Medication Policy

Young Epilepsy will ensure all young people requiring medication receive medication in a correct, proper, timely and safe manner according to the guidance and procedures which follow.

Day Student Medication Procedures exist as separate guidelines to this Policy. These provide guidance on the process for the administration of medication to young people in Day Placements and are available on Sharepoint.

- **This policy is agreed by the Health Services Committee and will be implemented by all departments.**

Signed: **Date: 24 November 2022**

Director of Health, Research and Compliance Date of next review: 31st March 2023

Medication Policy and Procedures

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1 Introduction

1.1 These procedures are based on the following professional guidance/legislation:

- Managing Medicines in Care Homes. NICE, March 2014
- The Handling of Medicines in Social Care. Royal Pharmaceutical Society, 2007
- The Mental Capacity Act 2005: Medication
- Medicines Act 1968
- The Misuse of Drugs Act 1971, and their associated regulations
- The Safer Management of Controlled Drugs Regulations 2006
- NMC guidelines on record keeping 2011
- Guidelines from the Nursing and Midwifery Council

1.2 If any member of staff does not adhere to these procedures, the incident must be reported to their line manager and the Medication Quality Team.

1.3 Failure to report an incident of non-adherence is a disciplinary matter. The disciplinary action to be taken is to be determined by the Directorate Head, in consultation with the relevant line manager and the HR Manager.

1.4 Where the non-compliance may have a detrimental effect upon any young person the safeguarding officer or duty manager must be immediately informed and their advice sought on how best to proceed.

2 Medication responsibilities

2.1 The Pharmacy Adviser ensures that the organisation operates within guidance and supports staff.

2.2 All line Managers are responsible and accountable for ensuring that all members of staff and volunteers are aware of the Young Epilepsy Medication Policy and associated procedures and guideline documents and how to access them from Young Epilepsy Sharepoint library where appropriate.

2.3 The maintenance of accurate and current signature sheets is the responsibility of:

- the Registered/House Manager in the care environment.
- the Principal/Assistant Principals of School/FE in the education environment.
- the Health of Health in the Medical Centre.

These should be updated every 6 months and when new staff begin medication training. The records in school/FE and the houses must also include signatures of doctors and nurses who may administer medication or sign MAR sheets. No one is authorised to administer medication until his/her signature has been formally recorded providing a sample signature and initials as they would be signed on documentation.

2.4 The Director of Integrated Care has overall accountability for the implementation of the Medication Policy and associated procedures and guidelines and ensures that the Young Epilepsy medication policies and procedures comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and requirements from NICE which governs the management of medicines.

Responsibility and accountability in the medical centre

2.5 The registered nurses are responsible for ensuring the safe storage of medication and the implementation of the Young Epilepsy policy within their area. They are also responsible for administering prescribed medication in accordance with Young Epilepsy policy and the directions provided by authorised prescribers. They must follow the NMC Codes of Practice.

2.6 All staff with any responsibility or accountability on the Medical Centre should ensure when leaving the building that other appropriate members of staff know of their whereabouts on campus and how to contact them should this be necessary.

Responsibility and accountability on the houses

2.7 The Registered/House Manager has overall accountability and responsibility for monitoring policy and ensuring that it is safely implemented on their House, considering any advice from the medical team.

2.8 The house manager is also responsible for developing, reviewing, and monitoring the training and assessment of individual care staff.

2.9 It is the responsibility of the designated staff member in charge of each house to ensure that all relevant staff within their house are aware of the medication prescribed and any subsequent amendments.

2.10 The medication trained care staff are responsible for ensuring the safe storage of medication and the implementation of Young Epilepsy policy within their area. They are also responsible for administering

prescribed medication in accordance with the Young Epilepsy policy and the directions provided by authorised prescribers.

2.11 All staff with any responsibility or accountability on the House should ensure when leaving the House that other appropriate members of staff know of their whereabouts on campus and how to contact them should this be necessary.

2.12 It is the responsibility of the Registered/House Manager or designated care staff member in charge to ensure that the medication trained house staff administer prescribed medication in exact accordance with the MAR sheet.

2.13 **Responsibility and accountability in school/further education college**. (see also Medication Procedure in St Piers school and St Piers College Day Students)

2.14 The School/College Principal has overall accountability for policy and implementation in the School and Further Education college.

2.15 The teachers and other trained education staff are responsible for the implementation of the Young Epilepsy policy within their area. Trained staff are responsible for administering prescribed medication in accordance with the Young Epilepsy policy and the directions provided by authorised doctors.

2.16 It is the responsibility of the Teacher or Lecturer, as appropriate, to ensure that all education staff in contact with a young person are aware of his/her prescribed medication, emergency protocol and any subsequent amendments.

2.17 **CD (controlled drugs) Accountable Officer:** The role of the CDs Accountable Officer ensures that Young Epilepsy has robust arrangements for the safe and effective handling of CDs. The Accountable Officer for CDs across the campus is the pharmacy adviser. If there are any CDs issues on a day when the pharmacy adviser is not working, the Director of Integrated Care should be contacted along with the nursing team.

3 Who can administer which types of medicines?

3.1 A registered nurse or doctor, who is legally and professionally competent in administering drugs, may singly administer drugs. (Controlled drugs and insulin administration require a trained witness). Individual practitioners must by so acting, assume responsibility for this practice.

3.2 Single administration of medication is at the discretion of the Registered/House Manager in conjunction with the Head of Residential Services/Operational Leads (Controlled drugs and insulin administration always require a trained witness). A risk assessment for this practice must be available. No resident should be deprived of prescribed medicine because there is only one member of staff on duty when he or she needs it.

3.3 Apart from registered doctors and nurses, only staff that have successfully completed the training outlined in the Medication Training section 29 may administer regular medication to residential young people.

3.4 Medication should normally be administered by a member of staff who works with the young person regularly.

3.5 Intravenous injections can only be given by doctors. Intramuscular injections can only be given by registered nurses and doctors. Subcutaneous injections can be given by residential staff only after young person specific training has been delivered by the nursing team

3.6 Prescribed rectal and vaginal medications, enemas and suppositories may only be administered by appropriately trained staff. The nursing team will provide this training.

3.7 Special arrangements have been made to allow non-medical, non-nursing staff to administer rectal diazepam or paraldehyde for the emergency treatment of seizures (please refer to the Epilepsy First Aid Training in section 30).

3.8 Prescribed topical, eye, ear and nasal medication may be administered by any member of staff authorised to do so, as part of their medication training. Further advice is available from the nursing team if needed.

3.9 Care staff must undergo the necessary training to administer Insulin (please refer to the Insulin administration for young people with diabetes procedure - section 24).

3.10 Staff may only assist in the administration of an asthma inhaler after having received advice on this practice from a member of the nursing team (please refer to the section on Asthma Inhalers - section 18).

4 Reconciling information about a young person's medicines

4.1 (NICE recommendation 1.7.3) When a young person first moves to or from Young Epilepsy, the following 'medicines data set' must be available on the day they transfer:

- full name, date of birth, NHS number, address, weight (if under 16)
- GP's details
- other relevant contacts defined by the young person and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- medicines the young person is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- other information, including when the medicine should be reviewed or monitored, and any support the young person needs to carry on taking the medicine (adherence support)
- what information has been given to the young person and or family or carers
- the name and job title of the person who compiled this information and the date on which it was compiled.

4.2 This medicines data set, should be obtained/verified with a source, such as:

- An up to date discharge summary
- Recently dispensed medicines labels from the pharmacy
- A recent prescription repeat slip
- Medicines administration records from their previous care service
- The dispensing pharmacist
- The prescriber
- Another health professional
- The young person
- Their family/carers

4.3 The person responsible for collating this medicines data set should have the training and skills needed to carry out medicines reconciliation.

4.4 For incoming young people, the medical and/or nursing team assimilate this data set at a medical clerking appointment ahead of admission. EMIS records are created before admission. Medication details are verified at the point of admission by the doctor or pharmacist. Any out of hours transfers are handled by the nursing team.

4.5 Registration with the Lingfield surgery for incoming residential young people will commence when the young person starts their placement. Where parents are not happy for this to occur, arrangements must be

made with the Residential/House Manager and Pharmacy Adviser to ensure the procedures and guidance within this Policy can be followed regarding each aspect of medication management.

4.6 For emergency transfer to hospital, the EMIS summary screen is printed and a copy of the current MAR sheet transfers with the young person.

4.7 Where a young person attends a hospital outpatient appointment during the term time or holiday the Hospital Appointment Communication Sheet must be taken and completed by the clinician to capture any proposed medication changes. This ensures that the change can be implemented even when there is a delay to the clinic letter. Where there is any ambiguity the Young Epilepsy registrar team must speak with the hospital specialist(s).

4.8 The medical team produce a detailed discharge summary for young people leaving the organization.

5 Medication plans

Creating the medication plan:

5.1 Registrars must inform the house staff and pharmacy adviser of the intention to commence a medication plan.

5.2 The plan must display the total morning and evening dosage for each stage of the plan and be created using the electronic medication plan master form in the Registrars shared drive O:/Health Services/Medshare/Registrars/Medplans).

5.3 Care must be taken not to overwrite electronic plans and each plan amendment must be saved as a revised document name/version.

5.4 The starting dose must be included in the drug name box, indicating whether it is increasing or decreasing. The dates written for each stage of the plan must be a Tuesday where possible. The strength of each tablet required and quantity to achieve the required dose at each stage of the plan must be stated.

5.5 Plans must take into consideration Young Epilepsy holiday periods (for 38-week placements) where parents prefer not to make medication changes while away from Young Epilepsy.

5.6 Medication plans must be signed by the prescriber and dated. A copy of the plan must be sent to the house where the young person is resident, to the pharmacy adviser and scanned on to EMIS.

5.7 Once the plan is received by the house the date of each planned stage must be transferred into the house diary to flag the need for the MAR sheet(s) to be sent to the Medical Centre for alteration. Care staff must write clearly on the pink Medical Centre Attendance/Medication Change Request Form in the health care folder indicating what change is required. The Medication Plan and all MAR sheets for the young person must also be sent.

5.8 It is best practice for a medication trained member of house staff to have handover from the prescriber/pharmacy advisor/nurse where changes have been implemented. This must be cascaded to the staff team by the staff member receiving the handover.

5.9 Audit for medication plan items must be carefully documented (please refer to Receiving Medication and the Audit Trail - section 12). House staff must communicate any shortage in medication for medication plan items to the Pharmacy Advisor/Medication Quality Assistant, allowing sufficient time to acquire the medication.

