MEDICATION POLICY.

1. Introduction

Medication is an increasing and significant aspect of care currently being requested and delivered by domiciliary care organisations.

Prior to giving any assistance with medication and to meet the Regulator's registration requirements, Access Your Care Limited has developed a Medication Policy with accompanying procedures, which reflects our organisational circumstances, contractual obligations and indemnity insurance cover.

We ensure we keep up-to-date with changes to medication administration by taking note of regulatory guidance on medication issues, observing medication safety alerts and taking account of medication administration advice from organisations such as UKHCA, Royal Pharmaceutical Society, Department of Health and Local Authorities.

In order to ensure that our level of medication administration is delivered safely, we ensure that our Community Care Workers fully understand the constraints and implications of this policy and procedures and are trained to a competent level to deliver medication safely.

2. Definitions used with the document

We have used the term **Community Care Worker** to mean either:
(1) A person engaged by a member organisation to provide a homecare service to a client, or
(2) a worker introduced by a member organisation acting as an employment agency, where the agency does not have direct control over the Community Care Worker during the period of their employment by a client.

We have used the term **Manager** to mean a person responsible for the Community Care Worker's day to day line management.
This definition applies to the manager(s) of Community Care Workers on a day by day basis. It may also mean a person responsible for the selection, recruitment and training of Community Care Workers

Family Member means a person related to the client by blood, marriage or other significant personal relationship.

Client means an adult or child who receives a homecare service from our organisation.

We have used the term **Advocate** to mean a person who acts on the client's behalf. This can be with the formal consent of the client under a Power of Attorney in relation to financial matters and/ or welfare matters, or who has otherwise been attributed such rights. But in situations where the client has a lack of mental capacity the representative

is a person with a legal entitlement to act on the client's behalf for example a Receiver, Deputy or an Independent Mental Capacity Advocate appointed by the Court of Protection or under the MCA or otherwise. Representatives are most likely to be members of the client's family and friends or paid or voluntary advocates. In the case of children, representatives are most likely to be a parent or legal guardian. The term 'representative' in this Policy excludes commissioners.

We have used the term **Team Leader** to mean a person who takes advisory calls at the service headquarters and/or is normally responsible for co-ordinating care.

We have used the term **Team Leader** to mean a person who provides information, advice and team leader support to a Community Care Worker.

We use the term **Registered Manager** to mean the manager(s) registered with a statutory regulator and with a responsibility for ensuring that the homecare service operates efficiently and effectively.

We have used the term **Owner** to mean the person to whom the business legally belongs.

We use the term **Operations Director** to mean a person with managerial responsibility who travels throughout the region on behalf of the company and has a role of overseeing a specific aspect of care and/or support.

We use the term **Adult Community Care Worker** to mean a person at the local authority who has overall responsibility for the welfare of the client and is the named person with whom a domiciliary care organisation liaises.

We use the term **Social Worker** to mean a person qualified to Diploma in Social Work (Dip SW) level (including the Certificate in Social Service (CSS) and the Certificate of Qualification in Social Work (CQSW)) and has a responsibility for the welfare of the client and is the named person with whom a domiciliary care organisation liaises.

We use the term **Staff Led Team Leader** to identify a person more senior to a Community Care Worker either by way of qualification or experience. This person may be the line manager to the Community Care Worker.

We use the term **Medication Administration Record** to describe the document that records the medication a client requires assistance with and is signed when the Community Care Worker has helped the client to take the medication.

We use the term **Medication Record Sheet** to describe the document that
is completed by the Community Care Worker to record any information relevant to medication and any changes to the clients assessed level of support or changes to the usual support given during any one visit.

We use the term **Medication Support Plan** to describe the document where the Team Leader will document directions to Community Care staff regarding how the assessed needs for the client are to be delivered.

We use the term **Domiciliary Care** to indicate that the service is being provided in the client's own home.

We use the term **Local Authority** to identify the local government organisation that commissions social care services.

Medication Planning Documents

During assessment the Team Leader will complete a medication assessment record with the client detailing all medicines used by the client and how supplies are received and from which pharmacy. The level of support required with medication will also be discussed with the client and recorded on this form.

Clients file documents and procedure for recording assistance with medication.

Each file in the client's home contains a section marked Medication. Within this section there will be a medication Risk assessment document and medication support plan which details the level of support the client requires with their medicines and how staff are to carry out this support.
This section may also hold any documentation completed by the team leader pertaining to support the client may need with "when required medication", controlled drugs and any non-prescribed medicines.
The section contains the Medication Record Sheet, purchase/disposal of medication record and Mar chart.

Staff are required to check this section at each visit to the client.

Non prescribed medicines document.

In order for staff to assist with non-prescribed medication the client or their family (or, the Team Leader where this is not possible) must obtain written instruction from the GP or Pharmacist using the non-prescribed medicines form. Staff will not assist with non-prescribed medicines unless this is documented on the support plan.

Administering when required medication document

To be completed by the prescriber of the medicines; the responsibility for the completion of this form is with the Team Leader. Staff must report any as and when medicines immediately to the Team Leader prior to carrying support.

MAR chart
To be completed by staff when supporting with medication at Tier 1, 2, 3

Purchase/Disposal of medication document
To be completed by staff when medicines are purchased or removed from the client's home with their agreement.

Disposal of medication to pharmacist
To be signed by pharmacist and the Team Leader returning the medicines to the pharmacy

Medication Administration error/near miss document
To be completed by the staff and the Registered Manager when an error or near miss has occurred with a client's medication.

3. Scope of the policy

This Medication Policy outlines the requirements of Access Your Care Limited regarding the administration of medication by its staff.

Whilst this Policy covers all staff within the organisation, qualified nurses are also accountable for their own professional practice and must adhere to the Code of Conduct of the Nursing and Midwifery Council (NMC). Those managers who are themselves qualified nurses may be held professionally accountable for upholding the NMC code.

4. Aims of the policy

☐ To promote and maintain the client's rights, dignity and independence.

☐ To provide guidance for staff within the organisation to enable them to administer medication within the domiciliary care setting safely.

☐ To outline Community Care Workers' responsibilities when administering medication.

☐ To provide information to and work jointly with other members of the Community Team.

☐ To assist in compliance the minimum standards for domiciliary care.

5. Roles and responsibilities

Organisational Responsibilities

We will:

☐ Ensure that the medication policy and procedures for Access Your Care Limited are readily available and that all staff are aware of these and adhere to them.

☐ Ensure Community Care Workers receive administration of training preferably during induction, ensuring that they have theoretical and practical training on how to help with medication including when, how and who they should contact at Access Your Care Limited if they experience any problems.

☐ Have a medication administration record as part of the documentation given to clients. Medication records should indicate who the prescriber of each medication is, and how they can be contacted. (This is particularly important where more than one agency provides care).

☐ Ensure that a named health or social care professional has drawn up the medication administration record and a copy is kept at the client's home and forms part of the support plan and review.

- ☐ Ensure the assessment process includes the nature and extent of support required by clients and indicates how the client normally gives their consent to assistance with medication. These items should be recorded in the support plan.

- ☐ Put systems in place to ensure that a named health or social care professional makes changes to the medication administration record and that these changes are communicated to all relevant staff.

- ☐ Be responsible for liaison with any other member of the community care team involved in the client's care and to ensure that they are kept aware of any changes in circumstances whilst a member of staff is providing a service.

- ☐ Maintain the client's rights to independence, dignity and choice at all times.

- ☐ Ensure that all records and information relating to a client's treatment are kept confidential.

