EAST RIDING OF YORKSHIRE COUNCIL

NHS East Riding of Yorkshire

Medication Management

for Care Workers in Adult Care Sector Residential Services

Course Workbook
&
COMPETENCY RECORD

Care Worker Name (Block Capitals)	Signature	Date
Line Manager (Block Capitals)	Signature	Date

Important – keep this booklet safe as it is your evidence that you have completed Medication Training.

Aim of the Post Training Workbook

To provide information to support the Medication Training for Care Workers

To record Competencies for handling medication

To record information on Refresher Training attended

To record information on Specialised Administration Techniques

At the end of this training you should have:

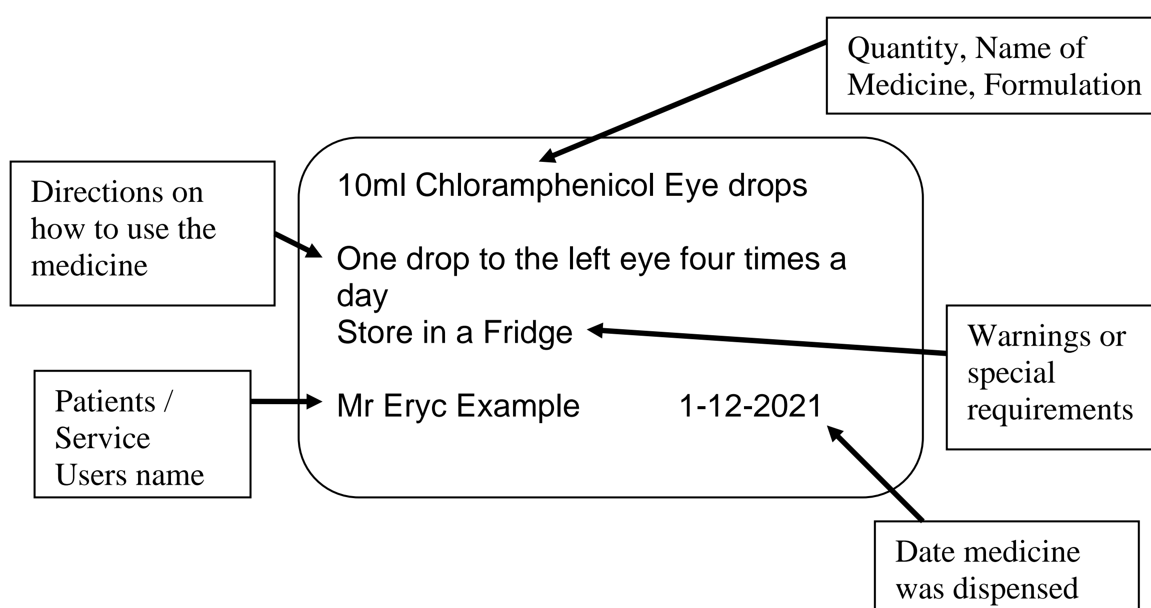
- ✓ Knowledge regarding the handling of medication in a Residential Care Home
- ✓ Awareness of the record keeping for medication in the context of your work setting
- ✓ Completed Competency check for handling medication

Information Sheets

What tells a Care Worker how to administer medication?

The Support Plan sets out the help Care Workers give to a Service User; this includes help with administering medications. Care workers can only administer medication to a Service user if it is written in the Support Plan. The Support Plan may require the Care Worker to administer some or all of the Service Users medication.
For example, a Care Worker may be required to administer only a Service User's creams/ointments and whilst the Service User is able to administer their own oral medication (tablets, liquids).
If you have a concern about a Service Users ability to handle their own medication you should report this to your Line Manager.

The Prescription Label



The Label contains lots of important information for the care worker. The information on the label should be the same as the information on the Medication Administration Record or **MAR** for each item.