5.10 Any deviation from the plan must be communicated to the house staff and pharmacy adviser and the master copy of the plan amended and distributed. (see 5.3 and 5.6)

5.11 **All Medication Plans must:**

- be coordinated to reduce unnecessary wastage of medication already ordered.
- allow a seven-day lead time to acquire any new medication.
- set Tuesday as the change date.

5.12 When amending the MAR sheets for Medication Plans care must be taken to:

- cross other entries that are no longer active.

- Write each new week of the plan in a separate box on the MAR sheet and reference the next change date.

- Check entries - a nurse/pharmacist must initial next to the doctor's signature/date and sign the checked box on the Medical Centre Attendance/Medication Change Request Form

5.13 The Medication Changes Checklist on the doctors shared drive provides more information about necessary checks and writing MAR sheets.

EMIS and medication Plans:

5.14 Each young person has a medical record on the EMIS database and this must be updated by the registrar/pharmacist if there are changes to a young person's medication profile.

5.15 Any planned changes to medicines, doses or directions must first be discussed with the parents/guardians of the young person, where they are under 16 or where a capacity assessment indicates they lack mental capacity. Planned changes must be documented in EMIS consultations detailing starting/finishing doses plus increment size and frequency.

5.16 Any new medication needed for the plan must be added to the young person's EMIS record. Liaison with the house will be necessary to establish what tablet strengths, if any, are stocked.

5.17 Each item for the plan must show the instruction "according to medication plan".

5.18 The days/quantity line should manually be set to a 14-day supply.

5.19 A screen message to suggest that a medication plan is in place is useful to post using the M command. Do not overwrite existing important messages.

5.20 Supplies for items on an individual medication plan will be co-ordinated by the Registrars/ Pharmacy Advisor/Medication Quality Assistant together with the Registered/House Manager. 28 days supplies may not be appropriate.

5.21 When the plan is completed EMIS must be edited in accordance with the final dosage and a 28-day supply set for subsequent Boots cycles.

5.22 Where medication has been weaned completely the medication lines courses must be ended on EMIS and placed into past drugs

6 GP consultations

6.1 Care staff attending a GP appointment with a young person act in loco parentis and should inform the young person's parents of the outcome in accordance with Information Governance Guidelines.

6.2 In line with NICE recommendations 1.3.4 and 1.7.3, when attending medical appointments, care staff should provide the prescriber with relevant information from the minimum medicines data set (as described in 4.1)

6.3 A record of the consultation must be written in the pink Medical Centre Attendance/Medication Change Request Form in the Health Care Folder. Where appropriate medication course duration or review dates must be communicated.

6.4 Where a telephone consultation occurs at the Lingfield surgery a request of the consultation should be made by the healthcare assistant and uploaded to EMIS to ensure medical advice is followed carefully.

6.5 Where young people have medication prescribed by a doctor from Lingfield Surgery this must be prescribed on the young person's MAR sheet before administration can take place. Lines ordered from Boots Homecare Services will arrive with a MAR sheet. If the item is acquired through a local pharmacy at a time where there is no doctor available to write it up, treatment must not be delayed. Follow the process in points 6.6-6.8 below:

6.6 To avoid unnecessary delay in starting a newly prescribed acute medication (eg antibiotics) this can be carefully transcribed from the pharmacy label to the MAR sheet by two medication trained care staff who have had the necessary training to perform this role.

6.7 The transcribing staff must satisfy themselves that the label instruction is clear and the dispensing date is within the last 7 days. Checks to ensure the correct item has been dispensed must be made by checking the pharmacy label against the manufacturer's packaging/medication blister pack. Where the item is in a plain box or bottle the pharmacy label must be trusted. The transcribed entry must be signed and dated by both staff making the entry. The pink Medical Centre Attendance/Medication Change Request Form in the Health Care Folder must be referenced for additional information regarding course length/review dates.

6.8 The patient information leaflet must be studied and special note made of any additional warnings around the medication.

6.9 The item must be checked and signed by a doctor at the first available opportunity and within 72hours. The course duration/any review date must be clarified and noted on the MAR sheet if not already apparent.

7 Review of medication

7.1 All medication prescribed to young people must, as a matter of good practice, be reviewed annually by a medical practitioner.

7.2 In the event of there being a difference in medical opinion between an external specialist and Young Epilepsy doctor, communication between the two parties must occur in order that a prompt resolution can be achieved and recorded.

7.3 In the unlikely event that the difference in opinion cannot be resolved this must be reported to the Head of Health who will escalate the matter to the Director of Integrated Care to arrange a best-interests decision and seek independent advice from an external consultant.

7.4 Medication changes recommended by external clinicians must be provided in writing/email to the Young Epilepsy medical team before the changes can be implemented. See also Section 4.2 - the Hospital Appointment communication sheet.

7.5 When an improvement or deterioration is noted in the young person's condition all medications must be reviewed.

7.6 In line with NICE recommendations the medical practitioner must negotiate medication changes with young people/parents/guardians and communicate changes to house staff. Start dates for medication changes must allow time to acquire medication from Boots.

7.7 The date and person who conducted the review must be recorded in the young person's EMIS consultation record and Medical Centre Attendance/Medication Change Request Form in the Health Care Folder (pink sheet)

7.8 It is the responsibility of the Medical Practitioner prescribing medication to ensure that an entry regarding the prescription is made on EMIS and that the designated staff member in charge of the house is aware of the amendment via face-to-face conversation, telephone or email.

8 Medication administration records (MARs)

8.1 Boots Home Care Services will supply a MAR (medication administration record) Sheet with dispensed medication.

8.2 Once an initial medication supply has been made by Boots, printed MAR sheets will be routinely sent reflecting the medication profile stored at Boots.

8.3 Medication dose changes will only be reflected in the MAR sheets where a prescription has been raised and dispensed.

8.4 To acquire printed MAR sheets for young people not registered with The Lingfield Surgery, parents must be contacted and asked to provide a one-off prescription/EPS token to be dispensed by Boots Home Care Services, Crawley (EPS Code: FXM67). This will need to occur for every medication change made to ensure accurate information is printed on the MAR sheet by Boots.

8.5 All medication to be administered must be entered on to MAR sheets for each individual young person.

8.6 Only those abbreviations listed below will be used for doctor's handwritten amendments:

AM	from midnight to midday
PM	from midday to midnight
IV	intra venous
IM	intramuscular
SC	sub cutaneous
PO	by mouth
INH	inhaled
PR	rectally
PEG	through a gastrostomy
Buccal	in the mouth between gums and cheek
Top	application to the skin
EC	enteric coated
M/R	modified release
S/R	sustained release
PRN	when required

8.7 Times and doses of regular medication must be indicated on the MAR sheet.

8.8 The following codes must be used on the MAR sheets when a medication line is not signed for to indicate successful administration:

A	refused
B	nausea or vomiting
C	hospitalised
D	social leave
E	refused & destroyed
F	other (define reason on MAR)
G	see note overleaf (reasons detailed on carers notes on reverse)
N	not required

P prompt
M make available

8.9 If there is another reason why medication has not been administered, not covered by the above coding, this must be recorded, using code G. All staff will be trained in the use of these codes during the training programme (section 29).

8.10 Entries made manually by a medical practitioner must be signed and dated at the bottom of the entry.

8.11 It is the prime responsibility of the prescribing Medical Practitioner to ensure that the medication prescribed on the MAR sheet is correct.

8.12 If it is necessary to add a medicine, delete one or amend a dose, then this should be done clearly and legibly. The person doing this must be competent to do so and should have had training in how this should be done (unless they are a doctor in which case it is assumed that they are competent). See also section 12.11

8.13 MAR sheets must be kept on the houses in designated MAR folders supplied by Boots.

8.14 Where a medication line requires amendment by the medical team all MAR Sheets must be transferred to the Health Care Folder and clear instructions written on the pink Medical Centre Attendance/Medication Change Request Form. The young person medication profile form (8.22) should be sent too so the doctors can assess whether a medication is to be taken outside the product licence.

8.15 An indication of the MAR sheet location must be placed on the MAR folder divider where MAR sheets have been removed from the folders.

8.16 When new medication is prescribed, prescribers must be aware that there is a lag time before medication administration can be commenced.

8.17 If drugs are to be crushed or administered in any way outside the product licence, this must be detailed in writing by the prescribing doctor or pharmacist. Where more complex dose form manipulation is needed to administer a medication, guidelines will be written and issued by the doctor/pharmacist.

8.18 Changes to MAR sheets requiring registrar input will be made between 2pm and 4pm Mon-Fri. Required changes must be documented on the Medical Centre Attendance/Medication Change Request Form. A nurse or member of the Medication Quality Team should check the entry for accuracy and sign the pink form.

8.19 Where additional MAR sheets have been added the numbers in the top right-hand corner must be amended eg 1/2, 2/2 changed to 1/3, 2/3 when a 3rd sheet is added.

8.20 Medicines must be given in accordance with the printed and handwritten instructions on the young person's MAR sheet.

8.21 If, for whatever reason, there is any doubt about the medication prescribed, staff must not administer it until the prescription has been clarified.

8.22 A Residential Student Medication Profile Form bearing a recent, dated photograph of the young person must be kept in the MAR folder. Forms should be updated every six months with a recent photograph or sooner if new allergies / administration preferences are identified.

8.23 Copies of old MAR sheets should be kept in the Health Care Folder for 6 months before archiving on the house, in accordance with the IG retention schedules.

8.24 In line with NICE requirements, MAR sheets will be periodically checked by the house manager to ensure that they have been completed correctly (i.e. there are no missing signatures, that the correct codes have been used, that flexible doses have been recorded correctly etc.). The results of this MAR sheet check will help identify if more staff training is needed on record completion and who this needs to be targeted

9 Ordering Medication

9.1 There should be at least two staff members who are trained and competent to order and check the receipt of medicines in each unit. The job can be done by one person but there should be another to cover their absence.

9.2 There should be protected time for staff to order and check in medicines.

9.3 All medication for residential young people registered with the Lingfield Surgery is supplied every four weeks against NHS prescription forms (FP10) issued by Young Epilepsy to Boots Home Care Services.

9.4 Primary Care lines on these forms will be signed by the visiting GP from Lingfield Surgery on Mondays and Fridays. Consultants or Registrars sign for specialist Red and Amber lines according to the Surrey CCG prescribing PAD. Emergency prescription forms will be only signed by a GP at Lingfield Surgery on request.

9.5 All Registered/House Managers are responsible for ensuring that there are sufficient supplies of medication for young people on their houses so that running out of medication does not happen. Medication must be ordered in conjunction with the schedule set by the Medication Quality Team. This considers Boots Home Care Services dispensing schedules and Young Epilepsy holiday dates. Over ordering must be avoided.

