Care workers and social care staff clinical tasks and medicines policy

Joint policy to assist frail, older and vulnerable people and adults with disabilities in the community with the administration of their medicines and clinical tasks.

This covers top-level agreements and guidance for Social Care / Supported Living / Care Providers / Somerset Clinical Commissioning Group. Care providers have additional detailed policies explaining working practices.

This is a working document and will be reviewed and revised regularly

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Contents

Contact for queries
If you have a question or query relating to this policy please contact Andrew Palk by email AJPalk@somerset.gov.uk

He can then put your question to a virtual panel which has representation from all organisations.

Glossary and definitions

Care manager	SW/DN/CPN who has the main responsibility for co-ordination of the care package
Care package	Services such as home care/domiciliary care purchased/arranged by health/ASC
Care plan	The document that outlines service users needs and how they will be met, identifying the care package needed for the service user
CCG	Clinical Commissioning Group
Clinical professional	Health professional responsible for communication / training of patient health care tasks
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
DCS	Domiciliary care staff employed by the provider
DN	District Nurse
DNAR	Do Not Attempt Resuscitation
GP	General Practitioner
Housing related Support	Preventative service for housing related support funded by SCC
MAR chart	Medicine Administration Record – documents all of a service user's current prescribed medicines, including externally applied and as required (prn) medicines.
Medicines	Examples of medicines include tablets/capsules/liquid medicines, ear/eye drops, dressings, creams/ointments, anti-embolic stockings and inhaler devices
Nurse	District Nurse / Community Nurse / Community Psychiatric Nurse
PEG	Percutaneous Endoscopic Gastronotomy
PPE	Personal protective equipment
Prescriber	GP/Doctor/Consultant and non medical prescribers who prescribed medication
PRN	Pro re nata (as needed)
Provider/s	Independent home care/domiciliary care provider
Service user	The person in receipt of the domiciliary care service provided
SCC	Somerset County Council
SW	Social worker

1 Introduction

This policy provides domiciliary care managers and their staff, who work for care providers registered with CQC to provide personal care, with a guide to good practice about supporting service users with their medicines. It sets out the maximum that commissioners can expect from domiciliary care providers. Individual providers will have their own detailed policies that will follow, but not exceed, the principles and tasks as set out in this policy

It details:

- The difference between assisting someone with medicines and administering medicines to them
- Specific health care tasks that may be carried out by domiciliary care staff (DCS)
- Recording
- Training and competencies
- Procedures

This policy supports key regulations as set out in the CQC Regulations for service providers and managers that are taken from The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Namely:

- Regulation 9 – Person Centred Care
- Regulation 10 – Dignity and respect
- Regulation 11 – Consent
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding people from abuse

Key Points

DCS are employed primarily to provide social care and should not undertake tasks that would normally be completed by trained nursing/medical personnel, even though some DCS may have nursing qualifications. Parents/relatives/carers should be made aware that nursing care will not be provided by DCS. Some nursing care tasks may be requested from health care staff to be undertaken in care establishments.

The responsibility for all delegated health care tasks remains with the clinical professional. Accountability for delivering the health care task is with the DCS providing the clinical professional and their employer has deemed them competent (see section 6). Training records must be completed (see appendix 7).

Any DCS who fails to follow the procedure following training will be the responsibility of the employer, unless it is proven that the training has not complied with the standard required. If this is the case the lead healthcare trainer is accountable for the individual and specific tasks.

Care providers must make sure that DCS job descriptions includes a reference to “adherence to all employer polices”

Any concerns with the management or use of medicines or controlled drugs should always be raised with the accountable officer for the organisation.

Any concerns with the care provision should be raised with the care manager or the lead for vulnerable adults.

Housing related support workers do not provide personal, domestic or health care. They will provide support for advocacy with health professionals over medicines, but do not administer or assist service users to take medication, but may carry out tasks outlined in section 3.1. In some cases DCS will also be carrying out housing related support through a joint contract. The distinction between the tasks and outcomes of the two roles will be made clear in the service user's care and support plans.

Providers registered to provide treatment of disease or disorder of injury are not required to follow this policy.

2 Principles of the policy

Definitions

Please note these definitions are as described by CQC for care workers and social care staff. The guidance for health staff may be different

Assistance with administration means that the service user defines and selects what medicine they require and the DCS assists them with this task. The service user is in control. Reminding a person can also be defined as assistance providing they have the capacity to refuse - but see section 3.1(a).
Administration of medicines means that the service user is unable to ask for their medicine and needs to be reminded, or where the medicine is directly administered by the DCS.

2.01 As a general rule people should be encouraged to administer their own medicine and all options to facilitate self-administration, such as reminder charts or compliance aids, must first be explored. However, there are people who are unable to manage this task on their own and have no alternative source of assistance. Many of these people receive domiciliary support from DCS employed by Domiciliary Care providers under contract to Somerset County Council.

The County Council has agreed that there are circumstances where service users may receive help with the administration of certain medicines from DCS employed by independent providers. This policy is designed to safeguard those unable to administer their own medicines and those undertaking the task.

2.02 Implementation of the guidance is dependent on close co-operation between Health and Social Care in partnership with providers. An assessment by a SW must confirm a need for assistance with or administration of medicines. More complex cases may need a joint assessment with a DN/CPN. The Lead Professional must include the Pharmacist in the decision making process. The DCS key workers who take the lead on medicines for the service user should be clearly identified on the care plan.

It must be emphasised that this guidance and agreement means that Social Care or providers of domiciliary care:

- Will undergo training regarding the administration of the agreed medicines and be signed off as competent by their employer.

- Will rarely accept referrals just to administer medicines, eye/ear drops and anti-embolic stockings. However if a person is at risk and meets the National eligibility criteria for care and there is no alternative person able to undertake the task they may be agreed on an individual basis. All alternative solutions must have been explored and exhausted.
- Will only provide **assistance**[1] with any 'as required' medicines to a service user (see appendix 10) when delivering a care package when there are clear instructions in the care plan and on the label of the medicine for:
  - the specific circumstances when the medicine is to be used
  - what dose of medicine is to be taken.
- Will only obtain or collect prescriptions in exceptional circumstances.

2.03 The guidelines are intended to assist staff when they help service users to take their medicines, ear/eye drops during routine visits for other purposes. They are not being asked to accept responsibility for 'managing' or 'monitoring' medication programmes.

2.04 Providers will have their own individual policies detailing how they will deal with Over the Counter (OTC) medicines.