The Service User may be well informed about their medication as they may have been taking it for quite some time. However, Care Workers should ensure that they have also read the medication label and support plan to confirm that the information the Service User has given them.
The Patient Information Leaflets (PIL) can be found in original medication boxes or attached to the side of the medication bottles or

should be supplied with by the community pharmacy if medication is supplied in monitored dosage systems. It is important to read the Patient Information leaflets they contain information on how to administer the medicine, possible side effects, storage requirements, contra- indications etc. that are specific to the medication.

The Care Workers Line Manager – as a Care Worker if you are unsure how to administer a medication it is important that you speak to your line manager / senior, who may than contact the Pharmacy or Doctor for further advise.

Your care home will have **a Standard Operating Procedure (policy)** which sets out how medication is to be handled in your residential home.

The procedure's objectives are:

- To enable, promote and maximise service users' independence safely.
- To give clear guidance to all staff involved in medicine management for adults in your care homes.
- To ensure all members of staff follow the same procedures.
- To meet all legal care home regulations requirements and Care Quality Commission (CQC) standards.

Under these procedures the service user's ability to self medicate is assessed and where a service user is able to manage their own medication then they are encouraged to do so.
(For information on Self medication see page 5)

Notes

Self Administration

Some service users will be able to maintain the ability to administer their own medication.

A service user who wishes to self medicate should be assessed as being capable of managing their own medication, by the Care Home Manager or their Deputy, using the Fuller's Self Medication Risk Assessment tool. There are a number of compliance aids available to assist in self medication.

The risk assessment and the support plan should note that the service user will be responsible for their own medication. The risk assessment should be regularly reviewed.
There should also be a signed Disclaimer Form from the service user or their representative, agreeing and accepting responsibility for their own medicine management including taking their own medicine and the safe storage of medicine. This form should be stored in the service user's file.

Service users responsible for their own medicines should be provided with a personal lockable drawer or cupboard. Staff should have access to such a drawer or cupboard, with the permission of the service user. For Controlled drugs if a service user is self-medicating and a risk assessment is in place, they can hold their own individually dispensed supply of controlled drugs in their personal lockable cupboard.

Getting Ready to Administer Medication

It is important to be ready to administer medication. This means making sure that you can focus on the task of administering medication and will improve your ability to administer safely.

Excerise1
Note down how you as a care worker can get prepared to administer medication.

Administration of Medication

Administering medication is all about common sense.

7 Rights of Administration.

- **Right dose of the**
- **Right medicine to the**
- **Right person at the**
- **Right time by the**
- **Right route**
- **With the Right Documentation**
- **And the Right to refuse**

Administration Techniques

The following sheets aim to provide you with information on how to administer the various types of medication. The information provided on these sheets is generic, specific information on the administration of a medication can be found in its Patient Information Leaflet (PIL) which is available with every medication dispensed.

Before Administering Medication to a Service User

- **Ask the service user if they are ready to take their medication. Do this before removing the medication from the container.**
- **Check that service user name is correct on MAR**
- **Check that service user name is correct on containers.**
- **Wash and dry hands.**
- **Get together any equipment needed to help with medication.**
- **Ask service user to sit upright**. (If this is not possible then the care worker must report this to the senior who can ask advice from the service user's GP, Community Pharmacist

General Procedures for Oral Tablets and Liquids

1. Medications should be handled as little as possible. Measure out correct amount of liquid or remove tablets from a bottle or push out of a foil (blister) strip onto a small plate or bowl for the service user to access. Dispersible or soluble tablets should be placed in a suitable amount of water according to the Patient Information Leaflet.

2. Administer medication to the Service User as laid out in the Support Plan.

3. As each medication is administered it should be recorded on the MAR.

Buccal tablets

1. Read the patient information leaflet for specific information about administration
2. If the Service User suffers from a dry mouth, ask the Service User to moisten the area where the tablet is to be placed with their tongue or a little water before they apply the tablet.
3. The tablet should be placed high up between the upper lip and the gum, to either side of the front teeth.
4. The tablet should not be placed under the tongue, chewed or swallowed.