9.6 Prescribed medications are the property of the person named on the dispensing label. We must ensure that medication prescribed for one person is not administered to another. Where a medication supply for a young person has run out, or is running low, this must be discussed with the nursing team at the earliest opportunity and referred to a medical practitioner where it is likely that doses will be missed.

> NB. During the COVID-19 pandemic where medication availability may fluctuate the DHSC has written a Standard Operating Procedure for use in Care Homes and Hospices which permits the re-allocation of medication lines no longer required by a resident to another where the medication is unavailable under strict protocols. This will be managed by the Pharmacy Adviser during the pandemic, should the need arise. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881838/medicines-reuse-in-care-homes.pdf

9.7 Supplies of some unlicensed drugs may need to be distributed from the medical centre.

9.8 Each month NHS prescription forms (FP10) are generated by a Health Care Assistant in the medical centre, according to an allocated schedule.

9.9 The back of the prescription forms (FP10) must be signed by a member of house staff or the Health Care Assistant.

9.10 **Week 1** – The medication representative for each house must complete the MAR ordering sheet. This will be sent to Boots together with the NHS prescription forms (FP10).

9.11 The ordering sheet can be used to inform Boots of any MAR changes that are needed eg items that need to be removed from the MAR. Any directions that need to be amended will only be changed by Boots on receipt of a FP10 prescription form for that item bearing amended instructions.

9.12 Boots service user update forms must be completed where changes to prescribed medications have been made and signed by the doctor or pharmacist.

9.13 Medical exemption certificates must be acquired for young people 19 years and over. Arrangement of this is the responsibility of the house manager. Failure to do so will result in Boots imposing a prescription

charge until such time as the exemption has been arranged. Exemption certificate details and expiry must be provided to the Medical centre and will be recorded on the young person's EMIS record. The card must be supplied to the young person's parents where they have less than a 48week placement package.

9.14 **Week 1 & 2** - Printed NHS prescription forms (FP10) are signed by a GP from Lingfield Surgery and Young Epilepsy prescribers. Boots Home Care Services collect the prescription forms along with the ordering sheet part of the Boots MAR sheets.

9.15 **Week 4** - Boots Home Care Services deliver medication to individual houses according to a regular schedule, ready for the new cycle start date (week 1).

9.16 There may be some variation to these timings where Young Epilepsy holiday dates disrupt the schedule.

9.17 During the summer break young people in 38/39-week placements and resident in England will be sent home with a supply of medication to last part of the holiday together with NHS prescription forms (FP10) to be dispensed by a community pharmacy near to the young person's home. The reasons for this are to:

- Avoid large quantities of medication having to be sent home with the young people
- Avoid incorrect or wrongly labelled items being sent home. This is a possible outcome if prescriptions are generated too far in advance and medication changes made

NB. It will be necessary to check whether young people who live within the United Kingdom but outside England can get FP10 prescriptions dispensed near their home well in advance of departure.

9.18 Items known to be difficult to access in the community will be supplied for the entire holiday.

9.19 Young people who live outside the United Kingdom and who are eligible for NHS services will need to have the medication supply for the entire holiday period provided before departure.

9.20 All medication remaining at the end of the holiday period must be returned to Young Epilepsy with the young person.

9.21 Prescriptions issued for the summer holiday (Aug-Sept cycle) will have the repeat side of the prescription record enabled. This will be completed by the Registered/House Manager on 38/39-week houses, for returning young people only, before the end of the summer term and returned to the Medical Centre to inform the Health Care Assistant which items to order for the September cycle.

9.22 52-week houses will have a continuous supply of 4 weekly deliveries and will order their prescriptions in accordance with the annual schedule.

9.23 Large excesses of regular medication should not be allowed to accumulate. Where it has, further stocks must not be ordered until the stock levels have been reduced.

Urgent/New Items

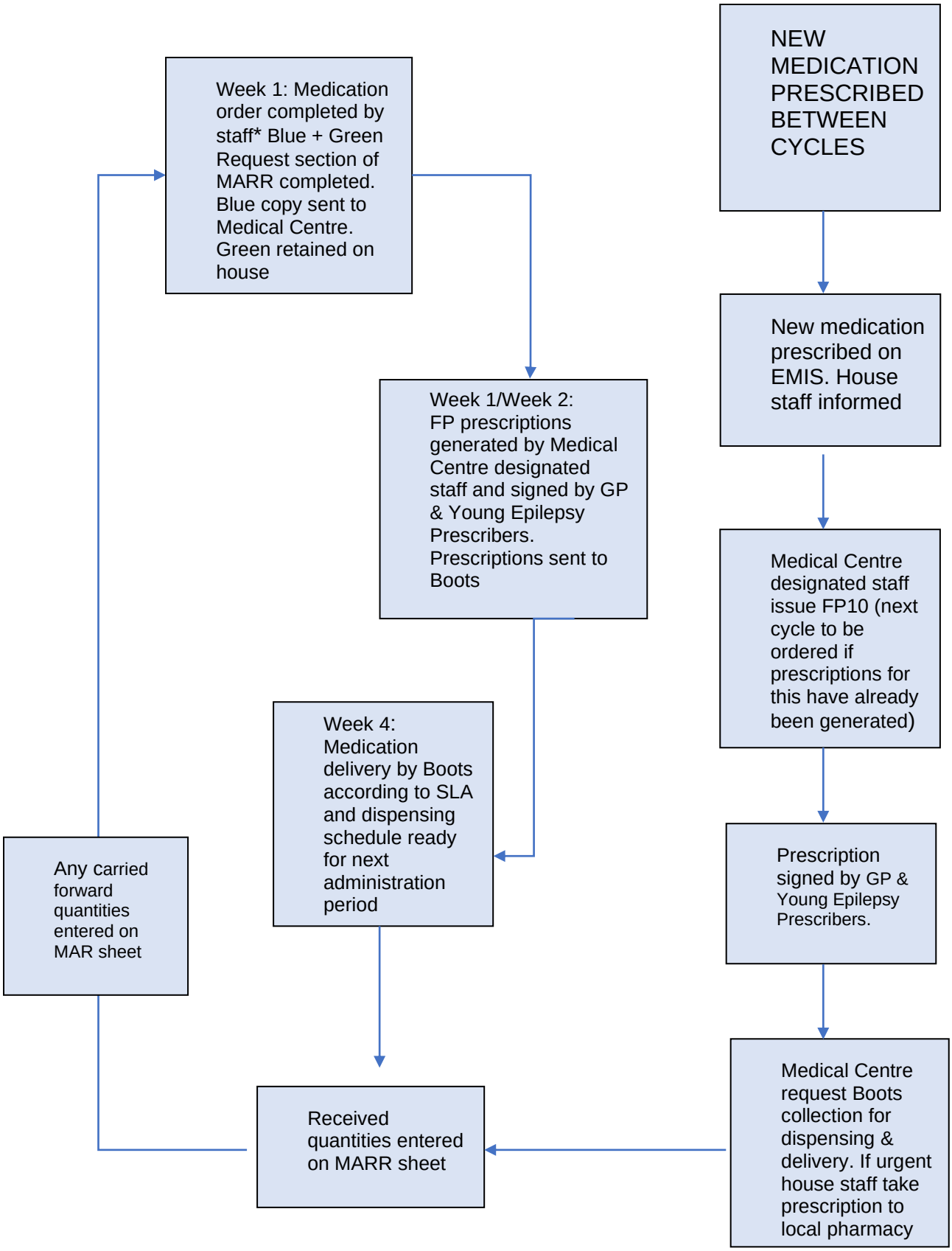
9.24 The registrars must liaise with the nursing staff responsible for generating NHS prescription forms (FP10) and the pharmacy adviser via email when new items are prescribed. This ensures that medication is acquired.

9.25 Boots Home Care Services can respond to urgent interim prescriptions although the original prescription must be received before processing/delivery. All urgent issues must be discussed with Boots by phone. They can deliver up to 8pm on weekdays and offer a Saturday service between 9am and 2pm. Sometimes it may be necessary to take the prescription to Boots pharmacy in Lingfield village for faster processing.

9.26 **Items not prescribed by Young Epilepsy Registrars:** all items, including vitamin supplements not initiated by Young Epilepsy medical professionals but requested by parents must be supplied by parents. The safety and appropriateness of such items must be ascertained by a Young Epilepsy doctor/pharmacist before being written on a blank MAR Sheet stating that it is at 'Parental Request'. Such lines must be reviewed every 6 months or sooner if deemed necessary. Where requested lines are not sanctioned the parent will be contacted by the doctor/pharmacist to discuss this.

9.27 **Medical Centre Stock:** stocks of Prescription Only Medicines (POM) for the medical centre can be obtained on a Signed Order form. The Nursing Team and Pharmacy Adviser/Medication Quality Assistant have responsibility for generating these. Signed Orders must be signed by a medical practitioner (registrar or consultant). Controlled Drug lines can only be acquired by a Young Epilepsy medical professional who has a private prescribing code authorised by Surrey CCG Controlled Drugs Team. Stock schedule 2 and 3 Controlled Drugs must be ordered on an FP10CDF form detailing the prescriber code.

Flow Diagram for Supply of Medication from Boots



*Ordering schedule can vary depending on Young Epilepsy holiday dates

10 Confidentiality and sharing of information

10.1 Confidential information about a young person must be treated confidentially, respectfully and kept securely in accordance with Young Epilepsy Information Governance Procedures.

10.2 Members of the care team should only share confidential information about a young person with health and social care professionals and other professionals (i.e. police, firemen, transport staff care of an individual) when it is needed for the safe and effective care of an individual. If in doubt, they should ask their line manager to confirm this is the case.

10.3 Records that contain confidential information about a young person must be held securely and must be accessed only by those people who need to have access to them.

10.4 MAR sheets should not be left open for longer than needed during the medication round as they contain sensitive information.

10.5 MAR sheets must be kept for three years from the last date of entry for adult young people. Children's records will be kept in accordance with the IG retention schedules.

10.6 If a young person's care is transferred to another care provider, copies of the MAR sheets will be made available to the new provider for reference (on a need-to-know basis in line with rules governing patient confidentiality). Actual records will be retained by the service where they were created.

10.7 When records are then destroyed, they must be shredded or destroyed in a way that preserves confidentiality.

11 Handling medication waste procedure

11.1 Any medication returned to the supplying pharmacy must be recorded in the returns book. This includes discontinued lines and isolated wasted doses.

11.2 Boots Home Care Services receive all pharmaceutical waste from the residential houses. Houses must individually arrange for waste to be collected by Boots.