2.05 All tasks that are undertaken by DCS **must be** recorded in the service user's record. The service user retains the right to refuse to take their medicines and staff assisting must respect this right. Under no circumstances should any staff assisting a service user try to force the user to take their medicine, or disguise it in their food or drink. Forcing a service user to take a medicine would constitute an assault. (Please see section 12.7 Mental Capacity Act). A clear process of what to do in these circumstances will be delivered by the Provider.

2.06 The service user must agree in writing to the provision of assistance and this agreement is believed to be valid during the period of assistance. (Please see section 12, Mental Capacity Act and appendix 1, consent form).

2.07 In the event of someone having no capacity (as defined in the Mental Capacity Act), the GP or prescribing practitioner must be consulted about establishing arrangements for administering medicines that protect both the service user and the DCS.

2.08 The Prescriber will require assurance that a DCS has received appropriate instruction and aids for each individual service user and that they are competent to undertake the task (see appendix 6).

2.09 Under no circumstances should a DCS take any instruction from a family member/ third party /non health professional to administer medicines in a way that is non-compliant with the prescriber's instructions.

2.10 DCS may administer prescribed medicines to the client for whom the medicines have been prescribed. However, administration of medicines by

[1] See definition of assistance on page 5

invasive techniques is the responsibility of the Health Service. For example, subcutaneous and intramuscular injections.

2.11 Both assistance with and administration of medicines must be approved by the Provider or Health as appropriate.

2.12 The DCS must have received the necessary training and guidance and will be signed off as competent by the Provider or Health before undertaking the tasks. The DCS should be aware of the escalation plans in place for the service user (see appendix 6).

2.13 DCS should check that the fridge appears to be working correctly if the medicines are stored within it. If the DCS has a concern with the temperature they should inform the service user or their family to make the appropriate changes. This should also be reported to their manager and an agreed course of action discussed.

3 Definitions of Assisted Clinical Tasks

a) There are important conditions attached to each level of task that must be fulfilled before a DCS undertakes any care. It should be noted that because a task appears on a list, it does **not** mean that a DCS will automatically perform the task. DCS are not obliged to carry out any task that has not been agreed in this policy.

b) Care should be taken by staff not to confuse intimate personal care tasks with clinical tasks. Intimate personal care will often be necessary to allow a clinical task to be carried out.

c) All tasks that are undertaken **must** be recorded in the service user's records and documented using the appropriate appendices attached (for example, for application of medicated patches use appendix 4).

Categories of task:
Training for tasks is the responsibility of the care provider. Approval and sign off of competencies is normally the responsibility of the care provider accept for those tasks listed in 3.3b

3.1

Level one – General Support. Also called Assisting with medicines
The DCS is always working under the direction of the person receiving care.

The support given may include some or all of the following:

a) **An occasional reminder or verbal prompt. This should be no more than once a week. A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medicines and should prompt a review of the person's care plan.**
b) **Collecting medicines from the pharmacy in exceptional circumstances.**
c) **Manipulation of a container, for example opening a bottle of liquid medicine or popping tablets out of their original pharmacy dispensed**

packaging at the request of the service user and when the DCS has not been required to select the medication.

d) **Requesting repeat prescriptions from the GP.**
e) **Returning unwanted medicines to the pharmacy (see section 10).**
f) **When the person receiving the care asks the DCS to put out their medicine to enable them to take it at a later time. This should only be permitted following a risk assessment and in accordance with the Handling of Medicines in Social Care.**
g) **If medication has not been taken and this is clearly visible, the DCS will document this in the client's notes and inform their manager who will report this to the clinical professional.**

3.2

Level two - Administering medicines/clinical tasks (Acceptable Tasks)

The task is within the range of activity normally undertaken by DCS who have received the appropriate training, and are signed off as competent by their registered manager, following the Department protocol. See section 5.
DCS should only administer medicines from the original container, dispensed and labelled by a pharmacist or dispensing GP.

Where these conditions are not satisfied, the responsibility for the task remains with the Health Service.

Administration of medicines may include some or all of the following:

a) The DCS selects and prepares medicines for immediate administration from the packaging as supplied by the pharmacy in accordance with the current MAR chart.
b) Administration of liquid medicines.
c) Application of topical creams and ointments where skin is unbroken.
d) Administration of ear drops, eye drops and eye ointments

Acceptable clinical tasks include:

e) Inserting hearing aids, fitting supports (trusses), artificial limbs, braces or non-prescription support stockings.
f) Basic mouth care.
g) Timely reporting of any problems about pressure care in relation to prevention and good practice to prevent skin breakdown.
h) Replacing a bag to an existing urinary catheter, emptying and measuring urine, if required. (If a care package is shared between providers just use one chart for monitoring activity. A lead provider must be identified).
i) Administration of PRN (as required) medicines (see appendix 10)
j) Applying a replacement dressing, without otherwise cleaning or treating the site (as a first aid measure)

3.3

Level three: Specialised techniques (Negotiable Tasks: for individual service users)

These health care tasks **may** be performed by DCS, in agreement with the Provider. The individual DCS will need to feel confident, have been trained by the Provider or Health and be willing to carry out this higher level of task. This will have been negotiated between Health, Provider and the service user following the agreed protocol (See section 4). The prescribing practitioner remains clinically accountable.

Where these conditions are not satisfied, the responsibility for the task remains with the Health Service.

This section may include some or all of the following:

3.3a (signed off by provider)

a) Administering patients own oxygen-which will be stored safely, following risk assessment procedures
b) Assisting cleaning around gastrostomy tube sites
c) Changing/replacing colostomy bags
d) Changing/replacing ileostomy bags
e) Changing/replacing urostomy bags
f) Cleaning of a supra-pubic urinary catheter site