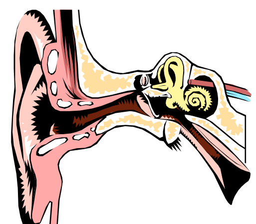
Sublingual tablets

1. Read the patient information leaflet for specific information about administration
2. If the Service User suffers from a dry mouth, ask the Service User to moisten the area where the tablet is to be placed with their tongue or a little water before they apply the tablet.
3. The tablet should be placed under the tongue.

Oro-dispersible tablets

1. Read the patient information leaflet for specific information about administration
2. If the Service User suffers from a dry mouth, ask the Service User to moisten the area where the tablet is to be placed with their tongue or a little water before they apply the tablet.
3. The tablet should be placed on top of the tongue and allowed to dissolve.

Ear Drops



1. Ask the service user to put their head to one side -
   left hand side if drops are to go in right ear or
   right hand side if drops are to go in left ear

2. Shake the container gently and remove container top

3. Place the number of drops stated on the label into the ear canal – squeeze the container gently if needed.

4. Ask the service user to keep head to one side for 2 minutes to allow the drops to get into the ear.

5. Wipe the end of the nozzle with a clean tissue, replace top and store container upright.

6. Repeat steps 2 to 4 for the other ear if asked for on the label.

Ear Drops should not be used longer that directed by the Doctor and should be disposed of four weeks after opening, as they may become contaminated.

Eye Drops

1. Ask service user to put their head back slightly

2. Shake the container gently and remove container top

3. Gently pull lower eyelid downwards and outwards

4. Place one drop in the space between the lid and the eye. Squeeze the container gently if needed. Do not let the dropper touch the eye.

5. Ask the service user to close their eye for 1 – 2 minutes to allow the eye drops to be absorbed.

6. Repeat in the other eye if stated on the label.

7. Replace the top and store container upright. Only store in the fridge if the labels say so.

8. If there are two or more different types of eye drops to be given at the same time, wait 5 minutes before giving the next type of eye drops.

Eye drops should not be used longer than directed by the Doctor and should be disposed of four weeks after opening, as they may become

contaminated. (Eye drops may also come in Minims which are single dose vials)

Eye Ointment

1. Ask service user to put their head back slightly
2. Remove container top.
3. Gently pull lower eyelid downwards and outwards
4. Place about ½ cm e.g. __ in the space between the lid and the eye. Do not let the container touch the eye.
5. Ask the service user to blink a few times to allow the ointment to work all over the eye.
6. Repeat in the other eye if stated on the label.
7. Replace the top.

Eye Ointments should not be used longer than directed by the Doctor and should be disposed of four weeks after opening, as they may become contaminated.

Nasal Drops

1. Ask service user to gently blow their nose and then to tip their head backwards slightly
2. Shake the container gently and remove container top
3. Ask the service user to close one nostril by gently pressing their finger against it.
4. Place the number of drops stated on the label into the open nostril
5. Ask the service user to sniff gently to allow the drops get into the nostrils.
6. Repeat in the other nostril if stated on the label.
7. Wipe the nozzle with a clean tissue, replace top and store container upright.

Nasal Sprays

1. If the spray is being used for the first time press spray several times into the air until an even spray is seen.
2. Ask service user to gently blow their nose and then to tip their head forwards slightly.
3. Shake the container gently and remove container top.
4. Keep the container upright, hold the container so that your thumb is underneath the container and your middle and fore finger are either side of the nozzle.
5. Ask the service user to close one nostril by gently pressing their finger against it.
6. Keep container upright and insert tip of nozzle into open nostril then spray once.
7. Repeat another spray and in other nostril if stated on the label.
8. Wipe the nozzle with a clean tissue, replace top and store container upright.

