Medication in Extra Care Housing

This factsheet updates the 2008 Housing LIN factsheet to bring it in line with policy, legislation, current guidance and best practice. It is aimed at practitioners, commissioners, care service managers and housing managers in extra care housing, an environment not specifically referred to in any guidance on the handling of medication. It highlights examples of practice, outlines areas for consideration by provider, sets out key lessons learned and provides a list of useful frequently asked questions.

September 2016

Table of Contents

1. INTRODUCTION

The handling of medicines in Extra Care Housing (ECH) can be challenging partly because of a lack of medication guidance relating specifically to this particular environment.

Registered care homes are different from extra care housing[1]; however, in February 2016 the Royal Pharmaceutical Society (RPS) published a report called, *The Right Medicine: Improving Care in Care Homes*[2], which contains a number of recommendations which could also be applied in an ECH environment, particularly relating to the support that a pharmacist could provide to ensure the safe and appropriate use of medicines.

Taking a medicine is the most frequent intervention that patients will use to improve their health. Residents in an ECH scheme who have been prescribed medication, often taking multiple and complex regimens, are some of the most vulnerable to problems with their medicines when they transfer care settings. Whether it's from primary care (GPs) to hospitals, or mental health hospitals to the community, or from hospitals back to primary care, these are times when the risk of things going wrong with medicines tends to increase.

It is the responsibility of all the professionals involved in the care of a patient to ensure the safe transfer of information about medicines. The RPS, in collaboration with other royal colleges, patients, health and social care professionals has developed professional guidance that is closely mapped to a range of related national initiatives and guidance: *Keeping patients safe when they transfer between care providers: Getting the medicines right.*[3]

Under an initiative called Medicines Optimisation, The RPS has also developed, *Good Practice Guidance for Healthcare Professionals in England*[4], which aims to help patients make the most of their medicines and improve patient safety through better partnership working between all health professionals and patients. The guidance covers what in essence are 7 principles centred on the patient to improve their experience and outcomes.

Furthermore, any support with medication supplied through a homecare provider should incorporate the principles of safe practice set out in the Royal Pharmaceutical Society's *Professional Standards for Homecare Services*.[5]

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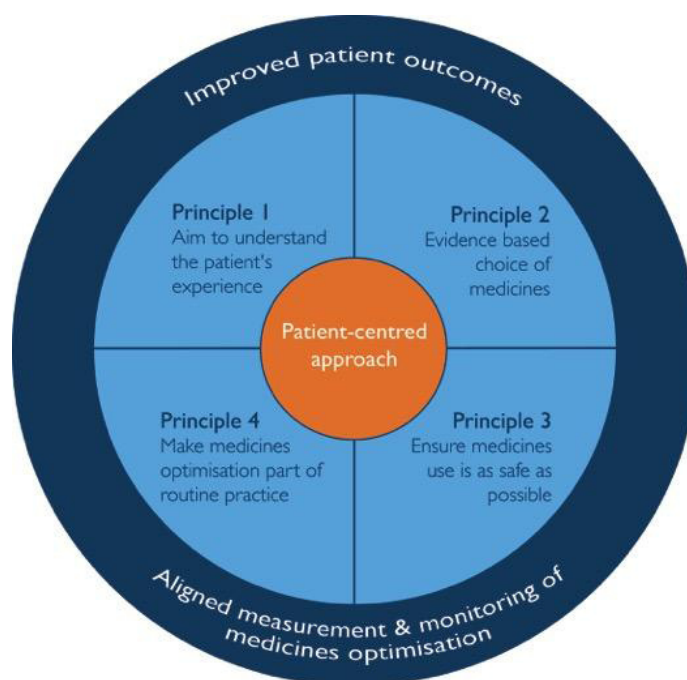
1 www.housinglin.org.uk/Topics/browse/HousingExtraCare/

2 www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf

3 www.rpharms.com/getting-the-medicines-right/keeping-patients-safe-report.asp

4 www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

5 www.rpharms.com/support-pdfs/homecare-standards-final-sept-13.pdf

These overarching standards give a broad framework to support teams providing and commissioning homecare services and will help individuals experience a consistent quality of services that will protect them from incidents of avoidable harm and get the best outcomes from their medicines. The Handbook for Homecare Services in England identifies currently available resources and good practice examples which may be used by homecare teams in the development of robust arrangements for compliance with the three domains of the Standard.[6]

If personal care is provided within an ECH scheme, this must be provided by a registered provider, hence the Housing with Care guidance[7] and the Guidance for Providers on Meeting the Regulations[8] from the Care Quality Commission (CQC) are relevant. It should be noted that the administration of medication alone does not constitute personal care.

The registered provider can be the same or different to the organisation managing the scheme and providing housing and/or support services. The personal care service can be achieved by in-house provision if the ECH scheme is registered or by a contracted service from a registered domiciliary care service.