3.3b (signed off by a registered professional)

a) Administering anaphylactic pens, as an emergency procedure only
b) Assisting the service user with the taking of a capillary blood glucose test before they self-administer insulin.
c) Administering pre-set doses of insulin (dependent on glucose reading and advice taken from clinical professional when required as set out in the care and support plan). Also see Exception Circumstances – Appendix 6
d) Administering rectal diazepam, only as an emergency procedure and subject to on-going review
e) Administering routine, pre-measured doses of medicines via an inhaler with a spacer if needed or nebuliser as a regular procedure for chronic conditions only.
f) Administering suppositories
g) Administration of liquid buccal Midazolam for status epilepticus
h) Administration of medicine through a gastrostomy tube (PEG)
i) Administration of regular rectal enemas. (Administration of phosphate enemas is only permitted following a risk assessment and only used in Learning Disabilities service in consultation with the health service).
j) Assisting with gastrostomy tube feeding, by attaching feed tube to PEG where not associated with medication and where the condition is stable. To include flushing/cleaning of the 'PEG Tube'
k) Assisting with obtaining midstream urine specimens, or a faecal specimen, that has been medically requested (not day care settings).
l) Assisting with Transcutaneous Nerve Stimulation (T.E.N.s) machines, only where their use has been approved by the GP or other appropriate health care professional
m) Changing dressings (as part of an agreed care plan)
n) Changing two piece system of stoma
o) Flushing to unblock PEG
p) Fitting prescription support stockings

q) Fitting prescription anti-embolic (TED) stockings
r) Inserting prosthetic eye (false eye)
s) Oral aspiration of excess saliva from the front of the mouth only
t) Administering Pessaries
u) Putting on penile sheaths and connecting sheath to urine bag
v) Removal and application of medicinal patches (First patch must be fitted by nurse) For example, Fentanyl patches (analgesia) and Nicotine patches (smoking cessation). (See appendix 4)
w) Toenail cutting

3.4

Level 4: Nurse Led – Care Management model: These healthcare tasks may only be performed by those care providers that employ Registered Nurses and are able to offer on-site training, assessment and supervision to the individual DCS.

Each healthcare task requires specialised training and the individual DCS must be signed off as competent by the Registered Nurse or health professional for each patient "Patient specific competencies". The Registered Nurse must review the care plan on a regular basis.

a) Administration of medicines through a nebuliser for acute or emergency conditions
b) Administration of medicines through a naso-gastric tube
c) Giving any medicines by injection
d) Intermittent catheterisation
e) Management of supra-pubic catheters, other than emptying the urine
f) Manual evacuation of the bowel
g) Naso-gastric tube feeding
h) Obtaining a specimen by way of an in-dwelling urinary catheter
i) Urine dip testing
j) Maintaining urinary catheter patency as part of an agreed care plan
k) Diagnostic recording: rating blood pressure, temperature or pulse

3.5

Tasks not performed by DCS

Any tasks that are not listed in levels 1-3 are not to be performed by DCS in any circumstances. The list below provides some examples of tasks not to be performed (in addition to those listed in 3.4).

a) Administration of pre-drawn medicines must **not** be given under **any circumstances**.
b) Aspiration of naso-gastric tube
c) Assisting with the cleaning and replacement of tracheostomy tubes
d) Assisting with the dialysis process
e) Bladder compression
f) Flushing to unblock central or peripheral access cannulae.
g) Management and treatment of pressure sores
h) Nasal washing
i) Syringe driver pain relief systems
j) Taking of venous blood samples
k) Use of the "Just in case" box

3.6 Emergency procedures

3.6.1 There will be occasions when a service user's personal safety may be at risk and where urgent intervention is required. However, whatever the circumstances, staff should not put themselves at risk.

3.6.2 If a DCS is seriously concerned about a service user's physical condition and they have had appropriate first hand training from a health care professional and feel confident of intervening in an emergency situation, they can do so only as a first aid measure. They must make sure that an ambulance is called using the 999 emergency service.

3.6.3 This particularly applies to the administration of rectal diazepam and Midazolam when a service user has an epileptic seizure and there is a risk of Status Epilepticus occurring. The preferred course of action is for an ambulance to be called using the 999 emergency service. For some service users more immediate intervention will be necessary and this may be carried out by named staff members in accordance with the procedures established in section 5 below.

3.6.4 In some specialist services for people with profound and multiple disabilities, frequency of seizures (and administration) would place a particular burden on the ambulance service and significantly impact on the care of the service user. In these circumstances as long as the procedures established in section 4 can be met, the administration of rectal diazepam is a task that may be delegated to social care staff.

3.6.5 In all circumstances the service user's GP, care manager, family or carer should be informed.

3.6.6 Administration of medicines from a Just in Case box is for use by health staff only and must not be used by DCS.

3.7 Resuscitation

3.7.1 In the event of a service user appearing to suffer a cardiac or respiratory arrest, an ambulance must be called using the 999 emergency service. In addition, a DCS trained in resuscitation should carry out emergency life saving procedures.

3.7.2 DCS must never make a decision themselves not to resuscitate.

3.7.3 If there is a valid Do Not Attempt Resuscitation (DNAR) directive recorded in the care plan this should be respected.

4 Developing individual protocols/care plans

4.1 Before carrying out any of the clinical tasks that have been identified as being within the provider's remit, it must have been agreed that:

a) If a service user lacks capacity, refer to Section 12, Mental Capacity. Consent must be documented in the care plan by the DCS.

b) As part of the induction training programme all DCS will receive the appropriate training from their Provider as indicated in Appendix 5.

c) If the task requires health training the appropriate health care professional will give clear instructions by means of an individually established protocol/care plan and will confirm that the DCS is able to perform the task by assessing competency.

d) The care manager who prescribed the treatment plan should review the protocol/care plan at least annually. The outcome of the review should be recorded. The review should link to the supervisory arrangements of the staff member within their organisation.

e) The protocol/care plan must be kept safely and be easily accessible to the person performing the care/clinical task.

5 Training

5.1 All staff must have received appropriate training and risk assessment completed where appropriate before the tasks listed in section 3.1 are undertaken.

5.2 The tasks listed in section 3.2 all require training to have been given by the Provider. Staff must sign to say that training has been received and understood.

5.3 The tasks listed in section 3.3 all require training to have been given by the relevant Health or Social Care Provider. Staff must sign to say that training has been received and understood and the trainer involved must sign to say the person is competent to complete the tasks. (See appendix 6).

5.4 Training can be direct to the patient or using a mannequin (body pump), but must reflect the individual care plan of the person and must be clearly recorded.

5.5 Tasks listed in section 3.4 are **not** to be carried out by DCS/provider staff and are identified as tasks that require a trained health care professional to perform.

5.6 DCS are not permitted to pass on any training they receive for tasks in 3.3 to other staff. Competence to complete these tasks must be signed off by the trainer and reassessed annually as part of their annual appraisal. The Provider may need to ask for reassessment by the health professional delegating the task.

5.7 In case of changes to local or national guidance that require urgent re-training, providers must be able to easily access information to identify which DCS are deemed competent to perform a particular task.

5.8 Basic medicines awareness training will be delivered by Providers to all DCS before assisting service users with their medicines.

5.9 This training will include administration of medicines from their original packaging and other dispensing systems and how to record on MAR charts.