Community Care Workers' Responsibilities

Community Care Workers will:

- ☐ Be aware of and follow Access Your Care Limited's medication policy and procedures to ensure the safe assistance with medication to a client within their own home.

- ☐ Attend training sessions when asked to do so.

- ☐ Request training for any situation for which the worker does not feel suitably prepared.

- ☐ Inform the line manager of any changes in circumstances to the client.

- ☐ To seek the consent of the client each time the Community Care Worker assists with medication.

- ☐ Maintain the client's rights to independence, choice and choice at all times.

- ☐ Keep all information about a client's medication and treatment confidential.

- ☐ Never introduce, sell, offer advice or recommend any form of medication, remedy or preparation, including homeopathic and herbal.

6. Risk Assessment

A risk assessment is carried out for all clients who require assistance with medication or may be self-administering but require the occasional prompting.

A risk assessment is carried out to determine the possible risk to the client and/or the Community Care Worker when assisting with medication.

A risk assessment will also be carried out when a client request to keep their medications somewhere other than the ideal storage place (i.e. a cool, dry place). This will also identify whether anyone else might be at risk by keeping medication in these new storage positions and to ensure adequate control measures are in place to reduce the risks to the client or anyone else who comes into contact with the medication.

Copies of the risk assessment are discussed with Community Care Workers and kept with the support plan and/or Medication Administration Record in the client's home.

Community Care Workers will identify any changes in the client's condition that may require a new risk assessment can be undertaken. They must inform their manager if they feel a new risk assessment needs to be carried out.

7. Medication Reviews

Review, is an important part of a client's care. The period of time between initial assessment and review is normally discussed with the adult Community Care Worker at the local authority and the provider organisation (or determined by the organisation for a private client).

The support plan should be reviewed as agreed, and this should include any medication issues that form part of the support plan.

Once the review has taken place, any changes should be documented in the support plan and/or Medication Administration Record and communicated to staff.

A review might also take place for other reasons, such as:

☐ A change in the client's condition

☐ A debilitating illness

☐ A change in the client's capabilities

☐ To determine whether a different medication or route or an aid might maintain independence.

If this is the case, the reason for the review along with any changes should also be documented in the support plan and/or Medication Administration Record and communicated to staff.

8. Procedures

The policy contains a series of procedures which are a set of instructions to enable the policy to be accomplished.

The procedures which accompany this policy are outlined on the following pages.

(1) Assistance with medication

Many clients are capable of self-administration of medication. Access Your Care Limited does not assume that all clients need assistance. We maintain that self-administration is the preferred option for all clients who are able to do so. Often, by discussing their needs during the assessment process, ways can be found to maintain the client's independence in respect of self-medication.

However, in some instances our clients may need help with taking their medication.

We will assist our clients with first, second and third tier administration. This means we will either help them to take their medication only at their request i.e. all interventions are initiated at the request of the client. Community Care Workers might be asked to help with opening bottles and packets; shaking bottles; removing lids from bottles; popping pills out of packages; pouring out medicine etc.

Alternatively, the Community Care Worker may need to ask the client whether they have taken their medication or remind them to take their medication.

Additionally, we will assist a client with the administration of their medication. This means we will check the medication requirements against the Medication Administration Record, and then prepare the medicines by opening bottles and packets of tablets and removing them for the client to take; pouring out and giving a dose of medicine; opening a Monitored Dosage System and giving the medication to the client to take; applying creams; applying eye, ear and nose drops, and sometimes administering specialist medication (additional training and procedures will be required for this).

Our Community Care Workers will:

- ☐ administer tablets from medication compliance aids
- ☐ take out and administer tablets from bottles and packets
- ☐ pour out and administer medicine from bottles
- ☐ select and apply creams and lotions
- ☐ administer eye drops
- ☐ administer ear drops
- ☐ administer nose drops
- ☐ prepare and assist with the administration of inhalers
- ☐ prepare and assist with the administration of nebulisers
- ☐ prepare and administer food via a PEG
- ☐ prepare and administer medication via a PEG
- ☐ prepare and administer controlled drugs (See Section 6 of Policy)

Our Community Care Workers will not:

- ☐ Leave out medication to be taken later unless this has been discussed, agreed and is documented on the medication support plan.

- ☐ Crush, break or administer any medication other than in its licensed form.

(2) Communication

A system for the accurate and relevant exchange of information is vital due to the regular changes in personnel dealing with clients and for changes in the medication requirements of the client.

This process should start off with an assessment of the client's medication needs.

The Team Leader carries out the medication assessment which includes the nature and extent of support required by the client. It will indicate whether the client has consented to receive this help and will record how the client will give their consent to assistance with medication on a daily basis.

These items are then recorded in the support plan.

The support plan will be kept in the client's home. All visiting Community Care Workers are informed of where the support plan is kept and are given details of what is required verbally.

Community Care Workers will check the support plan when attending the client.

Once the assessment is complete a Medication Administration Record will need to be written which outlines what medication is due and when. The Team Leader will complete the medication record and put it with the support plan in the client's home. The Community Care Worker will refer to the Medication Administration Record when attending the client.

There will be times when our organisation works jointly with another agency to provide a package of care to a client.

When this happens, a key person is appointed who will take responsibility for any changes to the Medication Administration Record and ensure that these changes are communicated to all relevant staff.

If this person is from our organisation, it will be the Team Leader who will undertake this duty and be responsible for any changes to the Medication Administration Record. They will liaise with any other member of the community care team involved in the client's care to ensure that these changes are communicated to all relevant staff.

There will be times when our organisation works jointly with the family to provide care to a client.

When this happens, we have a system whereby a key person takes responsibility for any assistance with medication. In our organisation this will be the Team Leader.

This person will liaise with the family to determine what role they will play in caring for the client, and to determine any issues such as:

- ☐ Ensuring the family does not fill medication compliance aids which the Community Care Worker has to administer.
- ☐ Ensuring the family does not leave out tablets in pots for a Community Care Worker to give at a later time.
- ☐ Ensuring that they discuss with the family who will do what at any given time.

These decisions will be recorded in the support plan and the Team Leader will ensure that the decisions made are communicated to all relevant staff.
It is imperative that when dealing with medicines you are focused and concentrating on the task at hand.

(3) Obtaining consent

Consent is required prior to assisting with medication and clients can withdraw their consent to take medication at any time it suits them. This should be without Community Care Workers coercing them into taking something they do not want.

Consent is obtained during assessment. The assessment will indicate how the client normally gives their consent to assistance with medication. These items are recorded in the support plan.

However, consent is also to be obtained each time that the Community Care Worker visits to assist with medication. The client must consent to the Community Care Worker undertaking each medication task.

Community Care Worker training includes the importance of gaining the consent of the client at all times. A client is within their right to withdraw consent at any time. Our Community Care Workers will respect clients' wishes regarding consent at all times.

If a client withdrawals their consent, even if this is only a one-off refusal, it is to be recorded in the support plan and/or Medication Administration Record and reported to the line manager.

There may be times when a Community Care Worker or manager may need to discuss the client's medication with others such as a doctor, pharmacist, other care professional, relatives and/or a solicitor with enduring power of attorney. As far as possible, the client's consent will be sought before discussing their medication with one of these people.

There may be a situation where the Community Care Worker has requested an over the counter medication, in this instance the Community Care Worker must obtain the client's consent to check the requested medication for contra-indications with the prescriber.