In a care home, although independence is promoted, many residents will have their medication administered by care staff either by choice or due to physical or mental frailty. However, in an ECH environment, in general, most individuals would be expected to manage their own medication and support may or may not be required.

The nature of the support required may well be similar to that undertaken by a domiciliary care agency. Individuals may require prompting to take their medication, on the odd occasion they may require support / care workers to order or collect their prescription. Occasionally, it may be necessary for support / care workers to arrange suitable safe storage for the medication if there is an excess of medication prescribed and / or accessibility by the individual is inappropriate.

Individuals may sometimes require administration of their medication, which is fundamentally different from assistance (usually referred to as "prompting"). In this situation, the support / care worker is responsible for selecting the medication and giving it to the correct individual (using the "5 rights" principle – right medicine, right individual, right dose, right time, right route) and then recording the action with the name of the medication, form, strength, dose, date, time and signature of the support / care worker responsible. Appropriate training is essential if a support / care worker administers medication.

The handling of medication in ECH relies very heavily on the assessment of risk. (See Appendix 1 for a sample risk assessment).

The registered provider should ensure their insurance covers the handling of medicines.

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6 www.rpharms.com/support-pdfs/homecare-services-handbook.pdf

7 www.cqc.org.uk/sites/default/files/20151023_provider_guidance-housing_with_care.pdf

8 www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

2. BEST PRACTICE RECOMMENDATIONS

In addition to the guidance covered elsewhere in this document, best practice recommends that for the safe handling of medicines, support / care workers should have a written policy that sets out:

- How to support individuals to take responsibility for their own medication.

- Actions to take if an individual becomes unwell and is unable to take full responsibility for their medicines.

- Obtaining the individual's consent for a support / care worker to give medicines.

- Which medicines the support / care worker is able to administer after appropriate training.

- Record keeping that is necessary.

- Provision of individual safe storage.

- Treatment of minor ailments.

It is essential for any medication-related task that a support / care worker is required to undertake (supporting, assisting or administration), that there are detailed written standard operating procedures in place i.e. a step-by-step guide on how the task should be undertaken.

2.1 Safe Storage

All medication should be stored in the individual's home and only in exceptional circumstances where a risk assessment has identified a risk to the individual by storing it there, should medication be stored centrally. In these circumstances it is necessary to have a system in place to monitor storage temperature, transfer of medication cupboard keys, expiry date checking etc. For medication stored in the individual's home, these systems are unnecessary.

Medication should be stored in a cool, dry environment and the accessibility of the medication by the individual is an area for risk assessment. For individuals with a mental health need or dementia, it may well not be suitable for the individual to have access. If this is deemed to be the case, a lockable cupboard would be required for the safe storage of medication and for which the individual did not have access. If the individual is able to manage their own medication and have access, no lock is necessary on the cupboard providing the door to their residence remains locked. In the event that the individual leaves their residence door open, again a risk assessment would need to be undertaken to determine how best the medication can be stored safely.

The storage of all medications, e.g. tablets, creams, eye drops etc., is treated as for any individual living in their own home, i.e. there is no special requirement to store internal and external preparations separately or to store Controlled Drugs in a separate locked area. Controlled Drugs will be stored as for any other medication and do not require the administration by two individuals (as in a care home). The issue regarding abuse of medication and in particular Controlled Drugs does need to be highlighted. Part of the risk assessment process should look at the possibility of abuse of medication with regard to excess medication building up in the individual's home and accessibility by the individual or indeed by others (visitors, family members, other individuals). If this is deemed a risk, then smaller quantities of medication or alternative preparations can be requested by the individual from the prescriber, or alternative storage arrangements made.

Medication that requires fridge storage will be labelled as such. If a medication requires fridge storage, the individual's domestic fridge would be used. In exceptional circumstances, if it was inappropriate for the individual to have access, a central lockable drug fridge would need to be used and daily monitoring of fridge temperature undertaken. General advice may be found on NHS Choices[9] and, out of hours, advice can also be sought from NHS 111.[10]

2.2   Obtaining Medicines

It is not usually appropriate for a support / care worker to influence how an individual chooses to obtain medicines; however, for some individuals (e.g. with more severe mental health needs or advancing dementia) it may be necessary for the ECH scheme to support the individual by arranging delivery or collection of medication from a local pharmacy. Local pharmacies will often offer a free prescription collection and delivery service. Some offer an arrangement whereby post boxes are fitted in the communal areas, where individuals can post their prescription requests. The pharmacy will then collect and deliver the medication direct to the home. Written operating procedures, record keeping and an audit trail are required to ensure continuity of supply and to ensure the appropriate individual receives the medication once it arrives at the ECH scheme. A lockable facility would be required to ensure safe storage of the medication until distribution by the scheme or collection by the individual.