Creams, Ointments and Lotions

In this section we are talking about Creams, Ointments and Lotions that are being prescribed for a medical condition and not being used as part of the daily personnel care for example moisturisers.

1. Check that the label states where the cream or ointment has to be applied and how often.
2. Put on plastic disposable gloves if provided by your employer.

3. Shake container gently if needed and remove top from the container
4. Gently rub in the cream, ointment or lotion as stated on the label. Emollients are absorbed better if applied to damp skin and in a downward motion.

5. Replace cap and store as stated on the label.
6. Wash and dry hands.
7. It is important to be aware of the potential dangers of skin products. Emollients can transfer from the skin onto clothing,

bedding, and bandages and can catch fire easily causing severe and fatal burns. Clothes should be changed and washed frequently to try to help reduce the build-up of emollient on them (but this may not remove the emollient completely so the danger may still remain) so it is important to stay away from naked flames and heat sources when using these products.

Patches

1. Check that skin is clean and dry before applying patch.
   If the skin does need to be cleaned, wash with water only and dry thoroughly.

2. Do not apply a patch straight after a bath or shower, wait until the skin is cool and dry. It is especially important to allow the skin to cool down as hot skin can absorb more of the medication in the patch and lead to an overdose.

3. Tear the pack open with your fingers along one edge and remove patch. Do not throw way the opened pack as this can then be used when disposing of the patch that you remove from the service user's skin.

4. Remove used patch from skin and fold it firmly in half so that the sticky side sticks to itself. Place in empty opened packet. The patch can then be thrown away in the normal waste bin. Always do this before applying a new patch.

5. Peel the backing off the new patch.

6. When applying a patch, it must be placed on a different part of the body from where it was removed and not where the previous patch has been. The patient information leaflet will specify which area of the body to place the patch and how to rotate the position. Check your body map/patch chart to see where previously applied.

7. Place the patch (sticky side to the service user's skin) onto the skin with the palm of your hand and hold for 30 seconds making sure it sticks well to the skin. Ensure the patch is applied to intact skin (i.e. not on broken skin).

8. Wash and dry hands.

9. If a patch falls off the skin before a change is due follow steps 1 to 8, record in diary sheets and contact your line manager.
10. Mark body map/patch chart with date and initials, if using.

Mouthwashes

1. Some mouthwashes cannot be swallowed. If this is the case the label will state 'FOR EXTERNAL USE ONLY' or 'DO NOT SWALLOW'.

2. Get a container ready for the service user to spit the used mouthwash into.
3. Pour out the required amount of mouthwash to be used.
4. Pass this onto the service user and ask them to rinse around their mouth for about a minute.
5. The service user should then spit out the mouthwash into a container.
6. If the service user complains that the mouthwash is stinging their mouth, you can add an equal volume of water.

Throat Sprays

1. Pull out the spray tube in accordance with the directions in the Patient Information Leaflet.
2. Hold the container in your hand and put fore finger on the top.
3. If the spray is being used for the first time, press the spray several times into the air until an even spray is seen.
4. Ask the service user where their mouth or throat is sore and spray in that area.
5. Repeat for how many sprays are needed.
6. Wipe tube with a clean tissue.
7. Push spray tube back in and store container upright.

Nebules

1. Hole the nebule upright and twist off the top.
2. Pour the contents of the nebule into the container.
3. Ask the service user to place mask on face.
4. Switch on the nebuliser.
5. When all the liquid has been used (after about 5 minutes) switch off the nebuliser.
6. If there is more than one nebule to be given at one time put them into the nebuliser at the same time.
7. Remove the container; wash in water and leave to dry.

Inhalers

1. Service users may be able to use their own inhalers and if they are having difficulty their health care practitioner should assess their inhaler technique and may suggest an alternative inhaler.
2. If a care worker has any concerns over the service user's ability to use their inhaler, they must report this concern to their line manager.
3. If care workers are required to assist a person to use their inhaler, they should read the patient information leaflet and follow the directions.
4. If a care worker is asked to administer a metred dose inhaler (MDI) they should request a spacer to be prescribed.
5. If the spacer device requires assembling the carer should do so following the directions in the Patient Information Leaflet (PIL).