11.3 Medication should only be returned on account of the 4 D's – **death** of a young person, medication **dropped** (or spat out), medication out of **date** or medication **discontinued**. (Please see also Refusal of Medication in section 15 30and 16)

11.4 All returned lines must be recorded on the Carers Notes of the MAR sheet and entered in the Boots medication returns book. Medication for return must be quarantined in an area of the locked medicines trolley or cabinet while awaiting collection by Boots.

11.5 Controlled Drugs lines must be entered on a separate page in the Returns book and kept in the CD cabinet until collection (please refer to Controlled Drugs - section 17).

11.6 Dropped or 'spat out' tablets and capsules must be wasted by placing them in a small sealable plastic bag bearing a label that details the contents of the bag.

11.7 Refused liquid medication doses must be disposed of in a sharps bin or waste bottle labelled for the purpose. Medication made up by aliquot (e.g. one tablet is dissolved in 10mls of water but only 5mls is administered and 5mls wasted), must have the non-administered portion disposed of in a sharps bin or waste bottle labelled for the purpose. Waste bottles, where used, must be kept in the medication returns section of the cabinet.

12 Receiving Medication and the Audit Trail

12.1 The audit trail comprises a record of medication:

	Where this is recorded
received	MAR sheet
administered	MAR Sheet
supplied for social leave, hospitalisation etc.,	Medication Collection/Return Record
disposed/returned to supplying pharmacy	MAR sheet + Pharmacy Returns Book

12.2 From these records it should be possible to calculate exactly the quantity of each medication a a young person has on the house at any time.

12.3 In this way any potential discrepancies in medication administration can be checked.

12.4 If any part of the audit trail is omitted this check is unable to be performed and compromises the safe handling and administration of medication on your house.

12.5 It is the responsibility of the house manager to appoint personnel to deal with the monthly counting and recording of medication stock and carried forward amounts. All staff dealing with and administering medication must understand the principles of audit trail such that in the absence of the appointed person(s) the trail is not compromised.

12.6 It is essential that all medication trained staff understand the importance of following the audit processes.

12.7 Upon receipt all medication must be checked, counted and recorded. A tablet triangle or capsule counting tray are useful for counting medication not in blister packaging.

12.8 Any dispensing error made by the supplying pharmacy must be immediately reported to the pharmacy and the Medication Quality Team contacted. Where the error has led to medication doses being given incorrectly the DSL must be informed. (See section 26 Medication incidents procedure)

12.9 The quantity and date received must be documented and signed for on the MAR sheet provided. Liquid medication quantities must be recorded in “mls”. Topical products must be recorded in “mls” or “grams” as appropriate.

12.10 Each new cycle MAR sheet must be reconciled with the outgoing MAR for the previous cycle. Where medication entries correlate, a small tick must be placed on the left-hand side of the entry and initialled and dated by the trained staff member performing the check. This must be counter signed by an equally trained and competent person to say that it is correct. The date the second check is performed must be written if it is done on a different date.

12.11 If it is necessary to add a medicine, delete one or amend a dose on the MAR sheet, then this should be done clearly and legibly. The person doing this must be competent to do so and should have had training in how this should be done (unless they are a doctor in which case it is assumed that they are competent). Where a trained carer makes the change, the transcribed entry should be dated and a reason recorded (on the reverse of the MAR) as to why the change was made. The date of the MAR sheet bearing the original doctor signed entry must always be referenced. It should be signed by the person making the entry and counter signed by an equally trained and competent person to say that it has been amended correctly.

12.12 Where care staff need to transcribe amendments of regular prescribed medications on each successive new cycle MAR sheets, the amendment must be signed off during the first week of the cycle and EMIS checked to ensure the item(s) bears the correct dosage instructions for further supply. (Printed changes to a MAR sheet only happen when a prescription is issued and sent to Boots for dispensing)

12.13 For young people not registered with the Lingfield Surgery, the accuracy of transcribed amendments of dispensed lines must be checked by a Young Epilepsy registrar each term and counter signed.

12.14 Any parental lines requested and sanctioned must be reviewed every 6 months. Where a parental line is sent for review the supplement/product must be sent with the MAR sheet so the product details can be seen and reassessed.

12.15 Large excesses of regular medication should not be allowed to accumulate. Where it has further stocks must not be ordered until the stock levels have been reduced.

12.16 At the end of each cycle, any excess medication must be counted and carried forward to the new cycle MAR sheet, carefully documenting the time and date this was performed.

12.17 Occasionally holiday dates at Young Epilepsy mean that some monthly supplies are received during week 2 or 3 of a Boots cycle, rather than in week 4. Where this happens, the delivery should be recorded in the current MAR sheet and a total carried forward quantity recorded after social leave to include this delivery. 52-week houses can carry forward in the usual way cited below.

12.18 Medication stocks should be reconciled each cycle and evidenced to check that medication has been given as intended during the last 4-week period and that no discrepancies have occurred.

12.19 “As required” medication must be balanced against the number of administration signatures, referencing the carers notes for doses given.

12.20 Any unexplained discrepancies in reconciling stock must be reported to and discussed with the DSL/Medication Quality Team who will triage the need for a concern to be raised (please refer to Medication Incidents Procedure - section 26).

Medication Collection/Return Record

12.21 Every time a young person is sent off site with medication whether for social leave, an off-site visit, or hospitalisation, the amount of each medication item sent must be documented on a Medication Collection/Return Record carefully noting each medication name, strength and dose form (eg Lamotrigine 25mg Tablets). This must be signed by the person taking the medication off site.

12.22 Medication must be carried in a Young Epilepsy green medication bag bearing the young person’s name. A copy of the Medication Collection/Return Record must be sent in the bag with the medication.

12.23 On return all medication brought back must be counted in and documented. Discrepancies must be recorded on the Medication Collection/Return Record and discussed with the parent/carer to try to establish how the discrepancy occurred. Such occurrences must be discussed with the DSL to establish whether a concern should be raised. Where no suitable explanation can be found and there is a recurring trend (e.g. three consecutive occasions) or there is a large unexplained discrepancy this must be discussed with the DSL and Medication Quality Team to discuss next steps. (please refer also to the Medication Incidents Procedure - section 26).

12.24 If less medication is returned than anticipated there is likely to be a shortfall before the end of the cycle. If this happens every effort must be made to recover the shortfall (eg if parents have failed to return medication). If there is a deficit that cannot be recovered additional medication must be acquired on prescription via the medical centre.

The Returns Book

12.25 Any medication returned to the supplying pharmacy must be documented on the MAR sheet and recorded in the returns book (see Handling medication waste procedure). This includes discontinued lines and isolated wasted doses.

Interim Ordered/Owing medication

12.26 The quantity of any medication received after the beginning of the cycle must be documented on the current MAR sheet.

12.27 This includes interim orders (eg where there has been extra medication ordered or where a new item has been prescribed mid cycle) and owing items delivered by the supplying pharmacy.

Medicines not accounted for:

12.28 If staff are aware that medication cannot be accounted for, this matter must be immediately reported to the DSL/Medication Quality Team/Duty Officer, who will advise on the appropriate action to be taken.

12.29 Once staff are aware that medication cannot be accounted for, an immediate search must be undertaken and any staff who are not on duty contacted to discover if they have any knowledge of the matter.

12.30 The MAR Sheets must be checked to discover whether the audit trail can explain the discrepancy.

12.31 Where the amount of medication is significant or the incident appears to be part of a trend a full investigation must be conducted. The Head of Residential Services will determine what further action is indicated.

13 As required medication

13.1 For medicines prescribed on a 'when required' basis, the prescriber will sign off a completed 'when required' protocol. This will give details of what the medicine does, the circumstances under which it should be offered, the minimum time between doses, the maximum dose in 24 hours, how much to give if a variable dose has been prescribed. When complete as required protocols are uploaded to Sharepoint by the HCA and scanned to the individual's EMIS record.

13.2 Where a doctor (GP/registrar) make changes to a prn medication dose or adds a new prn line to a young person's medication profile they must provide details to the healthcare assistants to ensure the prn protocol is edited/written.

13.3 Residential staff must ensure there is a MAR sheet entry for each prn line and that they have protocols for all prn lines. Where there are regular and prn doses for the same medication these can be entered under one MAR sheet entry.

13.4 As required medicines should be offered when it is needed and not withheld until the medication rounds

13.5 As required medication must always be dispensed in original packs rather than monitored dosage systems.

13.6 Administration of as required medication must be documented with a G code on the MAR sheet and recorded on the reverse of the MAR with the reason why this has been administered. The outcome of the as required dose must be recorded after a suitable time period in the Result section of the carer's notes. E.g. for additional laxative the evidence of the next bowel movement is recorded; for an elevated temperature paracetamol administration can document the time the temperature was repeated with the resulting temperature. As required medication outcome should always be pointing to an improvement in the young person's presenting symptoms and where this is not the case a record of other interventions must be documented.

14 Procedures when medicines are administered

14.1 Medicines should only be administered to a young person after checking the young person's identity against the Medication Profile Form (Residential Student Medication Profile Form). This bears a recent, dated photograph of the young person together with information about how the young person takes their medication. This must be kept in the MAR folder.

14.2 Every care must be taken by all staff to ensure that there are minimal distractions present to the person(s) administering medicines.

14.3 Care must be taken to ensure all of the young person's MAR sheets are referred to before the medicine is administered ("start with the chart").

14.4 Members of staff must act in accordance with any additional instructions specified on the MAR sheet or pharmacy label (e.g. give with food).

14.5 Medicines must be given in a person-centred way. If the young person is eating, then it may be better to wait until they have finished before giving them their medicine (but check to see if the medicine should be given on an empty stomach and young person preferences).

14.6 For young people who are asleep, check how much leeway there is with the timing of that medicine (refer to 14.13) as it might not be necessary to wake them up.

14.7 The MAR sheet must be checked to ensure that a medication has **not** already been administered by another member of staff for the dose time being measured.

14.8 The staff member measuring the medication should check and measure each item on the MAR sheet alongside the pharmacy medication label using the checks detailed in the '6 point check'© (this process is copyright of The Medication Training Company, Worthing). This ensures each of the 'The Right Checks for Drug Administration' are conducted in a systematic way (see page 32).

14.9 The 'pop, red dot, give and sign' method (see page 32) must be followed for each medication line, ensuring the MAR has a dot marked in red pen at the point it is measured.

14.10 Medication must be administered, and the MAR sheet signed immediately after successful administration (please see the procedure for Non Compliance with Medication refer to sections 15 and 16)

14.11 Responsibility for the accurate and correct recording of medication administered lies with the member of staff administering medication. The staff checking the medication against the MAR sheet/pharmacy label and preparing the dose must administer it to the young person and sign the administration record personally.

