tasks/procedures for which they have been trained and assessed as competent to do so<br>• reporting any concerns or errors to line manager<br>• ensuring that appropriate records are made of medicine tasks. |
| e) Others | The document could explain the expected roles and responsibilities of others involved in the care of the person and not mentioned above, for example GP, Pharmacist, District Nurse, Social Worker. |

## 5. FRAMEWORK OF SUPPORT

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| Assessment of capabilities with medicines<br><br>Any care service provision should be based on the desired outcomes of the person who uses the service. This may require an assessment of their existing medication capabilities and needs.<br><br>This assessment is central to the success of managing medicines in the care at home setting. It should be made with the input of the person themselves (or a suitable welfare proxy if required) and lead to a signed plan of care ("contract") that details the agreed roles and responsibilities of Care workers, the person themselves and/or any family members involved. | The procedure document should:<br><br>• Explain how a care worker could notice the need for a reassessment of medication capabilities as needs change over time, and the process for ensuring that this is done<br>• Clarify who is involved in the assessment of the medication capabilities of the supported person - this may not be just one person (for example GPs or other health members of the primary care team, social work staff, or independent care providers, for example)<br>• An example of paperwork used in the "contract" could be given in an appendix.<br><br>The review of medicine capabilities is an ideal time for a review of the person's medicines. A local authority/NHS board procedure may indicate how and when this should be done. |
| Level of Support<br><br>Some policies will use "levels" (the numbers or letters assigned to these levels will vary | Many policies will define a level of support that is to be given to a supported person, for example |

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| between policies) while others will reference words such as “managed medication support” to describe a level. The principle is the same.<br><br>If a person can self-manage some medicines, they may be able to manage others with a variety of interventions. A local pharmacy may be able to advise on the options available to help someone retain independence. | Level 0 or A – no support needed with medication<br>Level 1 of B- person is able to self-administer with some assistance/prompting<br>Level 2 or C- staff are required to manage medicines for the person<br>Level 3 or D– tasks/roles to be undertaken by external healthcare staff.<br><br>The procedure should make clear that:<br><br>• Level of support needed may change over time<br>• A person is not a “level” and may, for example, require no support with managing an inhaler but level 2 support with tablets. |
| Prompting, Assisting and Administering Medicines<br><br>The Care Inspectorate, Royal Pharmaceutical Society of Scotland and Social Work Scotland have produced a document with agreed definitions of these terms. See http://hub.careinspectorate.com/<br><br>Policies need to be based around the needs of people. A procedure which states the service will only “prompt” a person to take medicines when the person requires more support than that to meet their outcomes does not place the person at it centre of the process. | The procedure needs to make clear to staff what it means by:<br><br>• Prompting with medication<br>• Assistance with medication<br>• Administering medication<br><br>List definitions of these with examples. |

### Guidance Note

The Care Inspectorate has noted the following issues with assessments of medication abilities:

- Long time taken to get them done, especially when needs change and a re-assessment is needed
- Lack of detail in assessment outcome and/or lack of detail being passed on to independent provider who draws up the care plan/delivers care
- NOT done with person’s needs central to process, for example outcome of assessment is skewed to service offered rather than service needed.

## 6. RECORDING SYSTEMS

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| Prompting/Assisting | The procedure should show how is this done, and what is recorded. A worked example could be given in the appendix.<br><br>Where care staff prompt or assist with medicines they need to record that they have done this, and, IF observed, any outcome of the prompt/assist, for example did person choose to take medicines while the carer was in the home. This level of recording is normally done is a communications diary. |
| Obtaining Medicines<br><br>http://www.rpharms.com/social-care-settings-pdfs/the-handling-of-medicines-in-social-care.pdf<br><br>It can be a real challenge to find out what medicines the person has so that the care worker may support the person safely. The home care service may not be responsible for ordering repeat medicines and will not be notified officially when the person's treatment changes. Unlike a care home, there may not be links with a single community pharmacy. Communications between Care workers, their supervisors and prescribers must be robust and effective. | In some cases the person themselves or a family member may order medicines, and staff may have no role here and so no recording is needed.<br><br>If staff have the responsibility to order medicines they need to know how to do this, what and when to order, and record what they have done. The care plan should state who is responsible for this and ensure clear communication with all those involved when medicines are changed.<br><br>The procedure should cover the above points and the appendix could give examples of how this is done and paperwork used.<br><br>Staff obtaining controlled drugs on behalf of the person being care for may need to show proof of identity when doing this. The procedure should make this clear. |
| Administering Medicines<br><br>It can be difficult for a care service to create and maintain an up to date medicines record to detail the administration of medicine by formal care staff.<br><br>Where a local agreement means that pharmacies/GPs are producing and | The care service procedure will need to demonstrate how it will create and maintain an up to date record of current medicines.<br><br>If care staff administer medicines, the care service have a duty to ensure an up to date medicines record. This can be very difficult to do in a traditional care at home |