    - Take mouthpiece off inhaler and shake device.
    - Fit onto spacer.
    - Press down once on top of the inhaler to release medication.
    - Ask service user to breath out first.
    - Pass device to service user to place in, or for mask-type spacers over, their own mouth (with inhaler still attached).
    - Ask service user to take in one slow deep breath or 2/3 normal breaths to make sure the medication gets into the lungs.

- If a second dosage or puff is required wait one minute and repeat process.
- Wash the spacer once weekly by following the directions in the PIL and record in the support plan.
- Ensure each spacer is labelled with the resident's name, for infection control. This need not be a dispensing label.

Notes

Recording Administration

The administration of medication is recorded using a Medication Administration Record (MAR). Some care homes will have electronic MAR charts.

Staff must confirm that a dose has been administered by entering their initials in the appropriate box on the MAR; **this must be recorded at the time of administration.** The residential home should have a list of all care workers with their initials for reference.

Completed MARs should be kept in the service users file for eight years.

Exercise 2 – Look at a MAR for your workplace setting. Note down the codes used on the MAR and what they mean.

Looking at the MAR where do you record the use of Homely remedies?

When required (prn) medication

Medication which is prescribed 'when required' is intended to be given only when the person needs it. Care staff must be aware of what the medication is for and when to give it including any non-verbal signs that the person may show that would indicate the person needed the medication.
This information should be included in a 'when required' protocol which is kept with the person's care notes and a copy should be kept with the MAR chart where is can be readily assessed. The protocol should be reviewed regularly.

Recording the administration of 'when required' medication

'When required' medication must be included as an entry on the MAR chart in the same way as regular medication. If a supplementary chart is in use a note should be made on the MAR chart to indicate this so that all staff use the same record and to prevent double signing and overdosing.
Each time a 'when required' medication is administered staff must sign the MAR (or supplementary MAR) chart and record what time the dose was given, and the actual dose given (f variable dose).
It is helpful to keep a running balance of 'when required' medication to assist with ordering and auditing medication use.
DO NOT record the non-administration of a 'when required' medication on the MAR. A note could be made in the care plan if staff have offered a 'when required' medication in accordance with the protocol but the person has refused it.
Each person should have a 'when required' protocol for each 'when required' medication that they take which is specific to them.

'When required' medication could be needed at any time of day or night. It is essential that there are sufficient trained and competent members of staff available at all times.

Ordering, checking and receipt of medication

It is vital to ensure that the service user does not run out of medication. Residential homes must ensure that stock levels of medication for each service user are kept at an appropriate level dependent upon need. This is usually done by a senior member of staff

> ***Remember - When a medicine is dispensed it becomes the property of the service user to whom it has been prescribed.***

Records should be kept of all medication that has been ordered and medication that has been received. It is important for the care home to see the prescription before it is dispensed to ensure-

1. Anything missing can be chased up
2. Anything no longer needed can be crossed off to reduce waste
3. Anything not expected can be queried

If your prescription goes electronically straight to the pharmacy (called eTP) you should request a copy of the 'token'.

Exercise 3 – Write down the processes that happen in your work setting with regards to ordering new medication and receiving it into the residential home.

Collecting Medication

Most Pharmacies deliver medication directly to the residential home, however there may be occasions where you are asked to collect an urgent prescription (e.g. an anti-biotic that needs to be administered as soon as possible).

Disposal

Medicines remain the property of the service user at all times. They must be returned to them if demanded. If the medicines are no longer needed, they should be disposed of with the service user or the family's permission (this includes household remedies) and then returned to the pharmacy.