5.10 Training will include guidance about circumstances when staff should seek advice from their line manager before assisting with administration of medicines.

5.11 Training should include any actions to be taken in the event of an error or incident occurring in any medicines or clinical task.

6 Competencies

6.1 Through supervision and review meetings line managers will make sure that DCS are still competent to carry out the delegated health tasks they have received training to do. (See section 1). Refresher training and re-training should be available if identified by the DCS manager as needed, who will liaise with the healthcare professional to organise. This should always be given to staff that return after a break in service before carrying out these tasks.

7 Referrals

7.1 Assessment of the care needs of someone living in the community may identify a need for assistance with self-medication. The assessment will record the professional most involved and the care manager names will also be in the care plan. The care manager will make requests for assistance with administration of medicine. Details about administration of the medicine must be stated in the agreed care plan.

7.2 The key to the delivery of this service will be in the flexibility between nursing staff and care providers. In each case there will be a need to determine an appropriate DCS but to acknowledge that interagency working is essential, especially in emergencies.

7.3 If the person lacks capacity and has no one who can advocate for them an Independent Mental Capacity Advocate (IMCA) referral must be completed if patients are refusing serious medical treatment.

8 Procedures

8.1 In all cases the care manager should arrange for the service user to sign a consent form (appendix 1). When a person is unable to give consent, for example does not have capacity to sign, the prescribing practitioner must first agree that it is appropriate for a DCS to provide regular assistance with the administration of medicine in a person's home by signing the consent form.

8.2 The administration of medicine or assistance with ear/eye drops for example, must be recorded on every occasion. Any refusal, error, or other incident

regarding medicines or other clinical task must be reported to the Provider who will take the necessary action. This record should remain with the 'patient' notes within the service user's home.

8.3 In cases where a service user has capacity to retain responsibility for the management of their medicine, but is unable to self-administer without physical assistance, their consent covers the provision of this assistance only. In these circumstances the drugs record sheet must be completed for continuity purposes and as a means of protecting staff assisting with administration.

8.4 Reviewing of the appropriateness of administering medicines should be an integral part of all normal review meetings with each individual service user. Sometimes it may be necessary to have more frequent reviews to respond to changing individual service user needs. If a care manager becomes aware of any change to the medication needs or regime during their review visit this should be communicated to the prescriber. This may be through the DN/CPN and the provider. (Reference should be made to the Mental Capacity Act if required).

8.5 The review of administration of medicines should form part of the care plan review process and will be undertaken by the care manager in conjunction with the DCS and their line manager.

8.6 The provider maintains a file for each service user, detailing the care provided. Where DCS are involved in the administration of medicines, the file will contain information supplied by health service workers as follows:

a) A copy of the service users consent form

b) Medicines involved

c) Any concerns relating to the administering of medicines, eye drops/ear drops to a particular service user must be referred to the prescriber. This may be through the DN/CPN or pharmacist or the nursing team if they are involved in the care of the service user. Make sure the contact has been recorded.

8.7 If the drug label is more than twelve months old (during annual review checks) it should be referred back to the prescriber to check it is still relevant. If medicine is being hoarded this should also be referred back to the prescriber.

9 Changes to prescriptions

9.1 **(This section is proposed but not yet in operation as still awaiting GP feedback)**
Care providers can send a standard letter (appendix 3) to the prescribing GP or the discharge ward asking to be notified of any changes to the clients prescribed medicines. This will aid with the safe administration of medicines for both the service user and the DCS.

9.2 The prescriber should make efforts to understand the support the person needs to take their medicines, and to prescribe doses that take account of existing care and support arrangements where possible.

9.3 Where DCS identify problems with the medicines, for example it hinders the person's daily routines, contact should be made with the pharmacy and/or GP to check if an alternative is available to better suit the person.

9.4 If, for any reason a person is unable to take their medicines in the format provided, contact should be made with the prescriber to see if the medicine is available in another formulation. A DCS must not crush or split tablets to alter the dosage unless there is written confirmation from the prescriber.

10 Disposal of medicines

10.1 The disposal of unused medicines is the responsibility of either the service user or their relatives. We recommend that they are returned to the dispensing pharmacy for safe disposal.

10.2 When there is no one else who can dispose of unused medicines, a risk assessment should be completed making clear the procedure to follow. It is recommended that the pharmacy be contacted to ask if they will collect. However there may be a cost to the service user for this service

10.3 When all other options for disposal have been exhausted, to ensure service user safety, the DCS may dispose of the medicines. It is recommended that providers have an envelope that unused medicines can be returned to the pharmacists in, clearly labelled "medication for disposal"

10.4 The service user must sign to say they have given consent to this method of disposal, and confirm the contents of the medicines being disposed. On receipt of the returned medicines the pharmacy should also sign. Please see appendix 9 for a sample form to use.

10.5 If the service user is unable to give consent, the medicines should not be removed. Please notify a manager to agree the appropriate course of action to take in the best interests of the person

10.6 It is recommended that used patches should folded in half, sealed in a bag and thrown away in the refuse.

10.7 Clinical waste is any waste that poses a threat of infection to humans. This would include blood or bodily fluids, swabs or dressings, syringes or other sharp instruments used for treatment. Clinical waste collections can be arranged by contacting the Local Council (District level) in the area that the person lives. They will ask about the type of waste and recommend the best method of collection (some, low risk clinical waste, may be collected within normal refuse). They will supply appropriate sacks or boxes.

11 Non prescribed drugs

11.1 Care providers will have their own policies and procedures for managing drugs that have not been prescribed by a healthcare professional, whether these are illegal substances or drugs lawfully purchased over the counter.

12 Mental capacity

12.1 The Mental Capacity Act 2005 sets out a statutory framework for acting and making decisions on behalf of adults aged 16 years and over who lack the mental capacity to act or make such decisions for themselves. The Act sets out safeguards to empower and protect a person assessed as lacking mental capacity and those who can act on their behalf.

12.2 The five underpinning principles of the Act say:

1) A person must be assumed to have capacity unless it is established that they lack capacity.
2) A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3) A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

12.3 A person is unable to make a decision if they cannot:

1) Understand information about the decision to be made.
2) Retain that information in their mind.
3) Use or weigh up that information as part of the decision-making process, or
4) Communicate their decision

12.4 Mental capacity is the ability to make an informed decision. A person lacks capacity if they are unable to make a decision at the time it is needed because of an impairment of, or a disturbance in the functioning of, the mind or brain.