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| maintaining MAR charts for people supported in the community, an independent provider will/should probably work with this system.<br><br>However, if no such local agreement exists for creating and maintaining a Medicine Administration Recording chart for the supported person, then various sources of information may be used by the care service to create and maintain their own recording chart.<br><br>• Sight of prescription (e.g. GP10s) - may not be possible in many cases<br>• Communication with the GP or other healthcare prescriber<br>• Information from the person's usual pharmacy<br>• Communication with another healthcare professional involved in the person's care e.g. community nurse<br>• Information from the supported persons family.<br><br>The care provider should ensure a system to be able to identify from records which of their staff administered medication at any given time. | setting, for example the family may order medicines and administer the morning doses, with care staff only responsible for evening and night time doses.<br><br>In some parts of the country local arrangements mean that pharmacies produce and maintain Medicines Administration Recording (MAR) charts for people receiving a care at home service.<br><br>However, this may not be the case and the care service cannot expect or insist on it if such a provision does not exist.<br><br>Where possible, self-made records should not be created based on pharmacy dispensing labels alone (see guidance opposite).<br><br>The procedure should explain how the service will manage mid-cycle changes to medicines, including where the GP surgery has phoned the person or a relative to initiate a change of dose. Similarly the system needs to accommodate changes communicated by other members of the multidisciplinary team such as Nurse prescribers.<br><br>The service may also need to explain how it handles situations where one care service manages, for example, morning to evening medicines but another service manages bedtime medicines, or one service does weekday and another does weekends.<br><br>• How are changes communicated between services?<br>• Are there one or two separate recording charts being used?<br><br>A worked example of the type of recording chart and any paperwork |

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| | used in the service could be in an appendix. |
| Disposal | Medicines should not be disposed of by the service without the person's consent. Where staff return medicines to the pharmacy there should be a record of this. Normally this is done on the MAR chart or on a separate record. The procedure should offer guidance to the care worker on their role and any paperwork used. The appendix could give a worked example. |
| Electronic Recording Systems | If the care service operates an electronic recording of their roles in managing medicines, there should be guidance for care staff on how this will work in practice, taking into account many of the above issues. |
| Care Plans | Any "contract" of care should lead to a care plan covering responsibilities and roles of care staff.<br><br>The care plan should cover how the provider will monitor the healthcare needs of the person being supported, including where medicines are used.<br><br>There is no expectation that formal care staff would normally have a detailed clinical/monitoring role. Instead simple key information at the level of the Patient Information Leaflet (for example) should inform any monitoring. |

### Guidance Note

Where care staff are fully in control of medicines management, for example they order, receive, administer and dispose of medication, then a tight audit trail is expected and can be very useful. This is normally the case in many care homes, as well as some care at home services which have a residential nature with 24/7 support. In these type of services parts of the "Guidance about medication personal plans, review, monitoring and record keeping in residential care" should be relevant in terms of record keeping – this document can be found at http://hub.careinspectorate.com/

Where staff have a role in medicine management (ordering/disposal/ administration) then it would generally be good practice for that activity to be recorded. However in

some services/situations (for example a typical care at home service where care workers administer meds during the three or four short visits each day) then it can be difficult for a service to be able to achieve the tight audit trail of medication that we would expect from say a residential care home service. This might be because the family might be organising repeat prescriptions and also administering some doses.

If the care service operates electronic recording in managing medicines, Care Inspectorate staff should seek advice from the Care Inspectorate Health Improvement Advisers.

