DARLINGTON PCN PRIMARY CARE NETWORK

Darlington Care Home Team

PHD PRIMARY HEALTHCARE DARLINGTON LTD

Medicines Management Guidance

MAR charts and The MAR File:

- Signature sheet at the front of the MAR file: name, initials and signature of all staff trained to administer medicines. Update every 3 months. Ensure any agency staff sign this before administering any medicines.
- Resident identification cards should be used with a current photograph attached. Information should include: name, DOB, room number, allergies, any support the resident needs with taking medicines
- MAR charts should be: Legibly signed by care home staff, clear and accurate, factual, have correct dates and times, avoid jargon and abbreviation and have allergies recorded
- Any hand written MARs should only be done so in exceptional circumstances and should be written by a trained member of staff and checked for accuracy and signed by a second trained member of staff
- A record should be made on the MAR chart when the resident has taken each of their prescribed medication and should be completed before moving on to the next resident. There should be no missed signatures. Record when and why medications were not given ensuring the correct codes are used and adding details where appropriate to the reverse of the MAR.
- When required medication should only be recorded when they have been given. The reverse of the MAR can be used to record why given, time and dose. You should also record the outcome ie did the problem improve, was a further dose needed.
- Correct written mistakes with a single line through the mistake followed by correction and a signature, date and time of 2 trained members of staff.
- A record should be kept of medications administered by visiting health professionals on the MAR chart
- A record should be kept of medications administered by visiting health professionals on the MAR chart such as DN administering insulin.
- Controlled drugs: The controlled drug register should be signed by the staff member administering the medication as well as a trained witness. A balance of the remaining drug should be counted and recorded. Discrepancies should be reported to management and investigated. The MAR chart should be signed by the staff member administering the medication
- If there is a separate administration record e.g. for Warfarin, care home staff should add a cross reference ‘see warfarin administration record’. Topical MAR charts/ body maps should be used for emollient creams/ ointments and bath products. Annotate MAR with ‘see body map/ TMAR’. Medicinal creams such be on the MAR and administered by trained staff.
- Records should be kept of when drug reviews are needed
- Records should be kept of when injections such as hydroxocobalamin are due
- Records should be kept of when regular blood tests are due.
- It is good practice to highlight when weekly or monthly medicines are due on the MAR chart to ensure administration is not missed for example weekly doses of alendronic acid.
- Covert plans and guides for administering medicines when the resident has a swallow problem provided by the EHiCH team should be behind the MAR
- Stopped medicines mid cycle: cross through with a single line, add name of person stopping medicine and why. Sign and date by 2 trained members of staff.
- Dose changes to medicines mid cycle: cross through the entry. Anotate with ‘dose changed by….(and reason), please see new entry. Sign and date with 2 trained members of staff. Add a new entry with drug name, strength and dose. The date should start where the previous entry stopped. 2 signatures and date needed from trained staff. An interim prescription should be ordered if needed and the reason stated on the request to the GP.

The Medication Trolley:

The following items should be stocked on the trolley before each medication round:

1. MAR charts
2. Pens
3. Notebook
4. Clean Beakers
5. Clean water
6. Measuring jug- to measure water for sachets such as movicol, laxido
7. Medicine pots
8. Spoons- use spoons for mixing sachets or for assisting residents with medication
9. Syringes- for liquid medicines if spoon inappropriate
10. Gloves- to use for administering nasal sprays, eye drops or to be worn if unable to decant medicines without touching- change between residents.
11. Any Supplements needed for residents
12. Thickeners
13. Spacer devices for inhalers
14. Hand sanitiser- please use this if you are unable to decant medicines without touching
15. Rubbish bag- attached to side of trolley
16. Red tabard for drugs round

The Medication Round: best practice guidance

- Medicine trolley is taken to resident
- Medicine trolley is locked when not in use
- Ensure there are enough beakers/ medicine pots
- Ensure process for right medicine for right resident at the right time is followed.
- The senior member of staff should have an appropriate amount of uninterrupted time for the medication round. No talking with colleagues, answering telephone
- Staff administering medicines should explain to the resident that they have their medicines, check that it is ok to administer them and this should be in a way the resident prefers.
- Gloves should be worn for administration of eye ointments
- Ensure sufficient fluids are given to resident for taking medications
- Spacer devises and inhalers (where appropriate) should be washed after each round
- Ensure correct instructions from the pharmacy team are followed for crushed medicines and that these are taken with appropriate liquids. Hot drinks and food supplements should not be used.