12.5 Assessment of capacity must be undertaken for medical and clinical tasks as detailed in this policy.

12.6 If the decision is made that the person lacks mental capacity, the decision to continue with the administration of medicines in the person's best interest lies with the prescribing practitioner. (See appendix 8)

12.7 **Covert medication**. It is only permissible to administer medicines covertly if the person lacks capacity, they are refusing to take their medicines and the prescribing practitioner believes it is in the person's best interest to be given the medicines against their wishes, due to the potential seriousness of not receiving the treatment.

Agreement must be sought from the GP, family, relevant others and especially the pharmacist as detailed by National Medical Council, and there must be a clear care plan for the administration to be agreed by the prescribing practitioner.

13 General Information

13.1 Names of DCS involved in assisting the service user and dates of their medicine awareness training for delegated specialist tasks are held electronically by care providers.

13.2 This is a general policy and does not allow for events/circumstances not covered in this document.

14 References

- CQC – Professional Advice: The administration of medicines in domiciliary care
- CSCI – Professional Advice: Training care workers to safely administer medicines in care homes
- Royal Pharmaceutical Society of Great Britain: The Handling of Medicines in Social Care
- UK Home Care Association – Medication policy guidance
- Mental Health Act 2005
- Existing polices – SCC / LD / Brunelcare / Care South

15 Acknowledgments

The policy has been updated in 2008/09/10/11/12/13/14/15/16 in consultation with: Fred Parkyn (SCC ASC), Betty Chandler (SCC ASC), Michelle Crumb (Somerset Community Health), Nicky Dalton (Care Providers), Tina East (Care Providers), Mel Axon (Somerset Partnership for SCC LD), Denise Mutter (Supporting People), Andrew Palk (SCC ASC), Claire Waddon (Care Focus), Brian Brown (CQC), Dr. Harry Yoxall (GP), Viv Streeter (Supporting People), Helen Whyte (Care Providers), James Laing (Somerset Partnership NHS Trust), Andrew Cole (Somerset Partnership NHS Trust), Liz Harewood (Somerset Partnership), Sue Wilmot (SCC ASC), Deborah Avis (Care Provider), Julie Tyhurst (Care Provider), Amanda Smith (Somerset Community Health), Nina Vinall (Somerset Community Health), Vanda Squire (Somerset Community Health), Mary Martin (Somerset Community Health), Judi Crossman (SCC LD), Paul Rennie (NHS Somerset), Andrew Brown (Somerset Community Health), Shaun Green (NHS Somerset), Sheila Burridge (SCC), Kate Roberts (pharmacy), Catherine Henley (CCG), Paula Gue (Providers), Jill Pearson (Providers), Anne Whaley (Providers), Lisa Stone (Somerset Partnership), Jenny Coles (Care Focus), Sarah Pullen (CHC), Karen Taylor (CCG)

(Note: Some organisation names have changed over the years which is intentionally not reflected in the list) Andrew Palk (April 2016)

Appendix 1

Somerset County Council
Somerset Clinical Commissioning Group
Somerset Partnership NHS and Social Care Trust

Administration of medicines patient/service user agreement form

Name ……

Address ……

……

……

……

Section A – Your written consent

☐ I give my consent for a Domiciliary Care Assistant to support and assist me to take my medicine. I understand the staff member will not have a nursing qualification. Any medicine that they assist me with or which I refuse or omit will be recorded on a drugs record sheet.

☐ I give my consent for my GP to tell my care agency what medication I am using at any time

Signature ……

Date ……

Section B – Your verbal consent given to someone else

If you are unable to sign because of a disability, a relative / carer / advocate may sign for you providing you have given them verbal consent. Please tick this box to indicate this is the reason for someone else signing the form ☐

Signature and name ……

Relationship to service user

……

Date ……

Section C - Consent given by prescribing practitioner

If the person is not able to consent, then the prescribing practitioner must decide that the medicine maybe administered in the person's best interest. (A best interest's checklist must be completed. Please tick this box if the prescribing practitioner has signed for this reason. ☐

I believe it is in the person's best interest to receive their medicine, and therefore it should be administered on their behalf

Signature and name (print) ……

Date ……

Example template of **Medicine Administration Record**

Lead health care professional to identify medicine (including cream/lotion), when to be taken/applied and the number of tablets and complete this form

Name of lotion or cream, area of application and frequency:

Number of eye drops/ear drops to be given and how often:

Tablets/Capsules or liquid medicine:

Date/day	Time	Medicine	Dose	Route of administration (If cream/ointment where to be applied)	Signature of Health care professional

The disposal of any unused medicine remains the responsibility of the service user/relative. We recommend that it is returned to a pharmacy for safe disposal. This should be recorded on the form.

For use by domiciliary care staff

Service user [ ] **Month** [ ]

Medicine/ dose	Date ➡ Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

O = omitted or refused, not taken.

Appendix 3

This is currently DRAFT (awaiting agreement) – DO NOT USE

[*Insert Provider address*]

[*Insert date*]

Dear Dr

Home administration of medication by care agency

(Patient name, dob, address)

As part of a home care package [name of agency] has agreed to provide help to the above named person with the administration of their prescribed medication. Their signed agreement to this and consent to your disclosing information to us about their medication is enclosed.

He or she will be having [insert number] of visits daily at approximately [insert times].

In line with the policy for the pilot agreed by Somerset LMC and the CCG we would be very grateful if you could take the following actions:

Medicines reconciliation

1. Review their medication and, if possible, match the administration frequency to the times we are visiting.
2. Ensure that all medications are synchronised and on a 28-day repeat cycle.
3. Remove any non-current treatments from the medication list.
4. Identify any "as required" medications and make sure the prescription information makes it clear when they are to be used.

Medical record coding

1. Add Read Code .8BML (Needs domiciliary care worker to administer medication) as an active problem
2. Tag the medication record with the usual dispensing pharmacy, and, if your system allows it, associated free text "Home Medication Administration".

Current medication printouts

1. Print out a list of the reconciled current medication and return it to us at the above address attached to one copy of this letter
2. In future, each time you *change* the medication for this patient or *add a new acute prescription*, print out a copy of the new list and attach it to the prescription. Please make it clear when any medication has been stopped by adding this to the new prescription advice field or writing it on the counterfoil (For example, "Bumetanide 1mg, one daily at 08.00, replaces furosemide"). Please also specify the number of days an acute medication is to be used for.
3. If medication is stopped but no new prescription issued, please send the pharmacy a current list with a handwritten comment (For example, Furosemide stopped")

4. Where medication has to be stopped *immediately* it is best to discontinue it on the MAR chart as well.

Thank you very much for your help. If you wish to discuss this patient's medication with a senior member of the care team please telephone [insert number].