## 7. STORAGE OF MEDICINES

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| Storage of Medicines | The procedure should make clear that medicines are the property of the person being cared for and that any storage of medicines in the home has to be with the agreement of the person or their proxy if appropriate. The care service may advise the supported person on principles of good medicines storage. Any local storage arrangements should be detailed in the care plan.<br><br>However, there may be some cases where, following a risk assessment, secure storage is recommended, for example where the resident may seek or inadvertently take more of the medicines at one time than is safe. |
| Storage of Controlled Drugs | There are no special storage requirements for controlled drugs in a care at home setting. There is no requirement for storage of such medicines in a controlled drug cabinet. |

## 8. ADMINISTERING MEDICINES

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| **Tasks care staff can and cannot do**<br><br>http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf<br><br>The basic elements that a care worker needs to know before giving medicines include giving medicines:<br>• Into the mouth (tablets, capsules, liquids)<br>• Ear, nose and eye drops | The procedure should clarify, separately or under each “level” of support, the types of tasks (including administration of medicines) that care workers can normally do and those they cannot.<br><br>It should also clarify what roles are normally undertaken by external healthcare professionals. |

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| • Inhalers<br>• Medicines applied to the skin.<br><br>You should only give medicines that you have been trained to give. Care workers can give or assist people in:<br><br>• Taking tablets, capsules, oral mixtures<br>• Applying a medicated cream/ointment (or patch)<br>• Inserting drops to ear, nose or eye<br>• Administering inhaled medication.<br><br>**This level of training will not cover giving medicines that use 'invasive' techniques such as giving suppositories, enemas, and injections.**<br><br>**Specialised training to give medicines**<br>There may be occasions when Care workers are willing to give medicines that registered nurses normally administer. This only happens when the registered nurse 'delegates' and the NMC have set out their guidance for this. It is helpful in many situations, for example, when a rectal solution is given to a young adult to control an epileptic fit. No one would prefer to wait for a registered nurse,<br>doctor or paramedic to give such important treatment. The important issues are:<br><br>• The person consents to a care worker giving this treatment<br>• The care worker(s) agree to do so<br>• Clear roles and responsibilities are agreed by the agencies and the people involved in providing care.<br><br>This training is both person-specific and care worker-specific.<br><br>http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf<br><br>… if it has been agreed with the patient and it is the care plan, doses can be left out for that individual to take at a later time, for example sleeping tablet. | Normally the care worker will administer oral dose medicines, creams ointments, for example while external healthcare professionals will administer medicines by more invasive routes. However there may be some special cases (for example, rescue medicines for epilepsy or severe allergy) where carers, after appropriate training, are prepared to administer medicines normally given by external health care professionals.<br><br>(See advice left and guidance note at end).<br><br>A dose of a medicine can be left with the supported person to take at a time when the carer is not there IF the supported person has been assessed as being able to manage this and they/their proxy agrees to it. This assistance arrangement should be stated on the agreed "contract" and be noted in the care plan. Any assistance with medicines such as this should be recorded appropriately by the carer (see section 6). |

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| Involvement of Informal carers | In some instances, a family member or other informal carer may be supporting the person for some parts of the day, for example in the morning or at night. If a medicine is due to be given during this time and the informal carer is willing to be responsible for administering this medicine, this must be detailed in the agreed "contract" of care. The "contract" must make it clear which medicines the Care at Home service will administer and which medicines the informal carer will administer.<br><br>All medicines should be listed on the MAR or other recording chart to provide a complete record of medicines the person is taking. Informal carers can be asked to sign the MAR chart when administering a dose of medicine but this would be by voluntary agreement. Care workers should not record administrations on behalf of an informal carer. |
| Multi-compartmental Compliance Aids<br><br>The Royal Pharmaceutical Society document "Improving Patient Outcomes: the better use of multi-compartmental compliance aids (MCA)" recommends –<br><br>http://www.rpharms.com/unsecure-support-resources/improving-patient-outcomes-through-the-better-use-of-mcas.asp<br><br>The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of a specific need requiring an MCA as an adherence intervention.<br><br>In support of independence and reablement, patients who can safely self-administer their medicines should be encouraged to do so and where they are unable to do so, there must be appropriate training for care workers so that they are able to administer medicines from original packaging. | The procedure should note and take account of recommended good practice (see advice left).<br><br>The procedure should NOT insist that all solid oral dose medicines are supplied in a multi-compartmental compliance aid (MCA). The pharmacist is under no obligation to supply medicines in this way.<br><br>The procedure should clarify:<br>• IF a MCA is to be used (see above) then care workers must only administer medicines to people from a MCA that has been prepared by a pharmacy or dispensing practice. They must never administer medicines from a device that has been prepared by a family member, friend or the person themselves. |