2.3   Administration of Medicines

Although in ECH it would generally be expected that individuals would manage their own medication, there may well be times when the individual is unable to administer their own medication.

In the Royal Pharmaceutical Society: *The Right medicine, Improving Care in Care Homes*[2] there are many learns on good practice and it highlights the difference that involving a pharmacist can make to safe and good outcomes. Best practice recommendations can also be found in the NICE Guidelines on Managing Medicines in Care Homes.[11]

Medication should be administered from original pharmacy filled and labelled containers. Information regarding which medicines a support / care worker can administer (following appropriate training) would need to be stated clearly in the medication policy for ECH organisations who are prepared to administer medication. This should cover which tasks can be carried out by support / care workers, e.g. administration of tablets, patches, eye drops, creams, inhalers (Level 2 tasks), and which tasks would need to be delegated by a healthcare professional (Level 3 tasks), e.g. PEG feeds, oxygen, insulin.

These level 3 tasks may only be undertaken if the ECH scheme agrees to take them on, the support / care worker is trained by the delegating healthcare professional and the healthcare professional assesses the support / care worker as competent to carry out the task. Full documentation is needed and these tasks are support / care worker and individual-specific. Injections (with the exception of insulin) will normally be undertaken by a healthcare professional e.g. Community Psychiatric Nurse (CPN), District Nurse (DN) etc.

Some individuals will be prescribed medication "when required". In order to ensure consistent treatment if administration is undertaken by support / care workers, a "when required" protocol should be developed stating what the medication is for, how many tablets to give if a variable dose is prescribed (e.g. 1 or 2 when required), how often the dose can be repeated and the maximum in 24 hours.

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9   www.nhs.uk/pages/home.aspx

10   www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx

11   https://www.nice.org.uk/guidance/sc1

In very exceptional circumstances only, covert administration (disguising medication in food or drink) may occasionally be necessary. This may only be undertaken within the context of the Mental Capacity Act 2005[12] and if permitted within the ECH organisation's policy.

2.4   Monitoring and Record Keeping

General support with medicines should be recorded in the daily log and support plan. When individuals require administration of medication by a support / care worker then a medication administration record (MAR) sheet must be completed with full details of the name of the individual, name, form and strength of medication, frequency and dosage, time and signature of the support / care worker responsible.

Most pharmacy systems can create MAR charts and there are systems in use in care homes which use technology to support this. Yorkshire and Humber Commissioning Support have some best practice guidance on MAR in care home and domiciliary care settings.[13] (See Appendix 2 for a sample medication administration record[14]).

Discreet monitoring of medication use is important in reducing the potential for error or incident with medication. This must be achieved without invading the privacy of the individual. Information such as medicines left out untaken, build up of medication in their home, medication dropped on the floor etc. is useful in preventing harm to the individual. This should be reported to the line manager along with any changes to the individual's condition, which may be due to medication e.g. very drowsy, rash etc.

For individuals requiring additional support, e.g. requiring a support / care worker to request a prescription, audit trail documentation is essential. Information such as when the prescription was requested from the GP, when the prescription was ready for collection, when the prescription was taken to the pharmacy and when the medication was delivered to the individual's home can help the service ensure that individuals receive their medication on time.

2.5   Disposal of Medicines

It is not usually appropriate for a support / care worker to influence how an individual's medicines are disposed of. However, in exceptional circumstances, additional support may be required by the ECH scheme. In this situation, a returned medication record would be needed as a record of when and what was returned to the pharmacy and by whom.

If a medication was found to be out of date, the individual or their representative should be requested to return the medication to the pharmacy for its subsequent disposal. Only in exceptional circumstances would a support / care worker remove the medication for disposal and this would only be permitted if it was within the organisation's policy to do so and written permission had been obtained from the individual and the line manager.

Under the Environmental Protection Act 1990 legislation[15] and subsequent regulations, the recommended means of disposal for medicines is to return them to a pharmacy who undertake to receive and dispose of them under their contractual arrangements.

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12 www.legislation.gov.uk/ukpga/2005/9/contents

13 http://yhcs.org.uk/archive/wp-content/uploads/2014/12/MAR-charts-in-care-homes-and-domiciliary-care-YHCS-010415.pdf

14 www.coventry.gov.uk/download/downloads/id/5839/appendix_d_-_example_medication_administration_record_mar_sheet.doc

15 DEFRA, www.defra.gov.uk/environment/waste/topics/clinical.htm

2.6 Over-the-counter (OTC) and Homely Remedies

An individual may choose whether to buy and take an over-the-counter non-prescribed medication or a complementary treatment. The difficulty arises where an individual requests a support / care worker to purchase or administer an OTC preparation.