14.12 If a "change of face" is required where medication is initially refused, the staff administering must also check the medication against the MAR and satisfy themselves that the dose has been prepared (e.g. measured and checked) correctly.

14.13 We aim to give medicines on time but appreciate that some leeway might be needed from the time stated on the MAR. We will consult with some or all of the following to decide these times: the prescriber, pharmacist, young person, their carers or relatives. As a rule, we will aim to comply with the following time scales:

- Time-critical meds e.g. diabetes, epilepsy +/- 30 mins

- Twice a day, three times a day, four times a day, every four hours +/- 1 hour
- Once a day, once a week, once a month +/- 2 hours

14.14 If medicines are given outside of these time frames, a G code must be used on the MAR sheet and the following recorded in the carers notes on the back of the MAR: the actual time of administration, the reason why the administration did not occur on time, who was notified, any follow up action/observations taken. It may be necessary to delay the next dose.

14.15 Oral syringes must be used to measure liquid medicines as spoons and measuring cups are less accurate. There can be exceptions to this with medicines such as Gaviscon and lactulose (or other medicines where the consequences in less accurate measurements have negligible clinical impact).

14.16 All liquid and topical medicines must clearly show the date of opening and the discard-by date. This aids in the audit trail.

14.17 All medicine bottles should be wiped after use and oral syringes washed by hand in warm soapy water. Dishwashers will not remove medication from the tip of the syringe.

14.18 Medication with half tablet instructions will require breaking/cutting at the point of preparing a dose. Staff must use a tablet cutter to achieve the most accurate halving.

14.19 The remaining half tablet must be placed into a separate bottle, acquired through, and labelled specifically for this purpose by the medication quality team. This must be used when the next half tablet dose is needed. If this is more than 48hours after the first administration, the half tablet must be discarded according to the procedure for medication waste.

14.20 Steps 14.18-14.19 must not be carried out with sodium valproate (Epilim) tablets which deteriorate rapidly when exposed to moisture in the atmosphere. Remaining half tablets containing sodium valproate must be disposed of immediately according to the procedure for Handling Medication Waste – section 11.

14.21 Where half tablets are prescribed consideration should be given to whether an alternative strength of tablet (or a liquid form) is available that reduces the need for a half tablet to be administered.

14.22 Where the specified strength of medication is not available, but the dose can be achieved by giving alternate strengths of medication available to the young person this must be discussed with the doctor, nursing staff or pharmacy adviser (e.g. 100mg tablets have run out but 200mg tablets are also available and ½ x 200mg could be given). Code G must be used to record administration against both medication strength entries to indicate exactly what has been administered. Details must be recorded in the carers notes with the name of who authorised this practice.

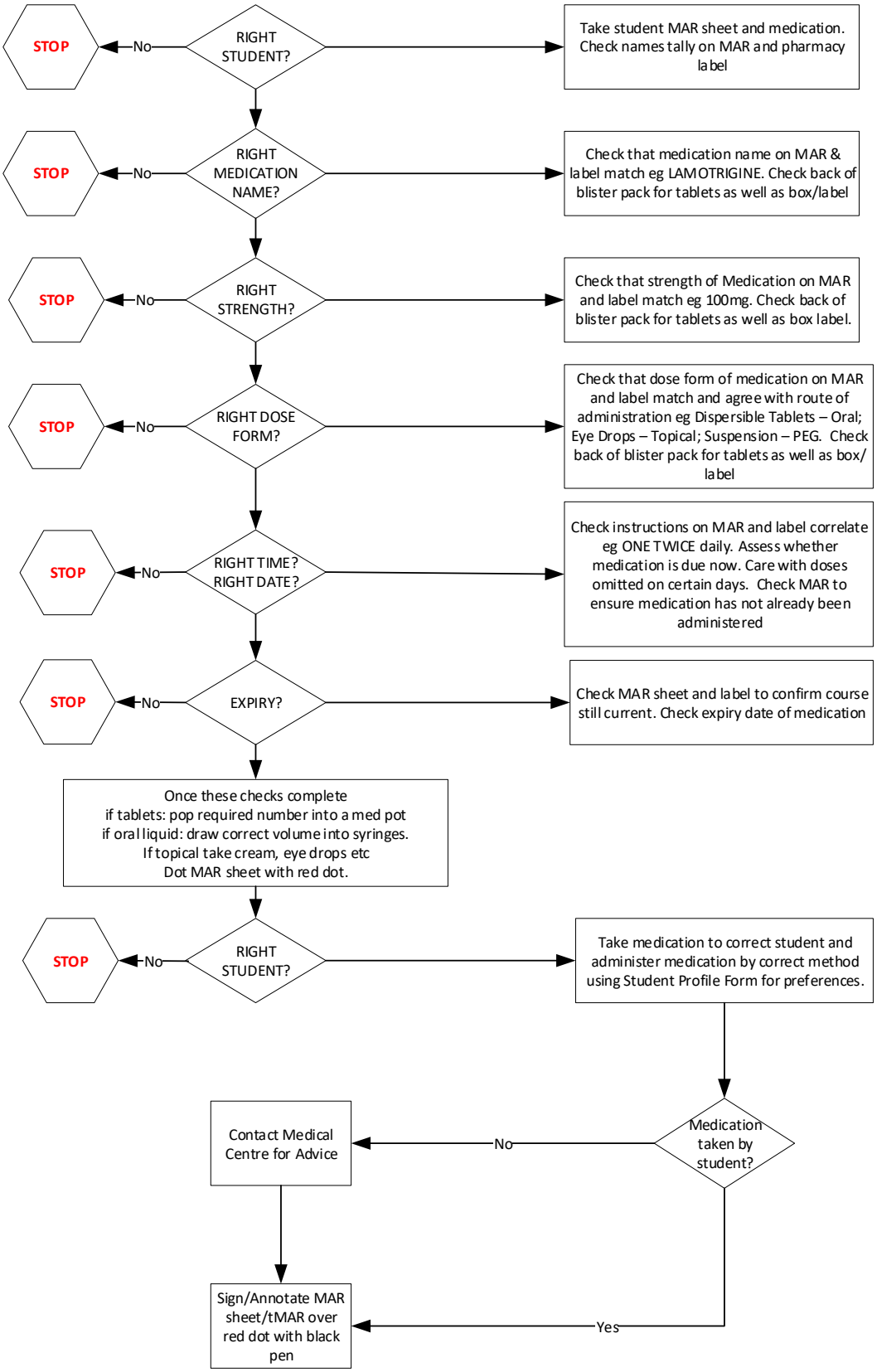
14.23 Medication must always be administered in a professional manner, maintaining the young person's privacy and dignity.

14.24 If a product in the list below (p. 31) has been opened then check to see if the manufacturer has provided a 'once opened, discard by date'. If not, then use the dates shown.

14.25 Staff who open medicine in the list (except for tablets and capsules) must add both the date of opening and the discard by date to the pharmacy label (or 'date opened/expiry' sticker provided by Boots).

Product	Expiry Date
Eye, ear and nose drops/ointments	28 days after opening unless otherwise specified by manufacturer.
Creams and Ointments	
Creams in a jar/pot	Manufacturer's expiry/in use expiry date. Follow infection control procedures
Creams in a tube	Manufacturer's expiry/in use expiry date. Check storage temperature requirements
Aerosols	Manufacturer's expiry/in use expiry date
Pump dispensers	Manufacturer's expiry/in use expiry date
Rectal preparations and pessaries	Manufacturer's expiry date on product
Internal or external liquids	
Manufacturers original container	Manufacturer's expiry/in use expiry date
Oral Liquids Dispensed in plain bottles by pharmacy	6 months from date of dispensing. Check dispensing label/extra information
Specials or unlicensed liquids	Manufacturer's expiry date, check storage conditions
Tablets and Capsules	
Manufacturers original container	Manufacturer's expiry date on product. Take note of 'in use' dates if specified
Manufacturer's foil or strip packaging	Manufacturer's expiry date on product. Take note of 'in use' dates if specified
Dispensed into tablet bottle by pharmacy	One year from date of dispensing unless otherwise stated
Monitored Dose Supply (MDS) prepared from pharmacy	8 weeks after dispensing

The Right Checks for Medication Administration



15 Refusal of medicines in young people with sufficient mental capacity

15.1 If a young person does not take routine medication at the allotted time, this must be reported to the nursing team*. The consequences of non-administration should always be considered.

15.2 All messages must be recorded in the young person's EMIS consultation record together with advice given.

15.3 If regular medicines are declined, or not given for any other reason, staff must also record this on the MAR with an appropriate code and record the reasons why they declined (if they can find out) in the carers notes on the back of the MAR

15.4 If non-administration is noted through a signature gap in the MAR sheet, an audit of the gap must be carried out to see if the medication may have been administered but not signed for. The missing signature box must be highlighted and recorded in the "Administration Record Gap Book/Document" with a record of findings.

15.5 If a young person declines their medication, the medication should be re-offered over a 1–2-hour time period with a "change of face".

15.6 If a young person spits out medication, the nursing team should be informed* If tablets are intact, the advice will normally be to repeat administration. Medication spat out and not successfully re-administered must be placed in a sealed bag for destruction.

15.7 If a young person vomits medication immediately after administration, the nursing team should be informed*. If the tablets are intact, the advice will normally be to repeat the dose with new medication. It is important that only the tablets seen and identified are repeated.

15.8 If a young person takes medication and then vomits and it is unclear how much has been rejected, the nurse shift leader should be informed*. Advice on the appropriate course of action will be given. The advice will normally be that if it is unclear what has been vomited then no re-administration of doses would occur.

15.9 If a young person takes the wrong medication or the wrong dose, the nursing team must be informed*. This must be reported to the doctor on-call. The young person must be monitored for any changes. The house staff involved should inform the DSL, parents and the senior care team. A concern must be raised on MyConcern. Refer to Medication Incidents Procedure – section 26.

15.10 *In the event of there being no nurse available for advice, the appropriate action to take should be discussed with a senior member of staff/Executive on call. An email detailing the administration problem should also be sent to the nurses' station.