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| | • Care workers must never fill a dosette box or similar compliance aid for a supported person. The reason for this is there are a number of safety concerns with the preparation of these boxes. |
| "When Required" (PRN) and Variable Dose Medicines<br><br>If the care at home service refuse to administer PRN medicines the Care Inspector should question if the service is meeting the needs of the supported person/their proxy. Are there alternative arrangements in place which do this? | The procedure should clarify how PRN and variable dose medicines (for example where directions are to taken 1-2 tablets) are managed by the service.<br><br>At prompt/assisted support level, there is no problem with PRN or variable dose medicines because the person retains responsibility for making decisions about their medicines.<br><br>PRN medicines present a particular problem for people assessed as needing managed support given that level of support is often defined as not having the capability to manage their own medicines. However, some people while not being able to be responsible for their medicines overall may still be able to indicate if they need a PRN medicine. In these situations, it is more appropriate to have prescribing of PRN medicines than to put such medicines onto a regular prescription.<br><br>In general for a person receiving managed support (where care staff administer medicines), the GP/prescriber and care service would need to agree the following - the maximum single dose, the dose interval, the maximum number of doses at one time/per day/week and the indication/criteria for giving the medicine and how this is recognised. The indication may range from "at the patient's request only" to "when the patient has leg pain". This framework for administration must be specific because the carer is not normally |

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| | responsible for making a blind judgement on whether a medicine is needed or the dose to be given: he or she will follow the criteria stated by the prescriber.<br><br>If the service has a specific form for gathering this type of information from the prescriber a worked example should be given in the appendix. |
| Controlled Drugs<br><br>If the care at home service refuse to administer controlled drugs the Care Inspector should question if the service is meeting the needs of the supported person. Are there alternative arrangements? | The procedure should clarify that controlled drugs CAN be given by care staff in the care at home setting, and should be treated like any other prescription medicine.<br><br>There is no requirement for two people to be involved in the administration and recording of controlled drugs. |
| Warfarin | Warfarin is a medicine that is still commonly prescribed for people in the community. It requires particular care to ensure the person receives the right dose at the right time. In some cases, often where dose changes are frequent, the local arrangements may mean that community based nurses administer this medicine. If the dose is more stable or because of other considerations the role may be taken by care staff.<br><br>The procedure should clarify arrangements for handling of warfarin where care staff are involved. There should be a safe system for ensuring results of blood tests and any warfarin dose changes are communicated to the care service from the GP practice.<br><br>Arrangements should also include a system to ensure the MAR, or other recording chart, is updated with every dose change, and also ensure continuous treatment (for example no doses are missed, nor the wrong strength administered). |

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| | Details of any complex dosing must be stated clearly on or referenced from the person's MAR chart. Particular clarity is needed when doses are different on different days of the week. |
| Procedure for giving oral medication | Describe procedures for giving oral medicines (for example, tablets, capsules, liquids, sublingual & buccal tablets). This could involve signposting of external best practice documents or copy/paste from reliable source. |
| Procedures for administering external medications | Examples would be creams, ointments, drops, inhalers, suppositories, pessaries, patches, for example.<br><br>Reference to external best practice if necessary. |
| Procedures for people with swallowing difficulties | The policy/procedure should clarify that where a specific request has been made to take a medicine with food (for example in a spoon of jam) in order to address swallowing difficulties, that this is done following health professional advice, and with the specific arrangements being clearly recorded in the person's care plan. It should also make clear that giving a medicine in this way is not covert administration if the supported person knows the medicine is there.<br><br>Administration of medicines via a tube (for example PEG tube) is a procedure not normally done by Care workers or in a care at home setting. Where it is done the procedure should clarify that the care plan will list how to prepare medications for the individual person being supported in this way, and cover any advice given on how to do this by a pharmacist.<br><br>Further guidance can be via signposting to external best practice documents or copy/paste from reliable source. |

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| Secondary dispensing<br><br>http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf<br><br>"Re-packaging a medicine that has already been dispensed by a pharmacist or a dispensing doctor.<br><br>Re-packaging of medicines by Care workers should not take place in care homes. The risk of making a mistake is too great." | The procedure should clarify what this is and that it is not good practice. (See also above under Multi-compartmental Compliance Aids). |
| Refusal to take | The procedure should clarify that care workers:<br>• Can encourage a person to take a medicine, for example by saying "Your medicines are there to help you" but must not force a person to take a medicine against his/her will.<br><br>If a person receiving managed support refuses to take his/her medicines, the procedure should clarify the following:<br>• The carer should record on the medicine record that medicines were refused and inform their line manager<br>• The line manager will have taken/ take advice on when refusal of a given medicine for a specific person requires contact with the prescriber<br>• Where any advice is given by the GP this is recorded and communicated to the carer<br>• If the refused medicine has already been prepared for administration, that the medicine(s) will be disposed of and how this should be done. |
| Over The Counter Medicines | Sometimes a supported person may want or need to take a medicine purchase over the counter (OTC) at a pharmacy or other outlet. Some of these medicines may interact with currently |