The risks are that OTC and complementary treatments e.g. herbal preparations and traditional Chinese medicines may interact with prescribed medicines. In addition, individuals may purchase preparations, which contain the same ingredient as in the prescribed medicines. It is recommended that individuals ask the pharmacist for advice on any non-prescribed medicines. Each ECH organisation should have a clear policy on which tasks support / care workers may undertake.

2.7 Side Effects and Contra-indications

Where individuals manage their own medication, support / care workers will not necessarily know what medications are being prescribed. Where additional support is being provided and the support / care worker administers the medication, the support / care worker should know what the medicine is intended to do, e.g. help the individual breathe more easily, and know whether there are any special precautions, e.g. giving medicine with food. It is the responsibility of the prescriber to ascertain whether there are any contra-indications. The pharmacist will provide appropriate information on the medicine label. In accordance with the Medicines Act 1968[16], the support / care worker can then administer the medication to a third party if it is to the individual it is intended for and strictly in accordance with the directions that the prescriber has given.

Occasionally a support / care worker might administer a new medication to an individual who may suffer an adverse effect. This may be due to the medication and in this circumstance a support / care worker would be expected to get medical help immediately. Generally, doctors, nurses and pharmacists would report adverse drug reactions to the Medicine and Healthcare Products Regulatory Agency (MHRA) through the *Yellow Card Scheme[17]* although the system does allow for the individual themselves or a support / care worker to make the report if appropriate.

2.8 Medicines Adherence Support

Community pharmacies in England are funded under their NHS contractual framework to provide individuals with formal support on certain new medicines (New Medicine Service[18] – NMS) and can offer a Medicines Use Review[19] (MUR) once a year to ensure that individuals get the most from the safe and appropriate use of their medicines.

2.9 Consent and Choice

Consent is required for any medication to be administered to an individual.

Where possible, the individual clearly provides informed consent. If that is not possible but there is a chance that the individual can give consent, then the individual should be given support to be able to make an informed decision.

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16 www.legislation.gov.uk/ukpga/1968/67/contents

17 https://yellowcard.mhra.gov.uk/

18 http://psnc.org.uk/services-commissioning/advanced-services/nms/

19 http://psnc.org.uk/services-commissioning/advanced-services/murs/

If it is impossible to obtain consent, key individuals (in line with the ECH organisation's own policy) act in the best interests of the individual documenting how and why the decision was reached. The Mental Capacity Act[20] is designed to protect and empower individuals who lack the mental capacity to make their own decisions about their care and treatment.

There is little published information about cultural requirements and medicines, however consideration should be given to administration of gelatine capsules to vegetarians and individuals from particular religious groups. Some individuals may prefer to have their medicines administered by someone of the same gender. During religious festivals that include fasting, some individuals may prefer to have their medicines at certain times and Muslims may be concerned about medicines containing so-called unclean substances.

2.10 Staff Training

For any ECH staff member involved in any way in the handling of medication, it is essential to have had appropriate training and had competency assessed. The training as a minimum should include instruction on the supply, storage and disposal of medicines, safe administration, record keeping and confidentiality. Further information can be accessed via Skills for Care[21] who produce knowledge sets for medication. Some community pharmacies may also provide training on the safe use of medicines for care teams. It is good practice for ECH providers to ensure that housing support and care staff receive medication training and they have a medication policy written specifically for the extra care environment.

3. ADDITIONAL CONSIDERATIONS

3.1 Dementia

The responsibility with regard to medication handling in individuals with dementia will be determined by the level of support required and whether the support / care worker undertakes administration of medication. If administration is undertaken by a support / care worker, then the support / care worker administering that medication is responsible for ensuring the right medication is given appropriately. Any other medication-related tasks will be identified and a written procedure will be in place for the task to be carried out effectively. The responsibility for having a robust medication policy, written procedures, provision of training and assessment of competency rests with the care services provider.

For individuals with mild memory impairment or early stage dementia, support / care workers may be responsible for "prompting" medication. Best practice would dictate that the ECH scheme should have a protocol in place to monitor compliance, e.g. the support / care worker reporting back any concerns with mismanagement of medication such as tablets not being taken, deterioration in the individual's behaviour. However, the prime responsibility for medication rests with the individual. (See Appendix 3 for a sample protocol for monitoring adherence).

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20 www.legislation.gov.uk/ukpga/2005/9/contents

21 Skills For Care, www.skillsforcare.org.uk

3.2 Telecare

Improving the way individuals can manage their own medicines is an area currently being addressed by telecare. There is a range of devices and systems available, e.g. stand alone devices or devices connected to a call centre or prompting systems. More information can be found in the Housing LIN factsheet No. 5 Assistive Technology in Extra Care Housing. There are a number of issues that need to be addressed to ensure a successful outcome in self-management of medication.