16 Refusal of medication in a young person who lacks mental capacity

16.1 Staff members can try the following:

- Try again a few minutes later (the person may have forgotten that they refused)
- Try a different staff member
- Explain to the person what the medication is for
- Talk to the doctor/pharmacy advisor to see if the timing and or form of the medicine can be changed
- Talk to the prescriber and arrange for a medication review

16.2 In line with the Mental Capacity Act 2005 Code of Practice and guidelines from the Nursing and Midwifery Council, a decision can be taken to give medicines covertly (e.g. hidden in food or drink). This must be in a young person's best interests when they lack mental capacity and are unable to properly understand the consequences of not taking their medication. An assessment of whether the young person has adequate mental capacity to understand if taking the medicine is in their best interests and that the medicine is essential for their wellbeing must be carried out. If it is established that the young person lacks adequate mental capacity, the assessor must consult with their healthcare professionals and obtain the views of everyone involved in the young person's care (e.g. CPN, staff, relatives, legal advocates). This may lead to a decision to covertly administer the young person's medicines in their best interests.

16.3 The assessment, consultation and decision must be documented in the young person's notes and reviewed regularly as mental capacity can sometimes fluctuate. A care plan will be needed to set out clearly how the medicines will be administered covertly to the young person. The Mental Capacity Act Code of Practice sets out that it must be assumed young people over 16 years have mental capacity. Therefore staff administering medicines must reasonably believe that the young person lacks mental capacity each time and the action they are taking when giving them their medicines covertly is in their best interests.

16.4 The prescriber should be asked to review the medication to establish which medicines are necessary.

16.5 The pharmacy advisor should be contacted to check if tablets can be crushed, or capsules opened and medicines are stable enough to be mixed with food or drink. This can be verbal authorisation, which can be written in the young person's notes and backed up with a written signed and dated statement.

17 Controlled drugs (CDs)

17.1 In social care settings (i.e. at Young Epilepsy) only the following CDs require extra controls:

- All schedule 2 CDs except quinalbarbitone
- From schedule 3, just temazepam, buprenorphine, flunitrazepam and diethylproprion
- From schedule 5, just Oramorph 10mg/5ml

17.2 This list may change hence check with the pharmacist. If unsure whether a medication is a CD, ask the pharmacy adviser/medical centre.

17.3 CDs must be kept in a designated CD cabinet secured to the wall.

17.4 Each house handling CDs must have a CD register. This must be used to record all CDS received, administered and returned to Boots. It must be counter signed by a medication-trained witness.

17.5 There should be one active register per house or in school or FE at any one time.

17.6 A separate page will be used to record each separate form and strength of CD for each young person. So, for example if one young person took both Concerta XL 20mg tablets and Concerta XL 10mg tablets these would be recorded on separate pages.

17.7 CDs must be entered into a CD register by a fully medication trained staff member upon receipt. A witness signature trained for this purpose is required for every CD entry.

17.8 A running tally of each medication must be kept in the CD register and stock counted at each administration.

17.9 Two fully medication trained staff must check each CD medication on receipt to ensure the correct balance is evident and sign for this.

17.10 Additional weekly counting of stock must be evidenced in the CD register by two medication trained staff.

17.11 There should be no crossing out in the CD register. Incorrect entries should be bracketed, and the correct entry written alongside it.

17.12 It is good practice to have the CD register out when administering the young person's medication so that entries do not get overlooked. Sign the register when preparing doses to be administered.

17.13 When CDs are administered, a record must also be made on the MAR by the person administering. The house manager can decide whether the MAR entry must be signed by a medication-trained witness.

17.14 If a medication-trained witness is not available, no young person should be denied administration of a CD. In such circumstances a responsible staff member must check and count the medication with the fully medication trained staff member explaining the checks required – Right Student>Right Medication>Right Strength>Right Dose Form>Right Dose>Right Time/Method>Right number in stock.

17.15 Residential young people receiving CDs from their house supply to take off campus for weekends/holidays/off site visits must have the quantity supplied signed out of the CD register. Medication returned must be entered back into the house CD register. Two medication trained signatories are required for this process. The same process applies for school or FE Day Young people requiring the administration of CDs during an offsite activity.

17.16 Any CDs unaccounted for must be notified to the DSL who will take advice from the Pharmacy Adviser regarding next steps. Where a discrepancy is verified, an investigation will commence and local safeguarding reporting processes followed. See also the Medication Incidents Procedure – section 26.

17.17 Any CDs for return to Boots Homecare Services, must be entered into a dedicated page of the Boots Returns Book and signed out of the CD Register. Two people must sign for this. Returns must be stored quarantined in the CD cabinet until collection. An entry in the carer's notes on the MAR sheet must be made regarding items returned to Boots.

17.18 Discontinued lines returned must show a balance of zero in the CD register and the rows remaining on the current page must be scored through with a zig-zag line.

17.19 Where CDs are taken on a residential visit exceeding 24 hours, they must be signed out of the house CD register and entered onto a temporary form available from the Pharmacy Adviser. A separate form must be used for each CD line per young people. The form(s) must be used for the duration of the trip following the guidelines above. The returned quantity at the end of the residential trip must be entered into the house CD register. The temporary form must be kept in the back of the CD register.

17.20 CDs for young people working towards medication independence must be kept in a locked receptacle in accordance with the risk assessment. If medication is not stored in the young people's room, CDs must be kept in the CD cabinet and weekly stock checks performed. Entries in the CD register must be made when the young person does not have full responsibility for their medication and supplies are not kept in the young person's room.

18 Asthma inhalers

18.1 It is the responsibility of the designated senior member of the care and education staff on duty to ensure that any young person with an inhaler always has access to his/her inhaler.

18.2 Young people may self-administer asthma inhalers according to their individual care plan and risk assessment.

18.3 Staff may only assist in the administration of an asthma inhaler if they have full and current Emergency First Aid training and have received information on this practice from a member of the nursing team. (Refer also to Emergency Medication Kits – section 22)

18.4 The emergency use of an asthma inhaler when a young person is away from the building where administration records are stored, must be documented on return using a G code which explains where this was given and who witnessed it. The nursing team must also be informed, and the event recorded in EMIS.

18.5 Young people in day placements using their inhaler must have this reported to the young person's parents/carers and entered in the communication book where this is in place. The emergency bag/Day Student administration forms must also be updated accordingly.

19 Side effects

19.1 Staff should have an awareness of which side effects to look out for with medicines that are taken by young people. Any serious side effects that must be monitored should be recorded on the Medication Profile Form.

19.2 The yellow card reporting system is available to report an adverse drug event for a young person. The event would be reported in the first instance to the nursing team, registrar, and consultant, and cascaded to the Pharmacy Adviser. Parents and staff caring for the young person would also be informed.

19.3 In line with NICE guidelines, a record of the adverse event must be made in the young person's care plan. This should describe the nature of the side effect, who has been informed, and when, what advice they gave and what action is being taken.

20 Promoting medication independence procedure

20.1 Before a young person can administer their own medication, they must be nominated by the care team and agreed by the Registered/House Manager. Following nomination, a risk assessment must be carried out and the necessary documentation signed by the Registered/House Manager.

20.2 The young person's capabilities, including mental capacity, must be assessed as part of the risk assessment to be determined on an individual basis in accordance with their care plan. The risk assessment must be reviewed at least annually.

20.3 The level of self-administration that can be undertaken must be clearly outlined in the individual care plan.

20.4 All documentation relating to self-medication, whether they prove successful or not, should be included in the young person's health care folder in the house.

Review of independent medication administration

20.5 It is the responsibility of the Registered/House Manager or designated senior member of care staff on duty to oversee the independent administration of medication by young people in their charge.

20.6 If at any time a member of staff becomes concerned about a young person continuing to independently administer; it is their duty to immediately report this concern to their line manager.

Storage and administration of medication for the young person working towards independent administration

20.7 It is the responsibility of the Registered/House Manager or medication trained shift leader on duty, to regularly monitor independent medication. Attention should be paid to:

- whether the correct amount of medication is used by the young person
- that all medication prescribed is taken by the young person
- that the medication is taken at the correct time
- that there is no deterioration in the young person's medical health.
- that the medication is safely stored.

20.8 In line with NICE recommendation, consideration should be given as to the best system for supplying medicines for each young person (in consultation with the young person) to support their independence. The system used should be appropriate to the care plan and risk assessment for each individual young person

20.9 Staff should not secondary dispense into dosette boxes. If dosette boxes (monitored dosage systems) are needed, then these should be filled and labelled by a pharmacy. The pharmacy advisor can be contacted for further information regarding compliance problems in a young person working towards independence.

20.10 All medication dispensed to a young person for independent administration must be kept in a locked receptacle in accordance with the risk assessment. Once a young person has been deemed fully competent to independently-administer, medication is controlled by the young person, with the house retaining a key for twice weekly checking.

20.11 Where young people working towards medication independence take CDs these must be kept in a locked receptacle in accordance with the risk assessment (please refer also to the Section 17 – Controlled Drugs)

Recording administration of medication for the young person working towards independent administration

20.12 If staff have any involvement in ordering or taking receipt of medicines for young people who self-medicate, they must record the medicines (and quantities of those medicines) that are handed over to the young person. They must make the same records of any medicines for which they have an involvement in disposing of on behalf of self-medicating young people.

20.13 If the young person is not in full control of their medication and part of the medication supply is kept in the house medication storage, the MAR sheet must be annotated regarding whether the medication has been made available or whether the young person has been prompted to take their medication.

20.14 Medication wastage must be handled as per the Handling Medication Waste Procedure in section 11.

21 Residential visits/short term leave medication procedure

21.1 Residential young people taking social leave or going on Young Epilepsy organised residential visits will take their Boots home care services supply.

21.2 Due to the nature of acquiring drugs, supplies for social leave or trips need to be checked at least five days before the departure day.

21.3 The Emergency Medication Bag must be provided for each young person requiring Emergency Medication with a copy of the emergency instructions kept in the Medication file (number 6). The contents of these bags must be checked regularly and at least before each half termly break (please see details in Section 30 - Epilepsy First Aid)

Young people on residential visits:

21.4 It is the responsibility of the group leader to ensure that young people have sufficient drugs for the duration of the visit. This must be checked allowing sufficient time to acquire any drugs from Boots if needed. The Residential Services' Off-Campus Trips Procedure should be followed allowing appropriate timescales.

21.5 It is the responsibility of the group leader to ensure adequately medication-trained staff (at least two) and epilepsy first aid trained staff are available throughout the period of the visit.

21.6 They should also ensure that young people have sufficient medication for the duration of the visit plus an extra 5 days. This must be checked allowing sufficient time to acquire any drugs from Boots if needed.

21.7 Medication must be signed out from the house and back in, on the Medication Collection-Return Record (see 12.21) and carried in a Young Epilepsy green medication bag bearing the young person's name.