When a client needs assistance with giving consent, if a Community Care Worker is concerned about the client's mental capacity or the client cannot give consent, then advice will be sought from key people (e.g. family member, medical personnel, and advocate) in the best interests of the client. This will be discussed with the Team Leader in the first instance.

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(4) Covert medication

Everyone is assumed to have the capacity to consent to whatever care and treatment is offered. This also extends to withdrawing this consent even if everyone else thinks this decision might be detrimental to the person's health and well-being.

Consent is therefore required prior to assisting with medication and likewise clients can withdraw their consent to take medication any time it suits them. This should be without Community Care Workers coercing them into taking a medication they do not want or without Community Care Workers giving the medication covertly (hidden in food and drink and taken without the client's knowledge).

Giving medication covertly could be interpreted as an assault on the client.

If the client is assessed as lacking the mental capacity to withdraw consent to a vital medication, but fights against taking it then 'best interest' meetings may be held to discuss whether covertly giving medication is in the client's best interests.

If this is the case, these meetings will be minuted and any decisions made translated onto the support plan for inclusion in the daily routine.

Community Care Workers will be informed about the new requirements and receive training to enable the covert medication to be given as decided.

Any covert medication to be given should be discussed with the pharmacist to ensure that the covert administration does not change the medication's licensed usage.
For each Medicine given covertly a separate risk assessment is required.
(See Mental Capacity assessment forms and Documents for further information)

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(5) Giving unlicensed medicines

Medicines are licensed to be used in a certain way, and this is explained either on the medication label or in the data sheet that comes with the medication. Therefore, medicines should not be crushed or capsules opened to enable clients to take medication more easily.

If a client is unable to take the particular form of medication, another form of the medication is often available.

The Community Care Worker should contact the Team Leader who will obtain the client's consent, and talk to the pharmacist to see whether another form of the medicine is available and whether this will require another prescription.

If the pharmacist advises that the prescriber must be contacted, the Community Care Worker should contact the prescriber to discuss a new form of medicine or a renewed prescription.

N.B. Staff **should not** take the advice of a doctor about crushing tablets or opening capsules. In extremely rare circumstances, this might be discussed with the pharmacist.

(6) Controlled Drugs (CDs)

Controlled drugs (CDs) are prescription only medicines which are controlled by the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. These controls are in place to prevent the medicines from being obtained illegally, from being misused or causing harm.

Controlled medicine is classified into five different groups (or schedules) which are dependent on their therapeutic use. Schedule 1 has the highest level of control (and is rarely used as it does not have any therapeutic effect) whilst schedule 5 has the lowest.

Community Care Workers in our organisation are able to administer controlled medication with the following restrictions:

Community Care Workers can only administer controlled medication from schedules 3, 4 and 5 of the Misuse of Drugs Regulations.

There are some additional safeguards that we expect our Community Care Workers to adhere to when giving controlled medication.
If the controlled medication is not in the MDS then a separate **Controlled Substances Medication Count Verification Form** must be completed.

Community Care Workers should note the amount of medication left in the care diary after administering each dose and record this on the **Controlled Substances Medication Count Verification Form**.

When collecting medication from the pharmacist, Community Care Workers ensure they take their ID with them and show this to the pharmacist if requested. If Community Care Workers are asked for their name and address this should also be given along with the name and address of the organisation.

Community Care Workers must also provide photo id and their signature on collection. They must inform the office of the collection date and time from the pharmacy. The delivery time to the client's home must be done immediately following collection of controlled medication from the pharmacy.

PRN (as and when required) controlled medication should only be given at the client's request and if there is a PRN document in the client's home file. When giving PRN controlled medication, Community Care Workers must be clear about the dosage and time that these can be given. Community Care Workers should carefully check when and how much of the previous dose was given, before preparing a new dose.

Once the medication has been given it should be recorded and the record should clearly state the dosage given and the time it was given so that Community Care Workers visiting at a later time are aware of what the client has received.

Community Care Workers must also, prior to administration of PRN medication ensure the correct timescale has elapsed between doses and that there are no contraindications with any other medication being taken by the client.

Once the controlled medication has been given, Community Care Workers must record accurately the time the medication was given, so that a Community Care Worker visiting at a later time does not give a second dose, thinking the original dose is late.

In addition, Community Care Workers should note that any liquid form or PRN medication of controlled drugs will only be administered if Access Your Care is solely responsible for the administration of medication to the client. If family or another agency has any involvement with the client's medication then Access Your Care will not administer any controlled medication with the exception of medication in the MDS.

If Community Care Workers are concerned about any controlled medication issues they must contact the Registered Manager to inform them of their concerns.

(7) Obtaining Prescriptions

There may be times when a Community Care Worker needs to order a prescription from a prescriber. If this happens, the Community Care Worker must go through the medications to find out which are required within the next week, they must then order these following the prescriber's usual ordering practice.

A record of the order will be made in the support plan or Medication Administration Record.

There may be times when a client requires a prescription to be collected from a prescriber. Our Community Care Workers are able to collect prescriptions from a prescriber.

There may be times when a client needs a Community Care Worker to take the prescription from the prescriber to the pharmacist to fill. Our Community Care Workers will provide this service.

There may be times when a client needs a Community Care Worker to collect a prescription from the pharmacy and bring it back to them. Our Community Care Workers will provide this service. (**Appendix 1)**

Any medication received that is to be administered by Community Care Workers is recorded on the Medication Administration Record.

The Community Care Worker collecting and bringing back medication from the pharmacy should enter in the Medication Administration Record, the generic name of the medication, the dosage, the frequency (including times) and the number of tablets in the package. The Community Care Worker will sign and date the record.

(8) Over the Counter (OTC) Medication

Over the Counter (OTC) is a term used to describe a medicine that is available from a pharmacist or a supermarket to treat common conditions without a prescription. For example, a cough medicine, pain killers or a hay fever remedy. They can also include some complimentary or homeopathic medicines.

Clients sometimes ask a Community Care Worker to purchase one of these medications from the pharmacist whilst they are out shopping.

The Community Care Worker must ensure that consent is received from the client to tell the prescriber what 'over the counter' medication has been requested so that any contra-indications or drug reactions can be identified.

The Community Care Worker must then contact the prescriber for permission to purchase this medication for the client. If the Community Care Worker is unable to get this permission, then they should not purchase the medication. Ideally, the Community Care Worker should ask the prescriber to prescribe the medication so that it can be given along with any other medication.

In this situation, if a client requests the Community Care Worker purchase such medication they must ask for a specific product by name, for example, 'Please get me some Ibuprofen cream' or 'Could you get me some Piriton tablets'. The Community Care Worker must not make decisions about the brand of medication, but can follow the advice of the pharmacist. E.g. If the client asked for Ibuprofen it would be acceptable to come back with Nurofen, if that is what the pharmacist gave them.

The Community Care Worker must follow the policy on shopping.

The Community Care Worker records the purchased 'over the counter' medication in the Medication Record Sheet and follows the procedure for Over the Counter medication attached to this Policy as **Appendix 2**

(9) As and when required (PRN) medication

'PRN' is an abbreviation of the Latin phrase for 'pro re nata', meaning 'when required'. The medication instructions should be written on the Medication Administration Record and/or support plan and should include a dose to be taken and also a maximum frequency.

It is at the discretion of the client when they feel that the medication is needed.

When a client requests a PRN medication the Community Care Worker will treat this as any other medication administration.

It is important that the dose given and the time it was given, is recorded on the Medication Administration Record.

Some PRN / 'when required' medicines are for use in an emergency, when a client may be unable to give clear instructions, for example vasodilator sprays prescribed for angina (cardiac chest pain) (E.g. GTN sprays).