Schemes have been successful where there is full collaborative working between GPs, PCTs, pharmacists, social services, District Nurses, housing schemes and the individual. The initial assessment of the individual is crucial to the success of the scheme. Experience from Staffordshire Medicine Reminder Initiative (SMRI) has shown that the choice of individual assessing the individual is very important. Initially a pharmacist carried out the assessment but the scheme developed to enable a pharmacist plus an individual from the housing scheme who knew the individual, to carry out the assessment, which ensured a more successful outcome. A delegated individual was then nominated from the housing scheme to monitor.

See Appendix 4 for the Staffordshire Medicine Reminder Initiative Pharmacist Assessment Guide.

The scheme operated by SMRI involved the use of telephone prompting via a Lifeline / community alarm unit, which gives an audible and visual alert when it is time for the individual to take their medication. The individual then presses a button on the unit to confirm compliance. For a verbal message prompt, a fundamental piece of information is to know how the individual wishes to be addressed, e.g. by first name, Mr or Mrs etc. This aids adherence. However, this system is unsuitable for "when required" medication.

The use of prompting systems has to date been found to be most suitable for individuals with mild memory impairment. Consideration also needs to be given to factors such as the individual's hearing ability (to hear the alarm) and English being their first language (for explanation and instruction). The terminology used is also important, e.g. there may be confusion between the terms lunch or dinner and the individual's perception of when that might be.

Limitations of the telecare devices also include the fact that some medications are not suitable for packaging into the device, e.g. "when required (PRN)" medications, effervescent or soluble medications, medicines that are sensitive to light (unless kept in their original packaging) and hygroscopic medicines (those that absorb moisture). Obviously other preparations, e.g. liquids, creams, inhalers, cannot be packed this way and therefore consideration needs to be given to these vital medications too. It is not appropriate for a support / care worker to fill the telecare device from the original labelled pack supplied by the pharmacy, as the risk of error with secondary dispensing is too great. Cost is also a factor for consideration.

Issues have also arisen over the labelling and filling of telecare devices. If the pharmacist fills the device, there may be insufficient space for a medicine label to be attached. The medicine label would normally detail essential information including the name, form, strength of the medicine along with the dosage and frequency but also additional information, e.g. whether it should be swallowed whole, taken with food etc. Best practice recommendations and guidance on labelling monitored dosage systems can be found on the Royal Pharmaceutical Society website.[22]

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22 www.rpharms.com/support-pdfs/rps-mca-july-2013.pdf

Pharmacies may only agree to provide the service of filling telecare devices if it has been agreed with the CCG as a local service (and payment can therefore be made by the CCG under the terms of a contract) or the individual has been assessed by the pharmacist under the Disability Discrimination Act[23] and the device / system has been selected as the most appropriate option. If the device is a 7-day system and requires the production of 7-day prescriptions, this would need to be agreed by the prescriber and CCG. Many CCGs will not allow the issue of 7-day prescriptions, as it represents increased workload for the GP practice (although no additional cost to the CCG drugs budget). If the prescription requests a 28-day supply but the supply is required in 4x 7-day instalments, the prescription would need to be dispensed at one time as there is no provision for instalment dispensing, which may provide problems with storage and confusion for the individual.

Liability and accountability, in the case of incidents, will be dependent on contributory factors. It may well be that there is joint liability depending on the incident and circumstances of the error.

The importance when considering telecare in relation to medication handling is adherence to a protocol, good communication and collaborative working. As telecare becomes more established and evaluation is provided, areas of good practice will emerge. There are still many areas to be considered and challenges to be overcome. Successes have been demonstrated, e.g. reduction of medicine-related referrals and emergency situations, for example an epileptic individual using the prompting system. The prompt ensured the medication was taken at the correct time and reduced the number of seizures experienced (Staffordshire Medicine Reminder Initiative).

3.3   Pharmacists and Compliance Aids

The pharmacist is responsible for ensuring the correct medication is dispensed and labelled according to the prescriber's directions. Various devices, monitored dosage systems and compliance aids are available to assist individuals to administer their own medication. The individual's local pharmacy of choice should be contacted for guidance on the systems available. Neither the NHS nor Social Care normally fund compliance aids or the filling of them, so individuals may be asked to pay for this service. Individuals can be assessed by the pharmacist under the Disability Discrimination Act for the support needed to manage their medicines themselves.

The Royal Pharmaceutical Society has prepared guidance on compliance aids in *The better use of Multi-compartment Compliance Aids.*[24]

As with telecare devices, support / care workers should not repackage medicines into compliance aids (secondary dispensing) as the risk of error is significant.