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| | prescribed medicines or an existing medical condition.<br><br>The procedure should clarify the role of care workers and OTC medicines. Generally this would involve ensuring that:<br>• Care staff do not offer their own advice on medication or recommend that a person takes a particular OTC medicine<br>• No OTC medicine is taken without first getting assurance from a pharmacist or doctor that the medicine is safe to take for that individual<br>• Appropriate records of administration are made where care staff have this responsibility. |

### Guidance Note

If the procedure indicates that care staff will only:

- Prompt or assist with medicines but not administer them,
- Administer solid oral dose medicines like tablets, but will not administer for example liquids or creams,
- Administer regular solid oral dose medicines but NOT administer "when required" medicines or controlled drugs,
- Administer medicines only if they are supplied in a Multi-compartmental Compliance Aid,

then the Care Inspectorate should question if this approach meets the needs of the people being supported. It should consider if alternative arrangements are in place which meet the needs of the supported person.

The Inspectorate should also consider if an individual care service is obliged to operate such a procedure through a service level agreement with a local authority (see below).

### Strategic Scrutiny

If a procedure with the above or similar aspects is written by a local authority, the strategic scrutiny of the health and social care partnership by the Care Inspectorate should consider if the approach above best meets the needs of the population being supported. This should include individual needs and effects on other services such as primary and secondary care.

## 9. DISPOSAL OF MEDICINES

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| Responsibilities and paperwork | The procedure should clarify arrangements for disposal of medicines that are no longer required, including refused or spat out medicines.<br>Normally medicines are disposed of by the taking them to the person's regular community pharmacy/dispensing practice for safe disposal. Unwanted medicines should generally not be flushed down the toilet or put into domestic waste.<br><br>If care staff have a role here the procedure should detail how this is done and any paperwork used to record this activity and consent for it – an example could be given in the appendix.<br><br>The care service should what to do if it notes unwanted medicines from someone who is self-administering their medicine. This may suggest that they are no longer talking them and may reflect that the person is no longer able to manage their medicines. |

## 10. MISCELLANEOUS

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| Handling Medicines Errors/Incidents<br><br>(Health and) Social Care Services in Scotland aim to provide high quality care that is safe, effective and person-centred. This is a complex system and adverse events occur that do, or could have, an effect on the people involved. Each of these events should be regarded as an opportunity to learn and to improve in order to increase the safety of our care system for everyone.<br><br>The national framework document below is intended to support health and social care providers effectively manage adverse events and drive improvements in care across Scotland. Key to handling of medicines errors is the development of a learning culture in the organisation. This can be aided by looking for | The procedure should describe the process for managing errors with medicines. It should clarify for the carer:<br>• Immediate actions on noticing an error, for example contact with line manager<br>• What type of errors should be reported to the line manager<br>• How this is done – an example of paperwork could be given in an appendix<br>• Any post error action that may take place.<br><br>The procedure should also clarify |

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| root causes and trends in errors.<br><br>Learning from adverse events through reporting and review: A national framework for Scotland: Second edition<br><br>http://www.healthcareimprovementscotland.org/ | actions for the care service:<br>• When a GP or emergency service should be called (not all errors will require this level of response)<br>• What errors/incidents it should report and to whom, for example Care Inspectorate, Local Authorities, Police. |
| Controlled drugs incident reporting | The procedure should cover the reporting to the Care Inspectorate of any incidents relating to controlled drugs, and how this is managed.<br><br>Guidance is available on the Care Inspectorate website/HUB.<br><br>http://hub.careinspectorate.com/ |
| Staff Training | The procedure should clarify that all staff must receive training in the management of medicines before starting to deliver any medicines-related care. Staff should receive training on any locally agreed policies and procedures.<br><br>The provider should ensure staff have the competencies found in the "Administer medication to individuals" (HSC375) unit of the SVQ level 3 qualification. This may involve doing this unit itself or via another training/assessment resource which covers the same competencies.<br><br>Following the initial training, Care at Home staff should be assessed on a regular basis for on-going competency, fitting in with staff appraisal system in the service. The procedure should clarify how this is done. |
| Adults with Incapacity and Consent | Consent to treatment covers more than medication and as such is probably best handled out with the medication policy. The |