21.8 The young person's MAR sheets and current emergency instructions must be taken.

21.9 Drugs must be stored in a locked receptacle and a safe practice established for the handling of keys.

21.10 Only fully qualified medication-trained staff may administer medication during any off-campus/residential visit.

21.11 The administration of regular, as required and emergency medication whilst away from Young Epilepsy must be recorded and countersigned on the MAR sheet. This guarantees that if the staff responsible had to leave the situation an accurate record remains with the group.

21.12 Where CDs are taken on a residential visit the supply must be signed out of the house CD register and entered onto a temporary form available from the Pharmacy Adviser. (see also section 17.)

21.13 A separate form must be used for each CD line. The form(s) must be used for the duration of the trip following guidelines contained in the section on Controlled Drugs – section 17. The returned quantity on return from the residential trip must be entered into the house CDs register following guidelines contained in section 17 - Controlled Drugs.

Young people on social leave:

21.14 Care staff must ensure parents or escorts have correct medication, complete with patient information leaflets (the leaflet that comes in each pack of medication), before leaving campus. A minimum

additional 5 day supply of medication above what is actually required must be sent for all periods of social leave.

21.15 Medication must transition to and from campus in a Young Epilepsy green medication bag bearing the young person's name.

21.16 Each house must keep an up-to-date folder with patient information leaflets specific for the medication prescribed for their young people. Copies of these can be provided where no leaflet is available for medication being sent for social leave

21.17 Secondary dispensing must not be undertaken. This involves removing tablets from the original pack/bottle supplied by Boots and placing them into another pack/bottle. Contact the pharmacy adviser if in any doubt as to what constitutes secondary dispensing.

21.18 All medication must be recorded as detailed in the Audit trail processes - section 12).

21.19 When a young person returns home or to other residential accommodation, the parents or carers must be informed of:

- Any medication already administered on that day
- When such medication was administered
- Any medication yet to be administered for that day
- When such medication should be administered
- Whether the medication is to be administered at other intervals.

21.20 This information may be communicated verbally, but a record should nonetheless be made of any instructions/information given to parents/carers in the house communications book. A copy of the most up to date MAR sheets must be provided to parents/carers.

Young people attending off campus/college

21.21 Young people going off campus to college and who need lunch-time doses must have any medication supplied from their Boots Home Care Services supply in the original container/packet.

21.22 These must be recorded as detailed in the Audit Trail processes - section 12).

21.23 Administration must be recorded using a G code and referencing the Medication Collection Return Record (see 12.21) noting the staff member who supervised the medication administration.

21.24 If attending external college courses is a regular occurrence Boots can arrange to dispense a small supply in separate containers.

21.25 If a young person is not accompanied by medication trained staff the young person must either have a risk assessment carried out with respect to self-medication (please refer to the Promoting Medication Independence Procedure - section 20) or prior arrangement must be made with the pharmacy advisor to assess the possibility of education staff being trained to administer isolated doses. A robust check list must be drawn up by the pharmacy advisor where this is sanctioned.

21.26 Medication must be carried in a Young Epilepsy green medication bag bearing the young person's name.

22 Emergency medication kits

Residential young people Residential young people

22.1 All residential young people requiring emergency medication lines (eg buccal midazolam, rectal diazepam, paraldehyde, adrenaline, behaviour medication) will have an Emergency Medication bag. On the houses these bags are stored in locked cupboards/cabinets which can be accessed by trained Epilepsy First Aid staff.

The Emergency Medication Bag is the responsibility of the House Manager/Care Co-Ordinator or designated care staff member in charge with respect to setting up/replenishing bags. Staff carrying out this activity must either be fully medication trained or have had the necessary training to carry out the task. It is essential that each kit contains a completed Residential EFA Kit Record Sheet to comply with audit processes Residential EFA Kit Record Sheet.docx (see Flowchart for making up emergency bags on page 44)

22.2 Emergency bags contain each line of the emergency instruction in a clear press-seal plastic bag. Each plastic bag is then further sealed with a tamper evident tag seal bearing a unique number. This number must be recorded on the EFA Kit Record Sheet. The expiry date of the kit must also be clearly displayed on the EFA Bag record Sheet and written on to the sealing tag. The emergency bag itself is not sealed to ensure that expiry dates can be checked. The contents of the kits must be checked regularly and prior to each off site visit and period of social leave. Enough emergency medication must always be sent home for social leave.

22.3 Young people who have frequent administration of emergency protocol lines must have backup stock on the house, stored in the medication cabinet. If medication must be acquired to replenish kits this must be sourced as a matter of urgency. Contact the nursing team for prescription issue. Where the young person is not registered with the Lingfield surgery call the parent/carer to discuss how further supplies can be accessed. The young person cannot access offsite activities until new stock has been received and the bag has been replenished.

22.4 From November 2022 the Emergency Medication Bags for residential students must transition with the young person between the house and school/FE. This ensures that emergency medication is always available should it be needed. This can only be administered by a nurse/EFA trained staff member.

22.5 Each student must have an individual sheet for signing kits in and out, in both the house Residential EFA Kit Sign Out Form.doc and classroom setting Day Students EFA Kit Sign In and Out 2022.doc

This provides an audit of kit location. Kits must be signed in and out by residential house staff and class staff trained in the process at each transition. The name of the staff member handing over/receiving the bag must be documented on the form. The house management team and class teacher/tutor are responsible for ensuring the Emergency Bag transitions with the young person at the beginning and end of each session and that the signing sheets are completed accurately.

22.6 If a young person transitions from the classroom for any educational activity the class teacher/tutor is responsible for ensuring that the Emergency Instructions and Emergency bag can be accessed for the young person should they be required.

22.7 The Emergency Medication Bag must be sent home during social leave. A copy of the current Emergency Instructions must be supplied. The contents of the bag must be itemised on the Medication Collection-Return Record (social leave form). Where a young person departs for social leave directly from school or FE it is the class teacher/tutor's responsibility to ensure that the Emergency Bag is sent home with the young person. This must be recorded on the signing sheet in the classroom. If an EFA line has been

administered prior to leaving campus the residential team must be contacted to ensure the bag is replenished. Call the nurse/Medication Quality Team where the residential team is not available

Day students

22.8 Day students will be issued with an Emergency Medication Bag for their emergency medication. Setting up and replenishing kits must be carried out either by a member of the nursing/Medication Quality teams or nominated education staff who have had the necessary training to carry out the task. It is essential that each bag contains a completed Day Student EFA Kit Record Sheet to comply with audit processes Day Students EFA Kit Record Sheet.docx (see Flowchart for setting up and replenishing making up emergency bags on page 44)

22.9 Nursing and/or Epilepsy First Aid trained staff will administer emergency medication and must be responsible for completing the EFA Kit Record Sheet. Training in how to do this this must be included in EFA Training.

22.10 Emergency Medication Bags can only be replenished by a member of the nursing/Medication Quality teams or nominated education staff who have had the necessary training to carry out the task. Where new medication stocks are required, the designated request form C must be completed and sent home. (See Medication Procedure for St Piers School and St Piers College Day Students). The young person cannot access offsite activities until new stock has been received and the bag has been replenished. The nursing team must be informed.

22.11 The emergency medication bag must be sent in with day students each day and stored in a locked cupboard/cabinet in the pod/classroom. Each day student must have an individual sheet for signing kits in and out of the classroom (see 22.5)

Emergency medication to be administered off-campus – All Students

22.12 It is the responsibility of the senior member of staff accompanying a student off-campus to ensure the emergency medication bag is available for any student prescribed emergency medication.

22.13 The activity organiser must ensure that all EFA bags are checked prior to any off-site activity to ensure correct and in date medication is contained within them. This check must not be compromised. The bag must be signed out on the individual student sign in/sign out sheet in the classroom/residential house. On return the bag must be signed back to the respective area by an EFA trained staff member. Where the staff signing out the kit will be handing responsibility for the kit(s) to other staff member(s) consideration must be given as to how the transfer of accountability is captured.

22.14 Where a residential student is received straight back into school/FE following the weekend/holidays, the EFA bag must be taken to the house to be checked by a medication trained member of the residential management team to ensure the bag is correct. If necessary, it must be restocked prior to any off-campus activity.

22.15 All Epilepsy First Aid trained staff accompanying a student off-campus must be aware of the prescribed emergency medication and the method of administration. The Emergency Instruction Document must be collected from the residential/school/FE storage point and taken on the offsite visit. The documents will detail a volume and strength of any liquid formulations to be administered.

22.15 Students moving towards independent living can be risk assessed to carry their own emergency medication kits. Kits must be locked away on arrival in school/FE/the residential house. Administration is still the responsibility of a designated Epilepsy First Aid competent member of staff accompanying the student.

22.16 The administration of emergency medication must be recorded on the emergency medication audit sheet in the emergency kit bag at the time of administration. It is the responsibility of the member of staff administering the medication to arrange for the MAR sheet to be updated for Residential Students or parents to be informed for Day Students. This ensures an accurate audit trail and that records are up to date.

22.17 The administration of emergency medication must be reported to:

- The House Manager/Care Co-Ordinator/Team Leader or designated care staff member in charge for Residential Students

- Nurse shift leader in the NCEC Medical Centre who will record this on the student's EMIS record

- Parents/Guardians and the Medication lead in school/FE in the case of Day Students

22.18 The administration of emergency medication to residential students when off campus for a period of more than 24hours should be recorded on the emergency medication sheet in the emergency kit bag at the time of administration. If the MAR sheet is available at the time of administration this should also be completed. If not it must be updated when available. Where emergency medication is administered, the member of staff in charge of the visit must assess the emergency kit bag to see if it needs replenishing.

22.19 Residential student kits used must be checked on their return by the House Manager/Care Co-Ordinator/Team Leader or designated medication trained care staff member in charge and restocked if necessary, in accordance with the procedure for Making Up and Replenishing Emergency Medication Kits. The Emergency Medication Record Sheets must be completed and replaced inside the kit bag (see 22.1).

22.20 Day student kits used must be checked on their return by nominated education staff who have had the necessary training or a member of the nursing/Medication Quality teams to carry out the task and restocked if necessary in accordance with the procedure for Making Up and Replenishing Emergency Medication Kits. The Emergency Medication Record Sheets must be completed and replaced inside the kit bag.

22.21 All students who are prescribed inhalers for emergency use should take these wherever they are on/off campus (please refer to the section on Asthma Inhalers - section 18). Instructions to take these inhalers are included on the Emergency Instruction Document (see below).

22.22 All staff responsible for students with allergies who may require emergency adrenaline (eg Jext, Epipen, Anapen, Emerade), must ensure that students have access to their adrenaline device at all times both on and off campus. Staff must have undertaken the necessary training, provided by the nursing team, in relation to their use.