Medicines should be disposed of when:

- The expiry date is reached. (Some products such as eye drops /ointments have a very short life).
- A course of treatment is complete or the doctor stops the medicine.
- The resident dies. The medicine should be kept for **7 days** after the death in case the Coroners Officer wants them.
- Individual medication (e.g. single tablet) that has been dropped on the floor, spat out or refused should be disposed of in a designated medicine disposal box / bag. It is good practice that this is witnessed. At the end of the month this box is to be returned to the pharmacist so all unused medicines can be disposed of in a safe manner.

(If a tablet has been dropped prior to administration and disposed of the Care Worker should administer a fresh tablet to the Service user and then report their actions to their Line Manager as this may mean that there is a shortage of medication to complete the 28day period.)

Disposal of medication must be recorded.

Disposal Records should include

- Resident's name
- Name, form, strength + quantity of medicine
- Date of return
- Reason for return
- Signature of person returning medication
- Signature from the pharmacy upon receipt of medications for disposal, where possible,

Exercise 4 – Write down the processes involved in the disposal of unwanted medication in your work setting.

Controlled Drugs

Some medicines have a stricter set of storage and recoding requirements, these are Controlled Drugs. They are medicines that are seen to be open to misuse or dependence.

Residential homes must keep a separate record of controlled drugs receipt, administration and disposal. These records must be kept in a controlled drugs register, which is a bound book with numbered pages. The bound book will include the balance remaining for each product with a separate record page for each controlled drug maintained for each service user. The balance of controlled drugs must be checked at each administration.

All controlled drugs should be entered into a controlled drug register once they have entered the building. They should be stored in a controlled drugs cabinet. For safe practice the controlled drugs

cabinet should only be used for the storage of controlled drugs. Only those with authorised access should hold keys to the controlled drugs cabinet, with access to the keys closely monitored.

Two designated staff are responsible for the administration, the member of staff administering must be trained and competent, and the other member of staff must be competent to witness the administration. Both designated people sign the controlled drugs register stating the time, the amount, the dose administered, and the amount left.

Any Controlled Drugs that need to be disposed of should be written in the CD register and separate disposal arranged to ensure they are not mixed up with non-CD medication.

Exercise 5. Make notes on how controlled drugs are handled in your work setting and which staff are designated to handle controlled drugs

Competency Record

Tasks in Handling Medication

Objective	Process	Care Workers Signature	Line Manager Signature	Date
To refresh knowledge	Read the full Residential Care policy			
Have knowledge of the ordering of prescriptions and processes involved	Demonstrate understanding of ordering process			
Have knowledge of the processes involved in receiving medications into the residential home	Demonstrate understanding of processes involved in receiving medication into the residential home			
Store medication appropriately	Demonstrate that medication is stored correctly Check fridge items are stored correctly Demonstrate understanding of the need to monitor fridge temperatures			
Recognise when it is necessary to speak to the senior about a medication concern	Demonstrate knowledge of procedure to be follow when care worker has a concern about a service user's medication. Demonstrate the ability to give a Senior clear information about a concern regarding medication. Demonstrate the correct documentation of concerns about medication.			
Recording accurately the administration of medication on the MAR	Check procedure for recording the administration of medication On the MAR Check the procedure for recording a Homely remedy on the MAR			
Recognising the types of medication administration that care workers cannot do without	Demonstrate knowledge of the types of administration techniques that Care Workers are allowed to perform having completed the Medication Training for Care Workers.			

further specialized training	Demonstrate an understanding that there are some Specialized Administration Techniques that will require further training before a Care Worker is allowed to perform.			
Have Knowledge of the processes involved in disposing of medication	Demonstrate an understanding of why medication may need to be disposed of. Demonstrate knowledge of the procedures for the disposal of medication.			
Have knowledge of the differences to the process for Controlled drugs	Demonstrate an understanding of the need for designated staff to handle controlled drugs Demonstrate an understanding of the processes for receiving a controlled drug into the residential home Demonstrate an understanding of the processes of recording the administration of a controlled drug Demonstrate understanding of the procedures for the disposal of a controlled drug.			