We will administer medication to clients who are suffering from the following emergency conditions:

- ☐ cardiac pain
- ☐ severe pain
- ☐ acute manic attacks
- ☐ hypo/hyper glycaemic attacks
- ☐ severe breathing difficulties
- ☐ Medication for anaphylactic shock/reactions. E.g. Epipens

Staff will be trained specifically to meet the needs of each client requiring any emergency medication. Staff will not be able to give emergency medication until they have been assessed as competent to do so.

(10) Seeking Advice

There will be times when a Community Care Worker will need to ask for advice about a particular medication issue, or might need to report a problem with a client.

There are many different reasons why a Community Care Worker might need to do this e.g.:

- ☐ Advice about a possible medication reaction
- ☐ Advice about a dropped dose of medicine from a medication compliance aid
- ☐ Advice about missing or missed doses of medication
- ☐ Refusal
- ☐ Withdrawal of consent
- ☐ A client not being able to take a dose of medicine

Prior to assisting with medication the Community Care Worker should be given the name of the person they should contact in this instance along with their contact details.

In this organisation the Community Care Worker will contact the Staff Led Team Leader.

This person will be available when required. If this person is unavailable the Community Care Worker will contact the Registered Manager or On call Manager as any delay may cause undue stress or concern to both the Community Care Worker and client.

There may be an occasion where another professional may need to be contacted for advice e.g. a prescriber, a pharmacist, a district nurse.

If this is the case, it is the responsibility of the person from whom advice was originally sought to seek the relevant advice.

Any advice given to the Community Care Worker should be recorded by them on the Medication Record Sheet with the name of the person who provided the advice. The Person (Staff led team leader/ Registered Manager/On call Manager will record all relevant information and actions on the electronic data base.

On occasions where an adverse drug reaction (ADR) has occurred the Staff led team leader will report the symptoms experienced to the Yellow Card scheme (**See Appendix 3**)

(11) Personal Protective Equipment

Certain medication requires the use of additional equipment when it is being given.

We expect our Community Care Workers to wear gloves when handling the following medication:

- ☐ tablets from medication compliance aids
- ☐ tablets from bottles and packets
- ☐ Medicine from bottles
- ☐ Creams and lotions
- ☐ Eye drops
- ☐ Ear drops
- ☐ Nose drops
- ☐ Inhalers
- ☐ Nebulisers
- ☐ Food for a percutaneous endoscopic gastrostomy (PEGs)
- ☐ medication for a percutaneous endoscopic gastrostomy (PEGs)
- ☐ controlled drugs

We expect our Community Care Workers to wear aprons when handing the following medication:

- ☐ tablets from medication compliance aids
- ☐ tablets from bottles and packets
- ☐ medicine from bottles
- ☐ creams and lotions
- ☐ eye drops
- ☐ ear drops
- ☐ nose drops
- ☐ inhalers
- ☐ nebulisers
- ☐ food for a percutaneous endoscopic gastrostomy (PEGs)
- ☐ medication for a percutaneous endoscopic gastrostomy (PEGs)
- ☐ controlled drugs

Staff must change gloves between each cream application or, application of the same cream to another part of the body.

(12) Safe Keeping of Medication

Medication will be stored in a safe place, in accordance with the client's wishes and the risk assessment carried out by us. This will normally be in a cool dry place, within the client's home.

If there are specific instructions of how it should be stored e.g. kept in a fridge, kept out of direct sunlight, it will say this on the medication label and Community Care Workers will ensure medication is stored this way.

If, for any reason, the medication is to be hidden, e.g. there are children in the house, details of where it is kept this will be identified on the risk assessment and will be included in the Support Plan.

(13) Incident Reporting

There will be times when an incident occurs which must be reported by Community Care Workers. This can include:

- **Medication errors (e.g. overdoses, missed doses, wrong doses given, wrong medication given), particularly those involving controlled drugs**
- **Near Miss**
- **Reactions to medication (e.g. rashes, nausea, diarrhoea, shaking, stiffness and headaches)**
- **The client refuses to take medication**
- **The Community Care Worker refuses to give medication.**

Medication errors (e.g. overdoses, missed doses, wrong doses given, wrong medication given), (APPENDIX 4)

An error is a learning exercise and it is important that within a medication management system, errors are reported so that all can learn from the incident.

Near Miss

Near misses are recorded so that they can be used as empirical evidence within medication training sessions.

Medication errors are regarded as potentially serious events and this organisation follows good practice and guidelines from both NICE and the Royal Pharmaceutical Society

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

a) The experience of staff with regard to any previous incidences/errors
b) The events which participated the error, together with the clinical effect upon the Client.

Any of the following events are classified as errors:

a) Medication are given that are not prescribed
b) Medication are given at a time other than that prescribed
c) Medication are given via a route other than prescribed
d) There is an error or omission in recording
e) There is an omission of a prescribed medication (other than a specifically recorded omission).

Reactions to medication (e.g. rashes, nausea, diarrhoea, shaking, stiffness and headaches)

If the person becomes unwell suddenly, you may need to use first aid procedures and/or phone for the emergency services.
Do not make the client vomit, this could be harmful to them.

The client may suffer from an allergic reaction to any medication given. This may show up

in a variety of symptoms, which can include:

- ☐ Rashes
- ☐ Breathing difficulties
- ☐ Swellings
- ☐ Nausea (feeling sick)
- ☐ Vomiting (being sick)
- ☐ Diarrhoea
- ☐ Stiffness
- ☐ Shaking
- ☐ Headaches
- ☐ Drowsiness
- ☐ Constipation
- ☐ Weight gain

It is important that a Community Care Worker can recognise these symptoms. If any of these symptoms are observed the Community Care Worker should record the possible reaction and symptoms on the Medication Administration Record and/or support plan.
On occasions where an adverse drug reaction (ADR) has occurred the Staff led team leader will report the symptoms experienced to the Yellow Card scheme (**See Appendix 3**)

The client refuses to take medication

Sometimes a client may refuse to take their medication. However, there may be a simple reason why they have refused. If a client does refuse, the Community Care Worker must remember that consent to take one or all of their medicines can be withdrawn at any time.

If this occurs, the Community Care Worker should ask the client why they have refused and to ensure that the reason for this is recorded on the Medication Administration Record and/or support plan.

The Community Care Worker refuses to give medication.

Sometimes a Community Care Worker may be unable to, or refuses to give medication to a client. There may be a number of reasons for this such as:

- ☐ Something may be wrong with the medication
- ☐ There may be no medication left
- ☐ There may be concern about a dosage
- ☐ There may be some concern over what is required to be given
- ☐ The Medication Administration Record and/or support plan may be unreadable
- ☐ There may be a lack of understanding about what is required
- ☐ There may have been a lack of training
- ☐ The Community Care Worker may not feel confident to give the medication
- ☐ The medication may have already been given by the family

In this instance the Community Care Worker should record the reason for not being able to give the medication on the Medication Administration Record and/or support plan.

The Community Care Worker will report any of the above medication incidents to the

Registered Manager who will decide whether they need to contact the prescriber. Any instructions given by the Prescriber will be passed to the Community Care Worker to follow. The Community Care Worker will record the instructions given and followed on the Medication Record Sheet.
If any of the above medication scenarios cause actual harm or could be or become a safeguarding reportable incident, the Local Authority Adult Protection Team and Regulatory Body must be informed.
The team Leader OR On Call Manager must report any incidences sited above, and their actions to the Registered Manager immediately or, in their absence the Operations Director and record all actions on the clients records immediately. The Registered Manager and or the Operations Director are responsible for informing all statutory bodies as applicable.