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23 www.psnc.org.uk/uploaded_txt/PSNC%20guidance%20on%20the%20Disability%20Discrimination%20Act%20051205.pdf

24 www.rpharms.com/support-pdfs/rps-mca-july-2013.pdf

3.4   Working with Other Healthcare Professionals

A good relationship with other healthcare professionals is key in ensuring the individuals' wellbeing. Some individuals may be prescribed four or more medications (termed polypharmacy) and often these medications are obtained via repeat prescriptions. Under the General Medical Services (GMS) Quality Outcomes Framework[25] (QOF) all patients over 75 should have their medicines reviewed at least annually and for those individuals taking 4 or more medicines, medication reviews are recommended every 6 months. Individuals should be encouraged where appropriate to request regular medication reviews from their GP. This will ensure appropriate treatment for their condition and reduce the likelihood of adverse drug reactions and interactions between medicines.

3.5   Adherence

It is thought that between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended. This may vary over time and represents a loss to patients, the healthcare system and society. The costs are both personal and economic.[26]

There are many causes of non-adherence but they fall into two overlapping categories: intentional and unintentional.

- Unintentional non-adherence occurs when the patient wants to follow the agreed treatment but is prevented from doing so by barriers that are beyond their control. Examples include poor recall or difficulties in understanding the instructions, problems with using the treatment, inability to pay for the treatment, or simply forgetting to take it.

- Intentional non-adherence occurs when the patient decides not to follow the treatment recommendations. This is best understood in terms of the beliefs and preferences that influence the person's perceptions of the treatment and their motivation to start and continue with it.

It follows that to understand adherence to treatment we need to consider the beliefs and preferences that influence motivation to start and continue with treatment, as well as the practical factors that influence patients' ability to adhere to the agreed treatment.

Applying this approach requires:

- a frank and open approach which recognises that non-adherence may be very common and takes a no-blame approach, encouraging patients to discuss non-adherence and any doubts or concerns they have about treatment

- a patient-centred approach that encourages informed adherence

- identification of specific perceptual and practical barriers to adherence for each individual, both at the time of prescribing and during regular review, because perceptions, practical problems and adherence may change over time.

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25 www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework

26 https://www.nice.org.uk/guidance/cg76/resources/medicines-adherence-involving-patients-in-decisions-about-prescribed-medicines-and-supporting-adherence-975631782085

4. DANGERS and PITFALLS

The following is a list of known dangers and pitfalls in the handling of medication in ECH:

- Doors left open by individuals affording access to their medication by others.

- Individuals requiring the administration of medication by support / care workers not being in when the medication is due.

- Individuals purchasing OTC medicines.

- The difficulty of assessing if a "when required" (PRN) medicine is required if administered by support / care workers and the individual cannot communicate their wishes.

- Administration of medication to individuals with swallowing difficulties (dysphagia).

- Individuals who have a tendency to overdose on their medication.

- Individuals who can take their own medication if prompted but who often make errors with their medication.

- Individuals who take a double dose of medication if the first dose has been forgotten.

- Individuals who are unable to read.

- Individuals where English is not their first language.

- Individuals who manage their own medication usually but are then prescribed a medication which they cannot manage, e.g. eye drops.

- Elderly diabetic individuals who are unable to manage their medication.

- Individuals with failing sight.

- Medication labelled "as directed".

- Needs of the individual with dementia or memory impairment changing over time.

- Lack of discreet monitoring.

- Individuals or their relatives adding medication to pharmacy-filled dossette boxes or devices.

5. KEY LEARNING POINTS

- It is essential to have a robust medication policy with written procedures to ensure medication is handled safely and appropriately.

- The level of support an individual needs with medication must be clearly identified through risk assessment.

- It is necessary to ensure reassessment of medication needs, particularly after hospital discharge.

- If appropriate, ECH staff should be trained in medication administration and their competency assessed.

- It is essential to have up-to-date records of medication if administration is undertaken by support / care workers.

- An open culture for reporting medication errors should be in place within the ECH scheme. A system should be implemented to provide a clear incident reporting structure, investigation and audit of errors, production of an action plan and lessons to be learnt for the future.

6.   FREQUENTLY ASKED QUESTIONS (FAQs)

1.   *What level of training / competence is appropriate for level 2 and level 3 administration?*

The basis for the training for level 2 administration of medicines can be found by accessing the Skills for Care knowledge sets for medication. There must be a formal assessment on completion of the training. The aim is to ensure the support / care worker can confidently and correctly give medicines prescribed for the individual. Accompanying the support / care worker when they give medicines and observing that they do the key important tasks linked to the medication policy and procedures can achieve this. An assessment of competency is required. Reassessment should be undertaken to ensure standards are maintained and particularly if a support / care worker is involved in an incident concerning medication.

For level 3 administration (administration by a specialised technique), a Registered Nurse must delegate this task and will provide the training. The training is both individual specific and care / support worker specific. The important issues are that the individual consents to a care / support worker giving this treatment, the care / support worker agrees to do so and there are clear roles and responsibilities agreed. Competency again must be assessed.