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| | medication procedure could cross refer to the consent procedure.<br><br>However there is scope within the medication policy to cover:<br>• The role of care staff in identifying that someone's capacity to make decisions on medicines may need re-assessing<br>• How care workers should raise these concerns with their line managers<br>• Who assesses capacity<br>• The role and importance of section 47 certificates in the management of medication for individuals who lack capacity to make decisions about medicines. |
| Procedures for covert medication | This is not likely to be common practice in a care at home setting but where it happens the policy should clarify what covert medication is, and how care staff may identify when this may be needed.<br><br>It should briefly cover the main steps involved before medicines are given covertly, namely:<br>• The medical practitioner primarily responsible for the individual's care taking responsibility for deciding on the need for covert medication, which medicines should then be given covertly, and in documenting the care pathway, in consultation with relevant others<br>• Certification of incapacity<br>• Documentation of advice from a pharmacist on how to give the named medicines covertly<br>• A care plan detailing how each medicine is to be given covertly. |

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| | The policy could refer to the Mental Welfare Commission's Covert Medication policy, and should describe the documentation used – this could be the Mental Welfare Commission's covert medication pathway or equivalent. A worked example could be given the appendix.<br>http://www.mwcscot.org.uk/ |
| Transfer to another care setting<br><br>http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-guidance.pdf<br><br>People who receive social care may need to transfer to another care setting. This may be a permanent move but can also be a short-term solution to a problem. Transfers include:<br>• Hospital admission<br>• Respite care in a social care setting<br>• Permanent move to a care home.<br><br>Transferring to another setting<br>It is essential that the person's medication is sent with the person. This is to ensure continuity of care for the person. The new care service may not have all the current medication available.<br>When Care workers are responsible for giving medicines to the person, a copy of the record of administration is also essential. | The procedure should describe what actions should be taken when a supported person is admitted to or returns from another care setting.<br><br>A stay in hospital may result in a change in medication. Therefore, it is vitally important that people receiving Care at Home managed support are identified in hospital so that appropriate arrangements can be put in place for their on-going care after discharge, and that the care service/care workers are informed of any change.<br><br>If the care service have responsibility for managing medicines then when a person is admitted to hospital, the Care at Home service should inform the person's community pharmacist of the admission so that no further supplies of medicines are made during the admission period. This will also alert the pharmacist to be prepared for a potential change of medicines on discharge. |

## 11. LEGISLATION, NATIONAL CARE STANDARDS AND GOOD PRACTICE

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| http://www.legislation.gov.uk/ssi/2011/210/contents/made<br><br>**Principles**<br>3. A provider of a care service shall provide the service in a manner which promotes quality and safety and respects the independence of service users, and affords them choice in the way in which the service is provided to | The procedure should reference key legislation that underpins practice in the service. This may include some UK wide medicines legislation but should include relevant Scottish legislation. |

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| them.<br><br>**Welfare of users**<br>4.—(1) A provider must—<br>(a) make proper provision for the health, welfare and safety of service users;<br>(b) provide services in a manner which respects the privacy and dignity of service users;<br>(c) ensure that no service user is subject to restraint, unless it is the only practicable means of securing the welfare and safety of that or any other service user and there are exceptional circumstances; and<br><br>**Personal plans**<br>5.—(1) Subject to paragraph (3) a provider must, after consultation with each service user and, where it appears to the provider to be appropriate, any representative of the service user, within 28 days of the date on which the service user first received the service prepare a written plan ("the personal plan") which sets out how the service user's health, welfare and safety needs are to be met.<br>(2) Subject to paragraph (3) a provider of a care service must—<br>(a) make the personal plan available to the service user and to any representative consulted under paragraph (1);<br>(b) review the personal plan—<br>(i) when requested to do so by the service user or any representative;<br>(ii) when there is a significant change in a service user's health, welfare or safety needs; and<br>(iii) at least once in every six month period whilst the service user is in receipt of the service;<br>(c) where appropriate, after any review mentioned in sub-paragraph (b), and after consultation with the service user and, where it appears to the provider to be appropriate, any representative, revise the personal plan; and<br>(d) notify the service user and any representative consulted under paragraph (2)(c) of any such revision.<br><br>**Fitness of employees**<br>9.—(1) A provider must not employ any person in the provision of a care service unless that person is fit to be so employed.<br>(2) The following persons are unfit to be employed in the provision of a care service:—<br>(a) any person who has been convicted whether in the United Kingdom or elsewhere of any offence which is punishable by a period of imprisonment of not less than 3 | Examples of the latter are given on the left. The list is not comprehensive. |