Yours sincerely

[insert provider name]

Usual Dispensing Pharmacy (if known)
[enter details]

This letter was drafted by Somerset LMC on behalf of the project team. Please contact the LMC office if you have any suggestions for improvement

Patches

Patient's Name ……. DOB……

Emergency Contacts

DN/CPN (Mon to Fri 9-5)

Name …….. Tel: ……

All other times

GP Surgery …… Tel: ……

General Information

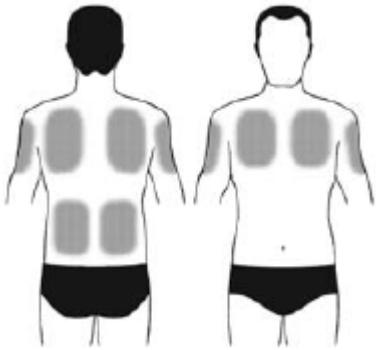
1. The initial patch will be applied by a DN/CPN who will mark the position and date applied on the body chart.

2. Thereafter the patch will be replaced by the DCS according to the instructions on the prescription.

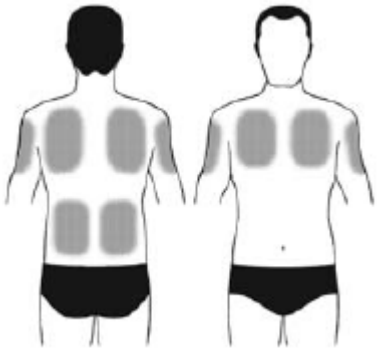
4. The old patch must be removed and the new patch applied to a **different** site.

5. The position of the new patch must be marked on the chart and dated.

6. If the old patch cannot be found, do not put on another patch. Report the concern.



Date……..



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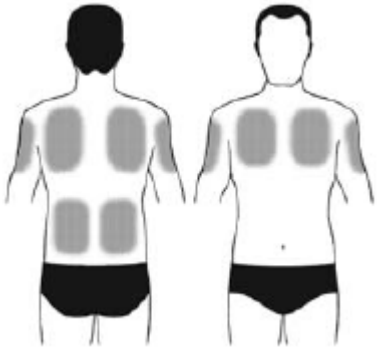
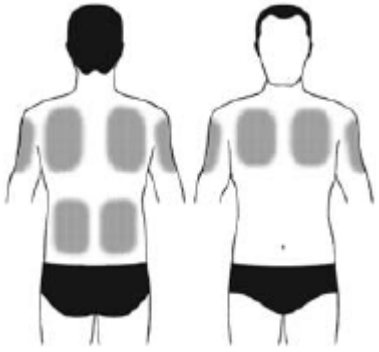


Date……..



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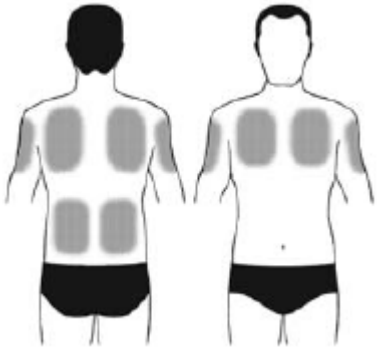
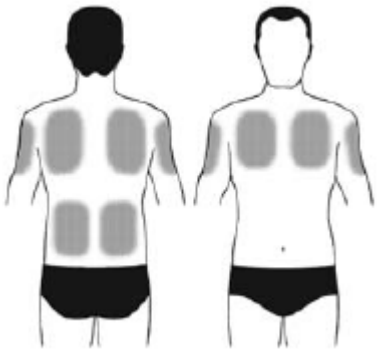


Date……..

Date……..



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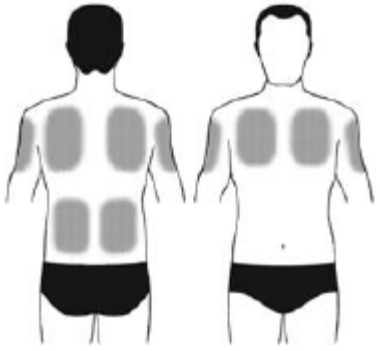
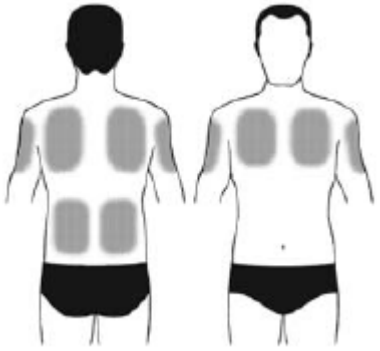
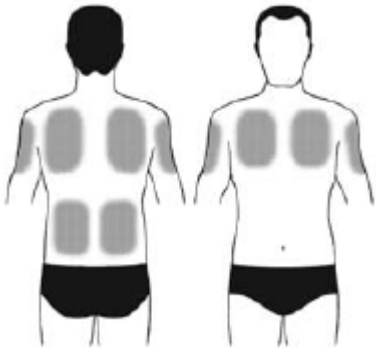


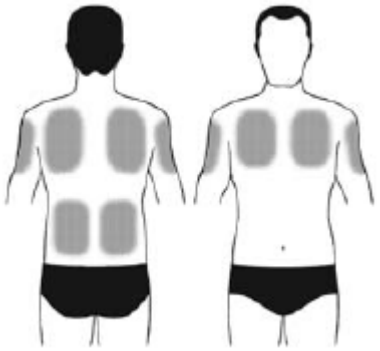
Date……..



Date……..



Date……..



Date……..