(14) Record Keeping

Medication records form a very important part of assisting with a client's medication. It is important that all medication records are easy to understand and follow and, most importantly, they must be legible.

Our records comprise of:

☐ A Medication Administration Record

☐ A PRN Recording Sheet

☐ An OTC Recording Sheet

☐ A medication Support Plan

☐ Medication Record Sheet

☐ Medication Risk Assessment

☐ Controlled Substances Medication Count Verification Form.

The Medication Administration Record, details what medication has been prescribed for the client, when the medication should be given, what the dose is and how it should be taken.

The Medication Administration Record indicates who the prescriber is and gives their contact information.

The Medication Administration Record is used to determine which medication is due at the time of the visit. It should then be used to match up the details of the medication required to the details on each medicine container and/or compliance aid. It must be completed in full each time medication is given or should indicate why a medication has not been given. If the Medication Administration Record contains codes e.g. 'R' for 'Refused' these will be shown on the form and must be used whenever necessary. **Community Care Workers must not make up their own codes.**

The Medication Administration Record will assist the Community Care Worker to ensure that the right dose of the right medication is given to the right person at the right time by the right route.

Once the medication has been given, the relevant code must be entered by the Community Care Worker in the corresponding box. If a client has refused the medication an 'R' should be placed in the initial box on the Medication Administration Record and the reason for the refusal documented in the Medication Record Sheet. The office must also be informed.

If a mistake occurs the Community Care Worker must follow the section 13 of this policy: Incident Reporting.

The PRN Recording Sheet is similar to a Medication Administration Record but is used as a separate record of any PRN Medication the client may also be taking.

It should be used to match up the details of the medication required to the details on each PRN medicine container.

It must be completed in full each time medication is given. The record should clearly state the dosage given and the time it was given so that Community Care Workers visiting at a later time are aware of what the client has received.

The PRN Recoding Sheet is also used when receiving medication from the pharmacist to note the name of the medication, the quantity received and the date received.

When the Community Care Worker receives PRN medication from the pharmacy, they will record the generic name of the medication, the minimum and maximum dosage, the minimum and maximum frequency and the number of tablets in the package on the PRN Recording Sheet. The Community Care Worker will then sign and date the record.

The Medication support plan will tell the Community Care Worker what level of assistance they need to give and other directions such as allergies, where the medication is kept. The Community Care Worker will record in the support plan when this occurs.

The Medication Record Sheet is also used to give longer explanations for any inconsistencies recorded on the Medication Administration Record for example, when the medication has been refused, an error has occurred or more medication has been ordered.

(15) Disposal of Medication

Old, unused or out-of-date medication should be disposed of. The safest way to dispose of this medication is to return the medication and its container to the pharmacy.

Medication should NOT be disposed of down the sink or in the toilet unless this is a one-off spat-out dose.

Medication is the property of the client. The Community Care Worker must not take on the responsibility of disposing of old or out-of-date medication without discussing this first with the client. To take medication from the home without the client's consent could be seen as theft.

If the client dies, and the Community Care Workers understands that a coroner might be involved in determining cause of death, the Community Care Worker should advise family members that the medication should remain in the home for up to 7 days, or until the Coroner issues the death certificate, after which time the medication can be disposed of.

See Appendix 5 for Procedure of the disposal of medication

Medication which can only be administered subject to Specific Conditions

There are three main methods of medication, which require specific training. These methods of administration are outlined below along with the related specific conditions. The specific conditions, which are in addition to the general conditions outlined in Policy need to be met prior to administration.

For the purposes of this Policy Guidance there are no differences between controlled drugs and other prescription-only drugs.

Methods of Administration Conditions
Eye, ear and nose drops (Instillation)

1. All general conditions above are met.
2. The Client consents to the Community Care Worker undertaking the task.
3. These are prescribed, and written on the MAR sheet as with any other form of medication.
4. The Community Care Worker has received suitable training to administer eye, ear and nose drops, been assessed as competent to complete the task, and a record of such training is held by the agency.

Inhalers and nebulisers; Oxygen (Inhalation)
All general conditions above are met.
The Client consents to the Community Care Worker undertaking the task.
These are prescribed, and written on the MAR sheet as with any other form of medication.
The Community Care Worker has received suitable training to administer inhalers, nebulisers or oxygen, specifically to meet the individual Client's needs, has been assessed as competent to complete the task, and a record of such training is held by the agency.
Training records are kept by the organisation.
It should be noted that often two inhalers are used and that they may need to be taken in a specific order. If this is the case the Community Care Worker should be made aware of this fact.
Oxygen therapy carries inherent combustion risks. The Organisation will take advice from the prescriber or from a competent care professional and/or health and safety advisor.
Oxygen has COSHH risk assessment implications over and above those normally associated with medication.

Any form of invasive therapy e.g. injections, enemas, suppositories, naso-gastric / PEG administration; Emergency PRN medication; Any form of medication that involves skilled observation to be made before, during or after administration; Cytotoxic Drugs

All general conditions above are met
These are prescribed, and written on the MAR sheet as with any other form of medication.
The Client consents to the Community Care Worker undertaking the task.
The Community Care Worker has received suitable training for giving the

identified invasive therapies, specifically to meet the individual Client's needs and has been assessed as competent to complete the task.
A record of such training is held by the agency.
All training received by Community Care Workers must be recorded and kept on file by the home care organisation.
Cytotoxic drugs have a COSHH risk assessment implication over and above those normally associated with medication.

Warfarin Guidance and Administration Record

This guidance has been developed to support the management and administering of warfarin prescriptions for Clients. If Warfarin is to be administered a separate risk assessment must be completed by the Team Leader and signed off by the Registered Manager

What is warfarin and why is it used?

Warfarin is a medicine in the group of medicines known as anticoagulants. Anticoagulants reduce the ability of the blood to clot. This is necessary if the blood clots too much, as blood clots can block blood vessels and lead to conditions such as a stroke or a heart attack.

Warfarin must be administered from original packs NOT MDS.

What other anticoagulants are available?

There are a number of new oral anticoagulants now available. These do not require the same blood testing regime as warfarin. These new agents include dabigatran, rivaroxaban and apixaban. These anticoagulants may be prescribed using a MDS

Why is warfarin a high risk medicine?

Many medicines, foods and alcohol can increase or decrease the effect that warfarin has on blood clotting. Achieving a dosage of warfarin that's both safe for the patient and sufficient to prevent thrombotic events needs regular blood monitoring. If a patient's score (INR) is too high on a blood clotting scale, then there's a real risk of bleeding; too low and there's a risk of blood clots.

Best practice points for safe administration of warfarin:

• The Organisation has a written protocol for administration for warfarin.

• Staff who administer anticoagulants or support people to take their own must be trained to undertake their duties safely

• Staff administering warfarin should be familiar with different colours of various strengths.

• Clients have copy of their "yellow book" which they should take to all warfarin clinic appointments.

• Staff administering warfarin should cross check the last INR result, when the next blood test is due and the current dose EVERY time warfarin is administered.

• Record administration on the warfarin administration record. The MAR sheet should be annotated 'refer to warfarin chart'.

• Warfarin should be administered at the same time each day.

• Record missed doses on the warfarin chart. Don't give an extra dose.

• Changes to medication or significant dietary changes may increase the frequency of blood testing required. Seek advice from the pharmacist, GP or clinic.