When required medication:

- ‘When required’ medicines should be kept in their original packaging
- Record 'when required' medicines only when they have been given on the reverse of the MAR chart, noting the dose given and the amount left (where possible), to make sure that there is enough in stock
- When required medicines should be offered either when the resident requests them or when visual signs of a problem are noted. They should not just be offered at the med round.
- Each when required medication should have a written protocol that is appropriate to the resident the medicine is prescribed for. This should include non-verbal signs of pain for analgesia, how the resident may react if they have constipation etc. It should state what the medicine is for and what it is expected do. There should be information how and when the medicine can be taken including time between doses. There should be instructions on what to do if the problem is not resolved with the when required medication.
- Variable doses should be clarified with the GP or pharmacist for more information on how the medicine should be offered to the resident and when.
- After administration of when required medicines the resident should be reviewed to see if the problem has

resolved or if further action is taken. This should be recorded on the reverse of the MAR.

- The Residents care plan should have full details of the when required medication in order to assist staff in administration. This should be a person centred approach.

Controlled Drugs:

- Access to the CD cabinet should be restricted. The keys should be kept under the control of a designated person and there should be a clear audit trail of the holders of the key
- The CD cupboard should only be used for the storage of CDs. No other items such as money should be placed there.
- In a care home with nursing a medical practitioner or a registered nurse should administer the CDs. In accordance with the Nursing and Midwifery Council (NMC) standards for medicines management (standard 8) the registered nurse should obtain a secondary signatory from a witness who has been assessed as competent in relation to CDs.
- In a care home without nursing, CDs should be administered by appropriately trained and competent care home staff, and this should be witnessed by another appropriately trained care home staff member. The use of a witness is intended to reduce the possibility of an error occurring. Therefore to be effective the witness must have the same level of training as the person administering the controlled drug.
- It is good practice that the second signatory witnesses the whole administration process.
- Administration of the CD should be documented on the medicines administration record (MAR) chart and the CD register.
- The care home staff responsible for administering the CD and an appropriately trained witness should sign the CD register.
- The staff member administering the CD should also sign the MAR (no signature is required on the MAR by the witness).
- The records should be completed immediately after the CD has been administered and not before.
- If medication is being administered by a visiting healthcare professional the care home staff should ask visiting healthcare professionals to make their record of administration available to the care home. The healthcare professional should also consider seeing the resident in the presence of care home staff responsible for administering medicines to the resident. Care home staff should keep a record of medicines administered by visiting health professionals on the resident's MAR. If the CD is stored by the care home, appropriate records should be made in the CD register if it is then given to a

visiting healthcare professional to administer. A second trained member of staff should witness the transfer.

- If the CD is transferred out of the care home, e.g. when the resident is away from the home for a short period of time or is transferred to another care home, a record should be made in the CD register and witnessed by a second trained member of staff.

Storage:

- Store external and oral medications in a separate locked cupboard within the treatment room. Creams/ ointments in use may be kept locked in the resident's room.
- Trolley should be locked and tethered to the wall within treatment room when not in use. It should be kept clean and tidy and each resident's medication separated and labelled with their name.
- Stock should be rotated so earliest expiry date is at the front and used first. Expiry dates should be checked each month.
- Date of opening should be recorded on the label of any liquid preparations and external medications including eye preparations.
- Medication room and fridge temperatures should be recorded daily. Fridge should be locked.

Examples of different wording of expiry dates:

Use before end of January 2017	Discard 31/01/2017
Use by January 2017	Discard 31/12/2016
Discard after January 2017	Discard 31/01/2017
Expires January 2017	Discard 31/01/2017
Use within one month of opening	Self-explanatory
Discard 7 days after opening	Self-explanatory

Suggested expiries from date of opening:

Part pack of tablets/capsules remaining in manufacturer's blister pack dispensed in pharmacy box or in original pack	Manufacturer's expiry on blister. If no expiry visible contact community pharmacy or dispensary for advice
Oral liquids in original container	6 months unless otherwise specified by manufacturer, remember to mark date of opening on container

Eye, ear, nose drops/ ointments	1 month, unless otherwise stated by manufacturer
Inhalers	Manufacturer's expiry
Insulin	4 weeks for insulin vials and pens unless otherwise stated
Pump action creams/ ointments	Manufacturer's expiry
Creams/ ointments in tubs	28 days
Tablets/capsules/liquids decanted into pharmacy bottle	Seek community pharmacy or dispensary advice

Waste management:

- Staff should check stock levels prior to ordering or usage of PRN medicines prior to ordering, including looking at body maps for creams/ ointments
- Staff should always carrying forward medications where appropriate to do so including inhalers, creams and PRN meds. The quantity marked in the carried forward box on the MAR chart.
- Staff should use hospital discharge medications however before continuing to re-order in a blister pack, when the medications remain the same.
- Clearly mark with a tick the items which are required. Only tick the repeat slip if an item is needed **Tick in haste, medicines waste**
- Warfarin: only order the strengths of warfarin that are required for the current dose, eg very few people need 5mg tablets. Do not waste the unused tablets at the end of the cycle- carry forward as doses change frequently.
- If a resident is not taking their medication refer to their GP for advice.
- Check stock levels of dressings and catheters are appropriate before ordering.
- Use date of opening stickers on all liquids, creams and ointments. Tubs of creams should be discarded 28 days after opening, pump dispensers and tubes are by manufacturer expiry date