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| months and has been sentenced to imprisonment (whether or not suspended or deferred) for any period without the option of a fine and who, in the reasonable opinion of the manager of the care service having regard to the circumstances of the conviction, is unsuitable to work in a care service;<br>(b) a person who does not have the qualifications, skills and experience necessary for the work that the person is to perform; and<br>(c) any person to whom regulations 6(2)(a) or 7(2)(d) apply.<br><br>**Staffing**<br>15. A provider must, having regard to the size and nature of the care service, the statement of aims and objectives and the number and needs of service users—<br>(a) ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health, welfare and safety of service users; and<br>(b) ensure that persons employed in the provision of the care service receive—<br>(i) training appropriate to the work they are to perform; and<br>(ii) suitable assistance, including time off work, for the purpose of obtaining further qualifications appropriate to such work.<br><br>http://www.legislation.gov.uk/ssi/2011/28/contents/made<br><br>**Records, notifications and returns**<br>4.—(1) On granting registration of a care service under Chapter 3 or 4 of Part 5 of the Act, SCSWIS must, in addition to issuing a certificate of registration, notify the provider of the care service of—<br>(a) the records the provider must keep and where they must be kept;<br>(b) any matters the provider must notify from time to time to SCSWIS whilst the care service is registered; and<br>(c) matters the provider must notify to SCSWIS in an annual return.<br>(2) SCSWIS may, from time to time, make reasonable variations to the information required under paragraph (1). | |
| http://hub.careinspectorate.com/<br><br>• Records that all registered care services (except childminding) must keep and guidance on notification reporting, 2012 | The procedure should reference any documents that underpin key legislation, such as those on the left. |

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| • Notifications about controlled drugs: guidance for providers, 2015<br><br>http://www.gov.scot/Publications/2010/10/20153801/0<br><br>Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act | |
| **If your service is specifically designed to meet a healthcare need:**<br>You know that the home care worker providing your care has the appropriate skills for the personal care and nursing tasks needed to maintain your health.<br><br>You know that the staff member providing your care will look out for any changes in your health. If they notice any, they will discuss these with you and, if you want and need help to do so, they will contact your GP or other member of the primary care team<br><br>The provider will get details of your healthcare needs from you or your doctor (or both). The details are recorded in your personal plan and your home care worker knows them.<br><br>The provider will have arrangements in place to meet your healthcare needs in the best way for you. With your agreement, the provider will monitor your healthcare needs and, if there are concerns, will seek advice from your doctor or other member of the healthcare team.<br><br>**If your service includes help with taking your medication, the provider has arrangements in place for this to be done safely and in the way that suits you best.**<br><br>You know that the service provider will find out and record details of your medication (type and dosage) in your personal plan. Your home care worker will know these details and maintain a record in your home.<br><br>The arrangements made to help you with taking your medication are planned and made with your agreement.<br><br>You are confident that the service provider has policies and procedures to make sure that best practice guidance is followed and records kept when your home care worker helps you to take your medication. | National Care Standards. |

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| http://www.rpharms.com<br><br>The handling of medicines in social care<br><br>www.mwcscot.org.uk<br><br>Covert Medication - Mental Welfare Commission for Scotland<br><br>http://hub.careinspectorate.com<br><br>Prompting, assisting and administration of medication in a care setting: guidance for professionals. | The procedure should reference any key best practice or guidance document used to underpin practice. Some examples of these are shown on the left. **This list is NOT comprehensive.** |

## Appendix

**Worked examples of key paperwork used in the management of medication may include:**

- "Contract" of care with supported person
- Ordering of medicines form
- Recording of prompting/assisting of medicines - care diary
- Recording of medicines administered – medicines recording chart
- Disposal of medicines chart
- When required medicines framework for administration form
- Handling of medicine errors form
- Covert medication pathway.

The above list is not comprehensive and serves only as an example.

## Glossary

A list of key terms and definitions will help staff.

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অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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Published by: Communications

HCR-0217-128