Exceptional circumstances or tasks requiring 1:1 training:

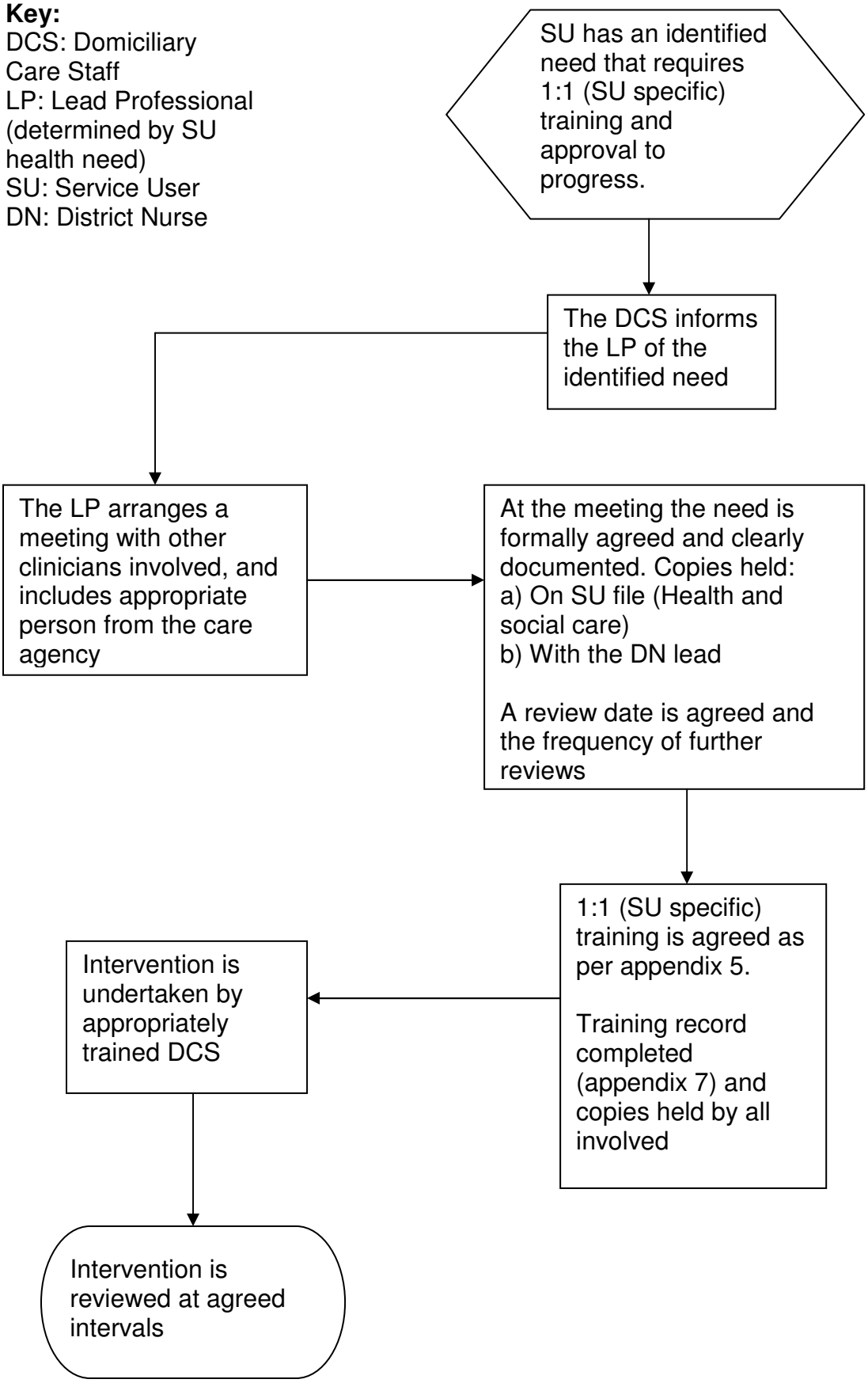
There may be occasions when the clinicians and providers may have to follow guidance for the training and delivery of tasks that fall outside those agreed in this clinical task policy. These are deemed “exceptional circumstances” (see appendix 6). These will reflect how there needs to be some ability to change or alter the responsibilities according to the needs of the individual described in the individual care plan. This will enable personalisation and to ensure that reasonable adjustments are considered in someone’s plan of care.

This **may only** occur when there has been full and explicit agreements between all the organisations involved which is clearly documented and all other possibilities have been fully exhausted (please refer to flow chart, appendix 6). An example of this could be insulin or pressure area care, or areas identified as requiring 1:1 discussion as indicated above.

Flow chart for Exceptional Circumstances

These situations may occur when the SU is being discharged from hospital, during transitions or when there has been a change in their health.

Key:
DCS: Domiciliary Care Staff
LP: Lead Professional (determined by SU health need)
SU: Service User
DN: District Nurse



Somerset Partnership NHS
NHS Foundation Trust

Appendix 7

Somerset medicines and clinical tasks training record

This document is evidence of any 'service user specific' training that has been delivered by Somerset Partnership staff to non-Somerset Partnership Staff in line with Somerset Partnership policies, protocols and guidelines.

The training required should be as part of the care and support plan/package being provided to the client/s and agreed as appropriate by the care agency line manager.

The Line manager is responsible for ensuring competence is reviewed.

This document is to be used for individual trainees and single training events only.

<table>
<tr><td>Date:</td><td>Name of trainer:</td><td>Designation:</td></tr>
<tr><td>Name of trainee:</td><td>Relationship to client, for example, relative, carer:</td><td>Care Agency name (if applicable):</td></tr>
<tr><td>Name of hospital / CCG / GP Practice associated with:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Description of training provided:

Feedback/comments:

Competent: Yes/No</td></tr>
<tr><td colspan="2">Duration of training delivered:</td><td>Service User Specific Yes / No</td></tr>
<tr><td colspan="2">Handouts given Yes / No</td><td>If yes, service users name?</td></tr>
<tr><td colspan="3">Date for training to be reviewed / updated: As specified by the Care Agency Line Manager/Non-SCH providers.</td></tr>
</table>

Place a copy of this completed document in the care plan.
Somerset Partnership Professionals to send a copy to their line manager and the carer's line manager.

Trainers signature:	**Trainee's signature:**
Date:	**Date:**

This document is to evidence any 'service user specific' training that has been delivered by a health professional for staff to learn and competently undertake a task that is required as part of the care plan / package being provided by the care agency.

Date:	Name of trainer:	Designation:
Name of hospital / CCG / GP Practice associated with		
Description of training provided:		
Duration of training delivered:	Service User specific Yes / No	
Handouts given Yes / No	If yes, service users name?	

Staff member (Print name)	Signature	Staff member (Print name)	Signature
Date for training to be reviewed / updated:			

Place a copy of this completed document in the care plan, in the service users file and each one of the staff members listed above files.

Trainers signature:

Mental Capacity Act 2005

Best Interests Checklist

Appendix 8

This Best Interests checklist can only be used once it has been established that the person lacks mental capacity to make their own decision. The form 'Record of an Assessment of Mental Capacity' is a tool to document this process.

The Decision Maker is responsible for assessing the capacity of the relevant person and for making the decision in his/her best interests. In determining best interests, the Decision Maker should avoid assumptions based on the person's age, appearance, condition or behaviour(s).