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Waste Log:

This should not have 'old stock' as a reason for waste. Please use the following descriptions:

- Patient is deceased
- Expired
- Stopped by GP
- Stopped by hospital
- Refused dose
- Spillage

Ordering:

1. **must** ensure that medicines prescribed for a resident are not used by other residents
2. should ensure that care home staff have protected time to order and check medicines delivered to the home
3. should ensure that at **least 2 members** of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff
4. should **retain responsibility for ordering medicines** from the GP practice and should not delegate this to the supplying pharmacy
5. should ensure that **records are kept of medicines ordered**
6. should **check medicines delivered** to the care home against a record of the order to ensure that all medicines have been prescribed and supplied correctly

Day in cycle	Processes
1	The start of the new 28 day cycle of medications. On change over day any leftover medicines should be carried forward into the new cycle providing they are to be continued and are still in date.
4-5	The order should be completed for the next 28 day cycle. Stock levels of PRN meds and creams should be checked and noted for ordering purposes. **Do not** routinely clear drug cupboards at the end of the month and order new stock. • Ordering should be done using the current MAR chart, the duplicate MAR copy for the pharmacy and the repeat slip for the GP practice. • If a regular 28 day medication is to continue it will need to be ordered for the next cycle therefore mark on duplicate sheet to continue and number of days required and then tick on the repeat slip. • If a medication has been discontinued then the duplicate sheet should be filled in for the pharmacy records. This does NOT need to be ticked on repeat slip. • If a medication is to continue but no supplies are needed, the duplicate sheet should have 0 days needed but the box ticked for it to continue on MAR. This does NOT need to be ticked on the repeat slip. • If a medication has been altered mid cycle and needs ordering you should write the details on the duplicate MAR of the changes and who made them. When ticking the repeat slip its good practice to write the new directions (which should have already been changed at the pharmacy) remember a new quantity may be needed. • Home should retain a photocopy of the FP10 order slip in each resident's file.
6	Send order to GP practice and duplicate MAR sheets to pharmacy
7-8	Prescriptions are generated at the GP practice.
9	Prescriptions are sent to the pharmacy via EPS
10-14	A copy of the prescription token should be obtained from the GP or the pharmacy. This should be checked against the homes record of the order. The Care Inspectorate advises that care home staff keep copies of the signed prescription form. This provides an audit trail

	and is evidence of the authorisation to administer medication. There should be a form provided at the care home to complete with any noted discrepancies. • Check all items ordered appear on the prescription. • Any items on the prescription that are not needed should be communicated to the pharmacy who can mark the prescription as 'Not Dispensed'. • Any items that the home have ordered which do not appear on the prescription should be notified to the GP practice and a prescription sent to the pharmacy- don't forget to obtain a copy of this from the pharmacy for the home records. • Don't forget to obtain a copy of any paper printed prescriptions which have been sent to the pharmacy- for example controlled drugs.
15-22	Order is processed at the pharmacy
23	Order is delivered to the care home
24-25	Order is checked in by care home. Check what has been received against the new MAR chart and the order sheet and the current MAR chart. The MAR chart should be annotated with 'see body map' for any external preparations, times should be highlighted, weekly meds highlighted with the day they are due,discontinued items still on the Mar should be scored through- witnessed and signed- contact pharmacy to ensure they know this medication is stopped. The CD register should be completed appropriately and witnessed and signed.
25-28	Any discrepancies should be recorded and rectified with the GP practice and pharmacy prior to the start of the cycle. This includes dealing with the missing item list from the pharmacy. If needed the GP may need to prescribe an alternative drug. Let other staff know when you have contacted the GP practice or community pharmacy about a prescription query so that multiple calls are not made about the same query.

Drug Audits and Error Reporting:

Each care home should have a clear process for reporting medicines related errors or safeguarding incidents. This should include when CQC or other regulators should be notified and which medicines related incidents need to be reported.

- The manger should be informed of any errors as soon as possible
- Accurate details should be recorded in writing as soon as possible and staff must try and find the root cause of any errors.
- Health professionals should be contacted immediately for advice in medicine related incidents to safe guard the resident from harm.
- 'Near Misses' and errors that do not cause harm should be recorded for monitoring and learning purposes. There should be a 'no blame' culture. Any safeguarding concerns from this should be reported to CQC.
- Information should be given to the resident and/or their family members about any error with their medications. They should be given full information on how to report a safety incident or use the care home complaints procedures.

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