2.   *Who is responsible for carrying out the risk assessment for medication and what is the situation if the individual has an individual assistant under the direct payments scheme?*

The individual responsible for undertaking the risk assessment will be determined by the policy of the registered provider. If a risk assessment is complex, the care provider may well wish to involve the GP. In the case of direct payments and individual assistants, the individual or someone who acts on their behalf will determine their own risks as they manage the whole process themselves.

3.   *What medication reminders and dispensers are available?*

There are a variety of medication devices available. Guidance on improving patient outcomes through the use of multi-compartment aids can be found here:

www.rpharms.com/support-pdfs/rps-mca-july-2013.pdf

4.   *Is there any further information available on how to manage medicines in individuals with sensory loss?*

Further information including patient information leaflets, Braille labels and talking labels can be found on the following websites:

www.rnib.org.uk/xpedio/groups/public/documents/publicwebsite/public_resoverviewmeds.hcsp

www.talkingproducts.co.uk/talking_labels.htm

www.pharmj.org.uk/Editorial/20060114/news/p33talkinglabels.html

www.rnib.org.uk/xpedio/groups/public/documents/publicwebsite/public_labelequipfs.hcsp

5.   *Are there any NHS / local interpreter services available for Patient Information Leaflets?*

To find out about the services available, contact your local social services or CCG (Clinical Commissioning Group) who will signpost you to the appropriate service provider.

Health information in other languages can be accessed via NHS Choices.

APPENDICES

Appendix 1 – Example Medication Safety Risk Assessment Tool[27]

Risk Assessment Tool for assessing the safety characteristics of medicines

Purpose

Pharmacy Voice's Patient Safety Group has worked closely with the UKMi to further develop their risk assessment tool, which is used regularly in secondary care settings, to make the tool more accessible and valuable for community pharmacy teams.

The Community Pharmacy Medication Safety Risk Assessment tool is designed as an aid in the systematic identification of potential patient safety issues associated with medicines before their introduction to clinical practice.

Background and definitions

New risks may be introduced into practice when a new medicine is introduced. Such risks may cause medication errors, harm, and potentially even fatalities to patients.

A new medicine could be
  ▪ any medicine which has not been used previously in a particular healthcare organisation or area of practice (including branded medicines recently launched onto the UK market and offering a new therapeutic option for a clinical indication)
  ▪ an established licensed medicine being used for the first time in a particular setting or organisation;
  ▪ unlicensed products being used for the first time
  ▪ a new strength, formulation or presentation of an existing medicine being used in response to a medicine shortage or for some other reason.

Individuals and organisations have professional and clinical governance responsibilities to ensure that the name, packaging and labelling of a medicine are compatible with its safe use.

This tool enables full consideration of the patient safety characteristics of all medications, whether they are licensed or otherwise. The tool is designed to be as holistic as possible; considering the pharmaceutical characteristics of the product, any links between a product's regulatory status and its safety in practice, as well as practical considerations such as issues associated with the product design.

How to use the tool

The tool can be used prospectively or retrospectively to assess products, their features, and how those could impact on their safe use. This will help determine whether any patient safety issues could arise in relation to a specific medicine. It can also be used as part of the learning process if any product-related incidents have arisen in a pharmacy.

The form should be completed by a pharmacy professional and any findings, particularly where the boxes next to text marked in red have been checked, should be shared with team members and the Superintendent Pharmacist if necessary.

Community Pharmacy Medication Safety Risk Assessment tool. Developed in collaboration with UKMi.

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27 http://pharmacyvoice.com/resource/risk-assessment-tool/