The following people should be consulted when determining best interests:

- anyone named by the person as someone to be consulted on the matter in question
- anyone engaged in caring for the person
- anyone with an interest in their welfare including close relatives
- anyone who has been given a Lasting Power of Attorney by the person
- any deputy appointed for the person by the Court of Protection

A referral to the Independent Mental Capacity Advocate (IMCA) service should be made whenever a person who lacks mental capacity has no appropriate family or friends to represent them in making a decision about:

a. serious medical treatment **or**
b. long term care and health moves (more than 28 days in hospital /8 weeks in a care home), **or**
c. residential or nursing care home reviews.

Name of person:	
AIS ID number:	
Decision(s) to be made:	

Please document clearly your reason for answering yes or no to any of the questions below

			Action taken/who consulted/date	Information obtained
1	**Has this person been assessed as lacking capacity to make this decision?**	**Yes** ☐ **No** ☐ If yes, give the date of the capacity assessment and proceed to question 2.		

		If no, a capacity assessment must be recorded in relation to this decision.		
2	**Does this person have a Lasting Power of Attorney or a Court appointed deputy who has authority to make this decision?**	**Yes** ☐ **No** ☐ If yes, the person holding the LPA or deputy must be consulted and has a legal right to veto the decision. If no, proceed to question 3.		
3	**If the decision under consideration is for medical treatment, has the person made an Advance Decision to refuse this treatment?**	**Yes** ☐ **No** ☐ If yes, the Advanced Decision is legally binding if valid. If no, proceed to question 4		
4	**Is it likely that the person will regain capacity in relation to the decision in question?**	**Yes** ☐ **No** ☐ If yes, go to question 5. If no, proceed to questions 6 and 7		
5	**Can the decision wait until the person regains mental capacity?**	**Yes** ☐ **No** ☐ If yes and it is reasonable to wait then you must do so. If no, proceed to questions 6 and 7		
6	**Has the person been helped to participate in the decision making process as fully as possible?**	**Yes** ☐ **No** ☐ If yes, proceed to question 7. If no, this step must be taken		

7. Please record all relevant information about the person's wishes and beliefs in relation to this decision.

(In particular, record any relevant statements made when he/she had capacity)

Decision(s) reached:

Alternatives considered and rejected: (Give reasons for rejecting these alternatives)

I confirm that I have understood and reviewed this checklist in respect of the above named person and the decision has been made in accordance with the guidance in Chapter 5 of the Mental Capacity Act Code of Practice.

Name of Decision Maker: **Contact details:**	**Date:**

When completed, this form must be stored in the person's electronic social care records

Medication returns inventory

Service Users Name	
Address	
Post Code	
Consent Statement	I _____ give my consent for the medications detailed on this form to be returned to the identified below pharmacy by_____ of [insert name of care agency].
Pharmacy Name	
Address	
Post code	

Name of medicine	Date dispensed	Dosage	Strength	Amount dispensed	Amount returned

Service User signature		Date	
Care agency staff signature		Date	
Person receiving medicine		Date	
Print Name			

Administration of 'when required' medicines
Care providers should have a process for handling and administering 'when required' medicines. This should also take into account how DCS identify when a person needs their 'when required' medicine, based on their capacity and information in their care plan.

The process should include the following:

- the reasons for administering the 'when required' medicine
- how much to give if a variable dose has been prescribed
- the minimum time between doses if the required outcome has not occurred after the first dose
- details of when to clarify instructions with the prescriber if there is any confusion or ambiguity about what medicines or doses are to be given
- recording 'when required' medicines in the person's care plan.

Appendix 11

Version 12 tracked changes

Page 5: Item 2.02. First paragraph amended: Old paragraph read:

> Implementation of the guidance is dependent on close co-operation between Health and Social Care in partnership with providers. A joint assessment by a SW and DN/CPN must confirm a need for assistance with or administration of medicines. The Lead Professional must include the Pharmacist in the decision making process. The DCS key worker who takes the lead on medicines for the service user should be clearly identified on the care plan.

Page 27: Item 36, missing trainer identifier added, (was blank, now reads "P")

Version 13/14 tracked changes

Cover: Title changed. Previous title was "Medicines and Clinical tasks policy"

Glossary: Added CCG, removed PCT

Page 5: Definitions of assistance and administration – the following wording was added:
Please note these definitions are as described by CQC for care workers and social care staff. The guidance for health staff may be different

2.02 Third bullet point amended, used to read:
Will not accept any responsibility for any as required medicines but may provide assistance to a service user with such medicines when delivering a care package.

3.2 Re-ordering of the list (medicines and clinical)

3.3 Delete section ff: Taking of temperature and pulse upon request by GP/nurse and add to section 3.4

3.4 Insert section u) Urine dip testing

3.6.2 used to read:

DCS must never make a decision themselves not to resuscitate, based on the service user's physical condition or age. They should always call the ambulance service as stated above, unless otherwise advised by a doctor.

9.2, 9.3 and 9.4 have been added.

10.4 and 10.5 have been added.

Appendix 5: The table heading has been changed from "trainer" to "responsible for sourcing training"

Appendix 9 has been added.

Version 15 tracked changes

Glossary. DNAR and PRN added

Introduction – last paragraph – policy name updated to reflect changes made in version 14
2.02 second bullet point. Fair Access to Care replaced with “National eligibility criteria” as per the Care Act

2.04 Added as new content (rest of section re-numbered)

2.09 Added as new content

3.2 Insert new j: “PRN” medicines

3.6.3 Added as new content

4.1 First para. Department’s remit changed to provider’s remit

5.3 Wording updated. Used to read:
The tasks listed in section 3.3 all require training to have been given either by the Provider or Health. Staff must sign to say that training has been received and understood and the trainer involved must sign to say the person is competent to complete the tasks. (See appendix 6).

5.4 inserted (rest of 5 below 5.4 re-numbered)

10.6 Clinical Waste - added

Section 15 – List of acknowledgements updated

Appendix 10 has been added

Version 16 tracked changes
Introduction revised and Key points heading added

Section 2. Definition of Assistance amended slightly.

2.02 DCS Key worker amended to read DCS key worker**s**

Section 3 – Categories of task – re-ordered following recommendation from task and finish group. Additional category (3.4) added to acknowledge care provider organisations that employ a registered nurse. (Subsequent sections numbering revised accordingly)

10.6 – New sub-section to support disposal of patches

11.0 – Re-worded to include non-prescribed drugs

Appendix 4 – New guidance added (Bullet point 6).

Appendix 5 – Training list deleted (as now covered within section 3 – tasks)

End.