• Report the following side effects immediately:

- Nose bleeds
- Black coloured faeces
- Severe or spontaneous bruising
- Unusual headaches

Further information can be found in the NPSA Anticoagulant patient safety alert - Advice for social care providers.

Managing dose changes for warfarin

• Warfarin doses should be confirmed by prescribers in writing or by fax where possible.

• If written confirmation is not available and a verbal instruction is given, dose changes should be recorded using the warfarin verbal instruction form
• Verbal instructions to change a prescription can only be made in the following circumstances
a) To discontinue a medication
b) To increase or decrease the dosage of a current prescription
• Verbal instructions cannot be taken for a new prescription.
• TWO staff members should independently receive and read back the instruction to the prescriber, record the dose and witness with a signature.

Recording administration of warfarin
As warfarin is a high-risk medicine, accurate recording of doses and administration is of paramount importance. The warfarin administration record (attached) must be used to facilitate accurate recording.
Administration should only be recorded and signed for on one administration record. therefore, each warfarin entry on the person's MAR chart should be annotated "refer to warfarin chart".
Warfarin will only be administered by this orgainisation if:

1. There is no other medicine or option for the client.
2. The client has no family or friends to assist them.
3. The Warfarin administration form is a pharmacy supplied document

9. Training

Access Your Care Limited ensures that staff are competent to help with medication. Training is done by a combination of simulation, observation and appropriate questioning techniques, which we fully document.

Training is broken down into two parts, induction training and training for first, second and third tier medication assistance.

- ☐ Levels of Administration of Medication
- ☐ Communication
- ☐ Consent
- ☐ Covert medication
- ☐ Giving unlicensed medicines
- ☐ Controlled Drugs (CDs)
- ☐ Obtaining prescriptions
- ☐ 'Over the Counter' medication
- ☐ 'As and When Required' medication
- ☐ Seeking advice
- ☐ Personal protective equipment
- ☐ Safe keeping of medication
- ☐ Incident reporting
- ☐ Record keeping
- ☐ Disposal of medication

The Training Plan is based on the above procedures and can be seen in Section 10 of the Policy.

10. Training Plan

Our medication training consists of two parts:

☐ Induction
☐ First, Second and Third Tier Medication Training

This training is based on UKHCA's Medication Policy Guidance and their Medication Train the Trainer programme.

INDUCTION TRAINING

Our Update Training consists of:

☐ ***Medication aims*** - This session will explore privacy, dignity, independence, choice and consent.
☐ ***Medication background and knowledge*** - This session will explore key legislation about medication.
☐ ***Policies and procedures -*** This session will summarise the importance of Community Care Workers understanding of our organisation's medication policy and procedures.
☐ ***Roles and boundaries*** - This session will explore levels of expectation
☐ ***What can and can't be done*** - This session will re-affirm Community Care Workers' role in medication.

The training will conclude with an induction competency test.

FIRST, SECOND AND THIRD TIER MEDICATION TRAINING

Our First, Second and Third Tier Medication Training consists of:

☐ ***Introduction -*** to the training
☐ ***Client Independence -*** this session will explain the importance of maintaining client independence
☐ ***Classification of medication*** - this session reviews how medication can be purchased
☐ ***Types of medication -*** this session covers what medication can be given including controlled medication and anti-coagulant patient safety alert
☐ ***Routes of medication -*** this session outlines the different routes permitted
☐ ***Contra-indications -*** this session will outline possible interactions with other medication
☐ ***Consent -*** this session will explore why consent is important
☐ ***Covert medication -*** this session will explain what this is and what to look out for
☐ ***Giving unlicensed medication -*** this session will explain what this means and what to look out for
☐ ***Risk assessment -*** this session gives advice on what to look out for
☐ ***The six 'Rights' of medication administration*** - this session gives advice to ensure safety
☐ ***Checking medication*** - this session is to ensure safety
☐ ***Problems checking medication***
☐ ***Preparing to administer medication***

- ☐ ***Reporting and seeking advice -*** this session outlines what should be reported and how to get advice
- ☐ ***Recording -*** this session looks at the recording process
- ☐ ***Medication storage -*** this session explains how medication should be stored
- ☐ ***Audit of stock -*** this session explains what to look out for
- ☐ ***Disposal of medication -*** this session reviews the legal issues about disposal including what to do in the event of death
- ☐ ***Conclusion -*** to the session

The training will conclude with theory and practical competency tests.

Policy Reviewed	Policy Updated (Pages)	By	Next Review Date
November18th 2018	Appendix 3	Wendy Finnegan	15.05.19
March 30th 2019	Additional guidelines for thickeners and change to drugs	Wendy Finnegan	15.07.19
April 12th 2019	Medication internal procedures updated ad reviewed	Wendy Finnegan	15.07.19

Appendix one

PROCEDURE FOR COLLECTING "one off" PRESCRIPTIONS

A Community Care Worker may be required to collect a prescription from the surgery or collect a prescription from the pharmacy.

This procedure should only be adopted where there are no family members, friends or representatives to undertake the task and where it forms part of a care package referral.

It is the responsibility of the Client or family to ensure continuity of supply of medication, in exceptional circumstances, where there is no one able to do this, it is the responsibility of the Organisation to ensure continuity of supply by submitting the prescription to the surgery on a regular basis. If this is the case this task must be documented as part of the Clients medication support plan.

1. The dispensed medication should be collected and taken to the Client in the Clients allocated time with minimum delay. Under no circumstances should staff hold onto medication until the next visit or pass the medication to another member of staff for delivery.

2. The Medication Record Sheet must detail what medication the Community Care Worker has collected. This must be completed by the Community Care Worker as a record of collection of the medication.

3. The Community Care Worker must check the medication collected against the current Medication Administration Record (MAR). If the medication collected is different to the current MAR the Community Care Worker must contact the office immediately to report any changes.

4. The Team Leader or Manager will give authorisation to the Community Care Worker to change the MAR. (Only Community Care Workers who have been trained to change medication records are permitted to do this task)

5. The Community Care Worker collecting and bringing back medication from the pharmacy should enter in the Medication Administration Record, the generic name of the medication, the dosage, the frequency (including times) and the number of tablets in the package.

6. The Community Care Worker will sign and date the record.

7. The Team Leader or Manager will amend the office MAR to reflect the changes.

8. It is the responsibility of the Team Leader to visit the client and sign off the changes in their home within 3 working days.

Appendix Two

PROCEDURE FOR Over the Counter Medication

1. A Community Care Worker may be asked by a client to purchase Over the Counter medicines.

2. This procedure should only be adopted where the client is unable to do so themselves and there are no family members, friends or representatives to undertake the task and where the task has been identified as part of the support plan.

3. The Community Care Worker must ensure they have gained consent from the client to discuss what over the counter medication they wish to purchase. This should be documented on the Medication Record Sheet.

4. Over the Counter medication cannot be collected or purchased by staff unless the over the counter assessment has been completed by the prescriber or Pharmacist. Once completed the Community Care Worker must ensure that:

5. The medication is collected and taken to the Client in the Clients allocated time with minimum delay. Under no circumstances should staff hold onto medication until the next visit or pass the medication to another member of staff for delivery.

6. The Medication Record Sheet must detail what medication the Community Care Worker has collected. This must be completed by the Community Care Worker as a record of collection of the medication.

7. The Team Leader or Manager will give authorisation to the Community Care Worker to change the MAR. (Only Community Care Workers who have been trained to change medication records are permitted to do this task)

8. The Community Care Worker collecting and bringing back medication from the pharmacy should enter in the Medication Administration Record, the generic name of the medication, the dosage, the frequency (including times) and the number of tablets in the package.