Medication Training for Care Workers Completed	**Date**
Care Worker Name (Block Capitals)	**Signature**
Line Manager (Block Capitals)	**Signature**

Administration Techniques

Objective	**Process**	**Care Workers Signature**	**Line Managers Signature**	**Date**
Administering oral medication to a service user	Demonstrate the correct procedure to administer tablets Demonstrate the correct procedure to administer soluble / dispersible tablets Demonstrate the correct procedure to administer liquids Demonstrate the correct procedure to administer sachets Demonstrate the correct procedure to administer buccal tablets Demonstrate the correct procedure to administer sublingual tablets			
Administering medication via the eye	Demonstrate the correct procedure to administer eye drops from bottles and Minims Demonstrate the correct procedure to administer eye ointment			
Administering medication via the ear	Demonstrate the correct procedure to administer ear drops			
Administering medication via the nose	Demonstrate the correct procedure to administer nose drops Demonstrate the correct procedure to administer nasal sprays			
Administering medication via the skin	Demonstrate the correct procedure to administer creams Demonstrate the correct procedure to administer ointments Demonstrate the correct procedure to administer lotions Demonstrate the correct procedure to administer Patches			
Administering medication via mouthwashes	Demonstrate the correct procedure to administer mouthwashes			

Administering medication via a throat spray	Demonstrate the correct procedure to administer Throat sprays			
Administering medication from nebules	Demonstrate the correct procedure to administer nebules			
Assisting to administer medication via inhalers	Demonstrate an understanding of the limitations for care workers to assist to administer via inhalers Demonstrate the correct procedure to assist to administer medication via inhalers			

Medication Training for Care Workers Completed	**Date**
Care Worker Name (Block Capitals)	**Signature**
Line Manager (Block Capitals)	**Signature**

Record of Medication Management Training Sessions for Care Workers in Adult Care Sector Residential Services

Name of Care Worker

Refresher course due (mm/yy)	Refresher course completed on (dd/mm/yy)	Course Provider / Tutor Name and Signature	Care Workers Signature	Line manager Signature

Record of Additional Training regarding Medication – including Specialized Techniques

Name of Care Worker:

<table>
<tr><td colspan="2">Date</td><td colspan="3">Title</td></tr>
<tr><td colspan="5">Description of Training and Objective</td></tr>
<tr><td>Trainers name</td><td></td><td>Qualification</td><td colspan="2"></td></tr>
<tr><td colspan="2">Observation of Practice</td><td>Trainer Signature and Date</td><td>Care Worker Signature and date</td><td>Line Manager Signature and date</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="2">Date</td><td colspan="3">Title</td></tr>
<tr><td colspan="5">Description of Training and Objective</td></tr>
<tr><td>Trainers name</td><td></td><td>Qualification</td><td colspan="2"></td></tr>
<tr><td colspan="2">Observation of Practice</td><td>Trainer Signature and Date</td><td>Care Worker Signature and date</td><td>Line Manager Signature and date</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="2">Date</td><td colspan="3">Title</td></tr>
<tr><td colspan="5">Description of Training and Objective</td></tr>
<tr><td>Trainers name</td><td></td><td>Qualification</td><td colspan="2"></td></tr>
<tr><td colspan="2">Observation of Practice</td><td>Trainer Signature and Date</td><td>Care Worker Signature and date</td><td>Line Manager Signature and date</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="2">Date</td><td colspan="3">Title</td></tr>
<tr><td colspan="5">Description of Training and Objective</td></tr>
<tr><td>Trainers name</td><td></td><td>Qualification</td><td colspan="2"></td></tr>
<tr><td colspan="2">Observation of Practice</td><td>Trainer Signature and Date</td><td>Care Worker Signature and date</td><td>Line Manager Signature and date</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td></tr>
</table>