Community Pharmacy Medication Safety Risk Assessment Tool

Product	Strength	Pharmacy	Date

Themes	Assessment	Details/ notes
Current status		
Does the product have a UK marketing authorisation?	Yes ☐ No ☐	
Is there a suitable product available with a marketing authorisation for the indication in question?	Yes ☐ No ☐	
Is the medicine a licensed generic product that is being used instead of a branded product?	Yes ☐ No ☐	
Is the product readily and reliably available from a recognised supplier?	Yes ☐ No ☐	
Name, packaging and labelling, and other pharmaceutical issues		
Could the name of the medication be confused with those currently in existence? (Sound alike / look alike)	Yes ☐ No ☐	
Is the generic name clearly identifiable in English on the external packaging and internal blisters?	Yes ☐ No ☐	
Are all other critical details clearly identifiable in English on the packaging (e.g. strength, form, any product specific warnings, Batch Number, Expiry Date & storage conditions)	Yes ☐ No ☐	
Where the medication contains more than one active ingredient, are all constituents clearly stated on the packaging alongside the approved name?	Yes ☐ No ☐	
Does the packaging clearly differentiate between the various strengths of the same product (especially those which are visibly similar (e.g. 10mg and 100mg)?	Yes ☐ No ☐	
Is an English language Patient Information Leaflet available with the product?	Yes ☐ No ☐	
Information provided with the product		
Is appropriate technical information available in English to guide calculations, preparation, and administration?	Yes ☐ No ☐	
Prescribing risks		
Is the dosing and prescribing complex? Where necessary, is additional patient information available to support safe use of the medicine? For example, are steroid or lithium cards present if necessary?	Yes ☐ No ☐	
Is the prescribed dose consistent with the way the strength, form, and (where applicable) base salt are presented?	Yes ☐ No ☐	
Preparation, Calculation, Labelling, Information & Administration		
Are there current known operator safety issues with the drug?	Yes ☐ No ☐	
In the form presented, are commonly used doses easy to measure?	Yes ☐ No ☐	
Is the medicine supplied to the end user in a presentation that is: ▪ ready-to-use (i.e. correct volume and correct strength and is ready to draw up)? or ▪ ready-to-administer (i.e. in a final container ready for administration to the patient)?	Yes ☐ No ☐ Yes ☐ No ☐	
Does the product easily enable essential labelling to be in place at point of dispensing?	Yes ☐ No ☐	
Is the product barcode visible and available for scanning once the dispensing label is in place?	Yes ☐ No ☐	
Storage & Disposal		
Are there any specific storage requirements? e.g. refrigeration, space (if bulky), secure?	Yes ☐ No ☐	
Does the product pose any special risks during disposal to either the user or pharmacy?	Yes ☐ No ☐	
Additional Comments		
Other comments, concerns or observations		
Summary & Outcome		
Completed by:		

Appendix 2 - Example Medication Administration Record (MAR) Sheet

The MAR sheet lists a patient's medicines and doses along with spaces to record when the doses have been given and to specify exactly how much is given when the directions state, for example, 'one or two'.

It is also important to keep a record when prescribed medicine has not been given. Different letter 'codes' can be used to record reasons for when medicines have not been given. The MAR sheet must explain what the codes mean. There should be no 'gaps' on a MAR sheet.

The information on the MAR sheet will be supplemented by the person's care plan. The care plan will include personal preferences, including ethnic issues such as whether the worker who gives the medicines should be the same sex as the person.

The MAR sheet can be a useful tool for the care provider to keep track of medicines that are not requested every month but only taken occasionally. The provider can use the MAR sheet to record medicines carried over from a previous sheet.

Neither the pharmacist nor the dispensing doctor is required to provide MAR sheets but may be prepared to provide them on request.

People may choose to select a pharmacy that does provide MAR sheets.

MAR sheets used in care homes and home care settings look similar to 'prescription' charts used in hospitals but they are not equivalent to the prescription chart. The MAR sheet is only a record of what staff administer to people who use care services and belongs to the care provider. It is not a chart for prescribing medicines.

Medication Administration Record sheet

Name:	Start date:	End date:
D.O.B.	Doctor:	
Known allergies		
Address:		

Medication details	Week commencing														
	DAY														
	TIME	DOSE	Adm	WT	Adm	WT	Adm	WT	Adm	WT	Adm	WT	Adm	WT	Adm	WT
	Received		Returned			Returned by									
	Received		Returned			Returned by									
	Received		Returned			Returned by									
	Received		Returned			Returned by									

Codes to be used: R – Refused T – Taken NT – Not taken Adm – Administrate by WT – Witness by C – Hospitalised D – Social leave
E – Refused and destroyed P – Prompt NR – Not required M – Made available

Appendix 3 - Sample Protocol for Monitoring Adherence

1. Is there any evidence of medication not being taken?

E.g. tablets found on the floor, tablets left out, service user unable to open the container, tablets left in a dossette box, excess medication building up

Please state:

2. Is there any evidence of medication not being available?

E.g. medication not ordered on time

Please state:

3. Is there any evidence of deterioration of the service user's condition?

E.g. very breathless, constantly in pain, very drowsy, confused, more forgetful

Please state:

4. Have any concerns been reported to the line manager or GP?

Please state:

Note

The views expressed in this paper are those of the authors and not necessarily those of the Housing Learning and Improvement Network.

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 40,000 housing, health and social care professionals in England and Wales to exemplify innovative housing solutions for an ageing population.

Recognised by government and industry as a leading 'knowledge hub' on specialist housing, our online and regional networked activities:

- connect people, ideas and resources to inform and improve the range of housing choices that enable older and disabled people to live independently

- provide intelligence on latest funding, research, policy and practice developments, and

- raise the profile of specialist housing with developers, commissioners and providers to plan, design and deliver aspirational housing for an ageing population

For information about the Housing LIN's comprehensive list of online planning resources on extra care housing for older people visit:
www.housinglin.org.uk/Topics/browse/HousingExtraCare/

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