9. The Community Care Worker will sign and date the record.

10. The Team Leader or Manager will amend the office MAR to reflect the changes.

11. It is the responsibility of the Team Leader to visit the client and sign off the changes in their home within 3 working days.

Appendix 3

PROCEDURE FOR MEDICATION INCIDENT/ERROR

- If a medication incident/Error occurs the Community Care Worker must report it to the Office team, On call Manager/Overnight Supervisor, the Medication Lead or Registered Manager.
- The person in receipt of the incident will inform the GP or 111 if required regarding the incident and seek advice and or medical attention for the client. They will also inform the Registered Manager or in their absence the Medication lead of the incident.

- The Community Care Worker must record the error immediately on the Medication Error form in the clients home and also on the Medication Record Sheet. In any case a medication error form must be completed either by the person who has made the mistake or the person who has found the mistake.

- The person in receipt of the incident will complete and action the Medication error form and give it to the medication lead or Registered Manager. If out of office hours the Error form must be completed electronically, actioned and saved in the Manager/Overnight Supervisor Handover to office folder.

- The person in receipt of the Error/Incident will contact the client's family/representative if appropriate to do so, their GP and where appropriate the Social Worker, Commissioner of the service and Regulatory Body.

- The person in receipt of the Error/Incident must open a client event "medication Error and document the events in detail with actions taken.
- The manager will investigate the incident, a meeting must then take place between the registered manager / Medication Lead and the Community Care Worker responsible for the error to ascertain the cause of the error and to plan what action needs to be taken to prevent the error occurring again.

- All actions will be recorded on the Medication Incident/Error form and, once completed will be filed by the Registered Manager in the Medication error folder.

- The Registered Manager/Medication Lead must update the event once they have completed their actions and are responsible for closing the event

- Lessons learnt will be documented by the Registered Manager/Medication Lead and disseminated to staff via the recognised communication channels.

For the avoidance of doubt if the Registered Manager is not available the Manager on Call must inform the Operations Director immediately of an error, near miss or reaction to medication.

Appendix 4

PROCEDURE FOR REMOVAL OF UNWANTED MEDICATION

The Client, a family member, friend or representative will undertake this task preferably. If however the client cannot manage this task independently then any unwanted, discontinued or expired medication must be returned to the office for disposal by the Community Care Worker.

Where no family or other person exists, staff should follow the procedure set out below:

1. The client must consent to the removal of medication. This must be documented in the medication support record

2. Staff should put the medication for removal to one side in a place of safety, so it cannot be administered by mistake

3. Staff should put the medication in a brown medication envelope and document the name of each table, colour, strength and the name of the client on the envelope (if a dosette box is to be removed, the medication should be left in the dosette box and the whole box removed)

4. The 'Disposal of Medication Form' (found in the client's home folder) must be completed and signed by the member of staff and countersigned with the client's consent to remove the medication

5. Medication must be returned immediately to the office and signed in by the member of staff by documenting the medication on the 'medication disposal record R24 office form'

6. The medication must be placed in the medication safe by a manager and 'medication disposal record R24 office form' countersigned

This procedure is the same for Controlled Drugs.

Appendix 5

PROCESS FOR DISPOSAL OF MEDICATION FROM OFFICE

1. The medication disposal record R24 document must be audited against all medications in the medication safe

2. The audit must be carried out by 2 people one of whom must be a manager of the service

3. Once the audit is complete and the contents of the medication safe correspond to the medication disposal record R24 the auditor takes a R24 medication return record sheet and numbers this.

4. All medication details are recorded on the R24 medication returns sheets. A photocopy is taken and placed with the original

5. The medication and return sheets are taken to a pharmacy for the pharmacist to countersign both copies

6. The copy is left with the pharmacist and the original brought back to the office

7. The auditor takes the R24 medication disposal record and the return. The forms are staples together and filed in the medication file located in the care office.

Appendix 7

Instillation of Eye Drops and Ointments

Following from the assessment of need and appropriate recording in the Medication Plan of Care, the care worker will assist with the instillation of eye drops and ointments. Care workers will only administer eye drops or ointments:

- From their original container
- When they have received appropriate training and been assessed as competent to carry out the task
- At the appropriate time according to the prescriber's instructions.

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

From the MAR chart, check

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

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

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

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

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

The care worker should collect the equipment and lay it on a suitable surface near the Client where there is a good light source; they should then explain the procedure to the Client.

The care worker should then check the following:

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

Once the care worker has washed their hands they should:

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

Eye Drops

- The dropper should be held approximately 2.5cm from the Client's eye, if they are being instilled without the use of an aid
- Gently squeeze the bottle
- Ask the Client to close their eye, keeping the tissue in place for one to two minute(s). Wipe away any excess from the Client's face.

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

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

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

Eye Ointment

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

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

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

Instillation of Ear Drops

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

- Have received appropriate training and been assessed as competent to carry out the task.

From the MAR chart, check:

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

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

- The name on the drops is that of the Client
- The label states clearly which ear the product is to be used for
- The dosage
- The time to be administered.

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

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

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

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

- Wash their hands thoroughly
- Complete and sign the MAR chart
- Record any comments relating to the product applied, including any observations

requested
- Return the product to where it is stored
- Assist the Client to sit up and adopt their choice of position and location.

Application of Hosiery

The care worker applying the hosiery should:
- Ensure the hosiery is clean and wrinkle free, with no tears or frays
- Explain the procedure to the Client
- Run their hand inside the stocking down to the heel and pinch the heel with finger and thumb
- Turn the stocking inside out leaving the foot part tucked in
- Pull the foot part gently over the Client's toes and ease over the foot taking care to check the toes and heel are correctly positioned and wrinkle free
- Gather up remaining stocking and take it over the foot and lower leg. Working in sections from the ankle pull the stocking up the leg in short folds of about 2 inches (5cm) at a time without forcing and keeping it wrinkle free
- When the stocking is fully extended on the leg, take the top back down to the calf hold the top stocking up the leg again to ensure it remains in place
- If applying thigh length hosiery secure with a suspender belt.

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

Hosiery should be washed at 40 degrees and hung to dry (UNDER NO CIRCUMSTANCES SHOULD THEY BE IRONED)
Clients should always wear hosiery on both legs.
Hosiery should be replaced every three months or earlier if they become damaged or worn.

Hosiery Removal

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

When the hosiery has been removed the care worker should gently wash and dry the Client's skin using warm water and soap. Skin covered by hosiery can become very dry; if a cream has been prescribed then this should be applied; if no cream has been prescribed then the Client's surgery should be contacted to seek advice.
If the hosiery is to be reapplied immediately following skin cleansing it is advisable to apply a light dusting of powder to the skin to aid application. If an application aid has been provided this should be used according to the manufacturer's instruction

Catheter Care

A catheter is a thin, hollow, flexible tube designed to drain urine from the bladder. The catheter is kept in place by a small balloon at its tip filled with sterile water which prevents it from falling out. It is inserted into the bladder through the urethra. This is a small opening above the vagina in women and runs along the length of the penis in men. In some people it may be necessary to insert the catheter into the bladder through an incision through the abdominal wall.

Catheter care when assisting in showering or bathing

- Hands must be washed before and after handling the catheter or drainage bag
- Disposable gloves must be worn
- The area around the catheter is required to be washed with soap and water at least daily or after every bowel motion.
- Before assisting the Client to shower or bathe, empty the drainage bag, but leave it connected.
- Avoid using talc or creams around the catheter.

Drainage Bags

- Leg bags should be worn in a comfortable position against the thigh, knee or calf area (according to individual preference) and secured to the leg by straps or a sleeve/holder. The Belly Bag is worn as a bum bag and is secured by a soft belt around the waist.
- In order to minimise the risk of infection it is essential to wash your hands before and after emptying, or changing the bag. Put on disposable gloves before starting the procedure.
- When emptying the bag make sure that the outlet does not come into contact with the toilet or other receptacle and the outlet tap is dried with a disposable wipe following emptying.
- The drainage bag should only be disconnected from the catheter when absolutely necessary to reduce the risk of introducing infection. It should be changed every 5 – 7 days unless discoloured/soiled. When applying a new drainage bag to the catheter it is important, when removing the cap, not to touch the sterile connector.
- All drainage bags are designed for single use only and must not be re-used. For whatever reason a drainage bag is disconnected from the catheter a fresh bag must always be re applied.
- At night connect a larger capacity bag onto the leg bag. The outlet tap on the leg bag should be in the open position to allow the urine to flow into the night bag. When removing the protective cap from the night bag do not touch the sterile connector which attaches to the outlet tap. A stand for the night bag will be provided and should be used to promote effective drainage.
- To disconnect the night bag from the leg bag wash your hands, close the outlet tap on the leg bag and disconnect the tubing from the tap. Dry the outlet tap with a disposable wipe Empty night bag into the toilet and dispose of the bag in the dustbin, ensuring it is wrapped in newspaper or a plastic bag. Wash your hands.

Disposing of Drainage Bags

- Drainage bags may be disposed of in the dustbin, provided they have been emptied and wrapped in newspaper or a plastic bag. If provided into clinical waste bags

Catheter Valves

- Catheter valves are used as an alternative for some Clients to a leg bag. A catheter

valve is a tap that is connected directly to the catheter outlet. It allows drainage of urine from the bladder to be controlled, and helps maintain bladder muscle tone and a good capacity.

- It is very important that the valve is opened at regular intervals throughout the day, every 3 – 4 hours to allow the bladder to empty. If you do not empty the bladder regularly you may experience some abdominal discomfort as the bladder becomes full or you may experience leakage of urine around the catheter.

Care of the Catheter Valve

- The catheter valve should be changed every 5 – 7 days. In order to minimise the risk of infection it is essential to wash your hands before and after emptying, or changing the valve. When emptying the valve try to make sure that the outlet does not come into contact with toilet or other receptacle and the outlet tap is dried with a disposable wipe following emptying.
- Attach an overnight bag to the valve. Once the night bag is connected, the valve should be in the open position to allow urine to drain.
- Disposing of Catheter Valves
- Catheter valves should be paced in a plastic bag before putting in the dustbin or in clinical waste bags if provided.
- It is important for a person with a catheter to have a good fluid intake. It is important to encourage the Client to drink as this helps prevent infection and helps avoid constipation. 2 litres is often the recommended amount unless indicated otherwise by a doctor or nurse.
- A healthy, balanced diet helps prevent constipation. Constipation can prevent the catheter flowing freely as a full bowel presses on the catheter, this is a common cause of leakage around the catheter.
- Where possible gentle exercise will help the catheter to drain

Indicators of a urine infection

- The urine becomes cloudy, contains blood or smells offensive.
- The Client complains of a stinging or burning in the bladder or low back pain.

This should be reported at once to the office who will notify the district nurse or GP. The Client should also be encouraged to drink plenty of fluids.

Blockage of the catheter

It may occur it the catheter or tubing becomes kinked, there is an irritation in the bladder, a build-up of debris in the catheter or if the Client is constipated.

- Check the catheter and tubing and release any kinks
- Check the drainage bag is not too full
- Make sure the leg or night bag is positioned below the level of your bladder or waist to allow urine drainage
- If no urine is draining contact the office and district nurse as soon as possible.

Stoma Care

An ostomy is a surgically made opening from the inside of an organ to the outside. Stoma is the Greek for *mouth* or *opening*. The stoma is the part of the ostomy attached to the skin. A stoma bag is then attached to the opening, in the case of colostomies, ileostomies and urostomies, so that either faeces or urine drain into this bag. There are various types of ostomies - for example:

- Colostomy - opening from the large intestine to the abdominal wall so faeces bypass the anal canal.
- Ileostomy - opening from the small intestine to the abdominal wall so faeces bypass the large intestine and the anal canal.
- Gastrostomy and jejunostomy - openings between the stomach and jejunum respectively and the abdominal wall, used predominantly for enteral feeding tubes.

Reasons for Stomas

- Gastrointestinal stomas are used in various disorders - eg, inflammatory bowel disease, neoplasia and diverticular disease.
- Stomas may be temporary or permanent. Temporary stomas are usually reversed at a later date, usually allowing the blind loop of intestine to recover.

Psychological effects

Having a stoma is a major event and Clients can become very anxious and depressed. Adequate counselling is vital and this may need to include mental health specialists. Quality of life can deteriorate for Clients following stoma procedure. The first few weeks post-stoma are the most vital. They may also have difficulty managing their stoma around their life - e.g., going out shopping and needing to change the stoma bag without adequate facilities. This can add to a low mood. Supportive family and friends are essential and may help in situations like this. Stoma bags will also have an impact on body image and intimate relationships may suffer
During the first few weeks following the formation of a colostomy or ileostomy, patients may experience sudden urges to defecate. This is known as the 'phantom rectum' and can be very distressing for patients. Reassurance and support are helpful
There may be changes to the amount and consistency of faeces. With ileostomies, faeces are produced about four hours after a main meal, whereas with a colostomy, faeces are produced the following morning. Ileostomies are associated with increased output. Often Clients have to change their diet to control wind and malodour - e.g., that caused by fizzy drinks and fish respectively. Flatus filters are also available.

Leakage of the contents of the stoma bag can occur and can make Clients very distressed. Recurrent leakage can lead to skin inflammation from contact.

Before carrying out Stoma care the staff member will be trained by a health professional. This will include use of equipment required for the cleaning of the individual stoma and recognising any abnormalities that need reporting

The aims of stoma care are:

- to ensure that the skin around the stoma (peri-stomal) is kept clean and dry
- to observe the stoma and discourage skin excoriation
- to ensure a safe and comfortable application of an appliance
- to help a Client in the acceptance of stoma (if a newly formed and permanent appliance)

Proceed as follows:

- Assemble required equipment.
- Inform the Client of the procedure and obtain consent
- After asking or supporting the Client to lie down, wash hands and put on gloves and apron to reduce risk of cross-infection
- Protect bed and Client by placing towel/disposable pads under stoma
- Remove soiled appliance, noting amount and consistency of contents to determine any abnormalities
- Observe stoma size, shape and colour to determine bleeding, prolapse, retraction, necrosis, infection
- Observe surrounding skin area to determine excoriation, redness, allergy or herniation.
- Wash the stoma and surrounding skin with warm soapy water. Dry thoroughly to ensure that adhesive will stick
- Fix the appliance into position, (different methods being used for a variety of appliances), ensuring that no peri-stomal skin is exposed to body fluids. Ensure also a "snug" fit so that leakage does not occur
- Remove gloves and apron, then wash hands. Reassure Client and ensuring comfort.
- Dispose of soiled materials into the toilet where possible or put in a plastic bag before disposal in the dustbin or clinical waste bags if provided
- Record results in the care notes. Report any abnormalities as required.