22.23 All students who are prescribed emergency behaviour medication should take this wherever they are on/off campus. Instructions to take behaviour medication are included on the Emergency Instruction Document (see below).

Emergency Instruction Document

22.24 Every residential and day student has an emergency instruction document attached to their EMIS record. These are separated into the following sections where needed: epilepsy/behaviour/allergy/inhalers.

Where no emergency instruction items are prescribed the record must state “No emergency medication required”. Emergency instruction documents must be generated for every student.

22.25 It is the responsibility of the Registrars/Nurse Consultants/Pharmacist to create and amend the emergency instruction document. They communicate with the Healthcare Assistants/Med Quality Assistant when an amended document is ready to be distributed. The healthcare assistant prints copies of the new emergency protocol and informs:

- 1. The residential house who collect the new version from the Medical Centre. On receipt the old version is removed from circulation and destroyed and the new version filed.
- 2. School (Sarah Darrell-Brown)/FE (Hannah Geer) by email. The email will be cascaded to the relevant class team to notify key personnel working with the student. The new Emergency Instruction Document is sent to the school/FE nominated person by internal mail and filed (see 22.31).
- 3. The nursing team, after replacing the hard copy document in the Protocol Folder

The healthcare assistant records information about new protocol generation/posting and collection on EMIS.

22.26 The Emergency Instruction Document must be reviewed annually for residential students. Review dates and comments must be recorded at the end of the protocol. All protocols have date and version control to ensure the correct protocol is in place.

22.27 The Emergency Instruction Document must always be referred to before any emergency medication is given. Sometimes the nursing team use their clinical judgement in treating students they know well. If they deviate from the instruction for any reason this must be clearly documented on EMIS and if they consider a review of the Emergency Instruction Document is required they must discuss this with a registrar/nurse consultant.

22.28 Changes to Day Student emergency instructions must be notified to the medical team by the parent/guardian by way of written medical correspondence.

22.29 It is the responsibility of all staff to report any error or ambiguity in an Emergency Instruction Document to the nurse shift leader as soon as the error becomes known.

22.30 Whenever a student is accompanied off-campus by staff, it is the responsibility of the senior member of staff to ensure that each student’s Emergency Instruction Document is taken with them.

22.31 Emergency Instructions Documents are to be kept in designated folders:

- In school and FE main offices

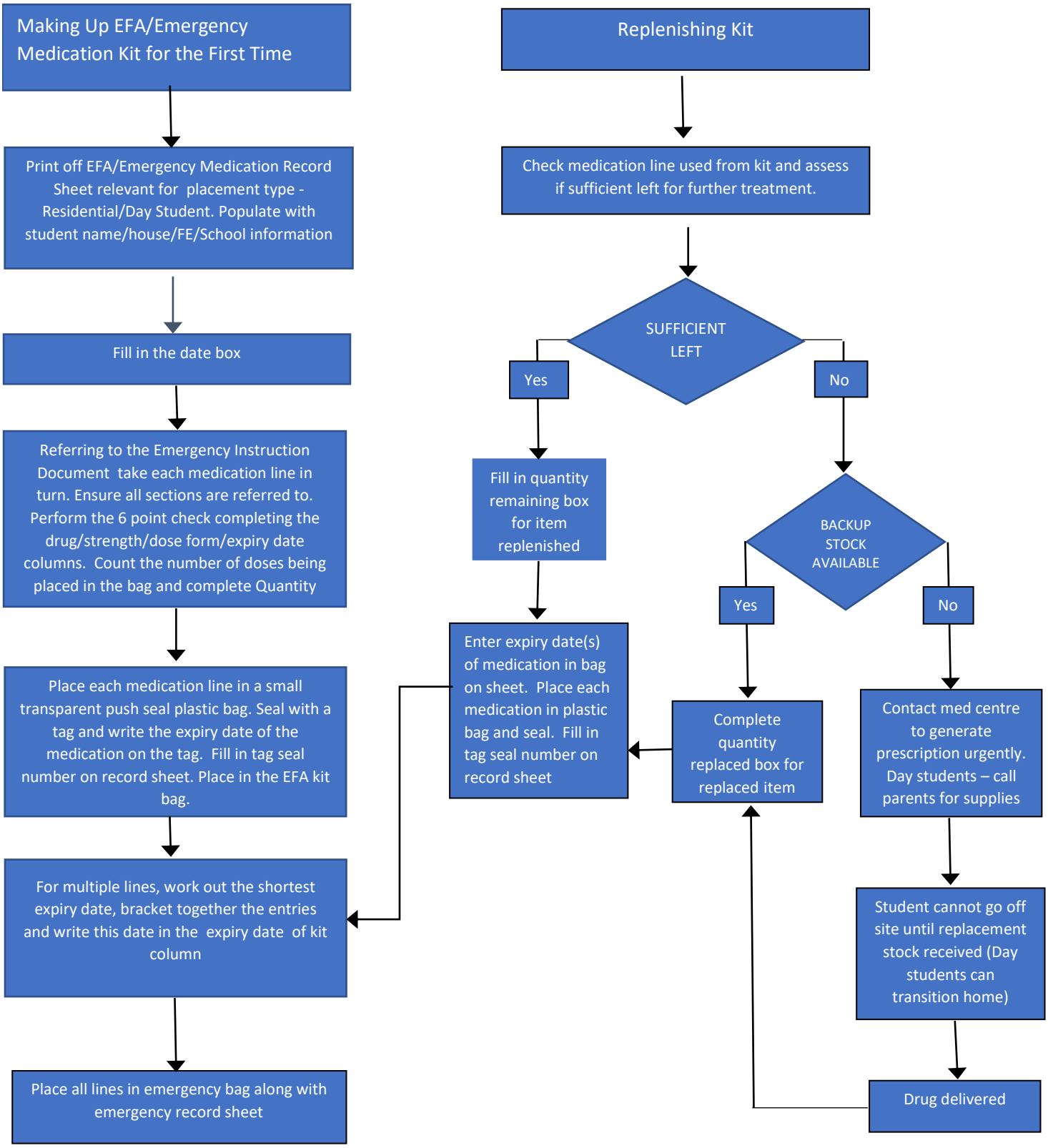
- On the student’s house (Medication Folder section 6)

22.32 Staff accompanying a student off-campus must ensure that the Emergency Instruction Document is returned to the original location as soon as the student returns to campus.

22.33 It is important that these cards are not photocopied and that ONLY the originals are used to minimise error.

22.34 Replacement documents will be reissued as soon as possible following the report of a missing card.

Setting Up/Replenishing EFA Kit Bags



23 Homely Remedies Procedure

23.1 Home Remedies are medicines, which can be bought 'over the counter', without prescription.

23.2 The Home Remedies listed in the link below are the only remedies that may be used by residential young people at Young Epilepsy who are registered with the Lingfield surgery. Home Remedies Policy 2020

23.3 A signed copy of the Home Remedies Policy must be visibly displayed.

23.4 If other Home Remedies not on the list have been authorised by a medical practitioner these must be prescribed on the MAR sheet.

23.5 For dosages, follow Policy guidelines, manufacturer's directions or seek advice of a medical practitioner or pharmacist. Please check the young person has no allergies to any of the ingredients before administering.

23.6 An audit sheet for Home Remedies must be kept. See link below. This ensures an accurate record of stock held and must detail recipients of the remedies. Home Remedies Audit Sheet 2020

23.7 Administered doses must be recorded on the carer's notes on the reverse of the young person's Medication Administration Record together with the reason for administration. The outcome of the dose given must be documented alongside the entry at an appropriate time after administration.

23.8 Home Remedies should only be administered for a maximum of 48hours, after this time a doctor must be contacted if symptoms persist.

23.9 Only staff who have received full medication training can administer and record homely remedies listed in the Home Remedies Policy.

23.10 In line with NICE requirements, a list will be kept of those staff who can administer homely remedies. Staff will sign this list to confirm that they have had training in giving homely remedies.

23.11 Homely remedies will be kept in their original packaging with the patient information leaflet. The expiry dates will be checked every month

23.12 Any topical Homely Remedies will be allocated to the young person requiring it and further stocks acquired as soon as possible. The allocated supply will be kept for future need until such time as the product expires or is removed from the medication list. It will then be wasted as per section 11. Oral liquids/lozenges can be used across the entire household and do not become young person specific once opened.

23.13 Residential managers can risk assess Home Remedy lines and elect not to stock them where doing so may contribute a risk to the young person cohort.

24 Insulin administration for young people with diabetes procedure

24.1 Insulin must only be administered by trained nursing staff, the young person or medication trained care staff who have undertaken the necessary in-house diabetes training course specific to each individual young person.

24.2 Wherever possible the nursing staff, doctors, and care staff, will seek to support a young person, in order that the insulin may be self-administered by the young person concerned.

24.3 The insulin must be checked and verified by two members of trained staff, one of whom will administer.

Diabetes awareness

24.4 It is the responsibility of the Department heads to ensure that all the staff members within their department are trained in this area. All staff members who work with a young person who has diabetes must be fully aware of the signs and symptoms of this disease.

24.5 An appropriate supply of a convenient form of oral glucose should always accompany a young person with diabetes and should be immediately administered where it has been authorised by the nursing team. This must be recorded on EMIS and the MAR sheet retrospectively, using a G code (see section on Procedures when medicines are administered - section 14 and Medication Administration Records – section 8). Parents/guardians must be informed where Day Placement young people with diabetes have been given oral glucose and the appropriate administration record signed.

24.6 This is the joint responsibility of the young person's Registered/House Manager and teacher/lecturer.

Please also refer to the Diabetes Training that is available through the Nursing Team.

25 Medication administration – behaviour programme procedure

25.1 In very specific situations, acting on the advice of the Medical Centre and psychology team, it may be that a behaviour programme, which meets the needs of the young person, is devised to ensure a young person receives anti-epileptic medication. This may occur when a young person cannot give informed consent but requires the medication to prevent the risk of prolonged seizures, which can be life threatening. The programme may involve holding a young person whilst the medication is given orally. If such a situation is considered very strict guidelines apply. The following conditions should be in place before such a procedure is implemented and a risk assessment performed.

25.2 All other avenues of administration of medication will have been exhausted

25.3 Parents, the young person (where possible) and psychology team will have been involved at all stages and will have given their written agreement that the programme should be implemented. The programme itself should have regular review periods. A copy of the detailed procedure will be given to the parents and a risk assessment performed.

25.4 The programme will have been agreed by the young person's medical consultant and written by psychology team. Any physical holding should be accurately described with the approximate length of time the procedure takes.

25.5 If at any time the member of staff is uncomfortable with the procedure or feels that it is not in the best interest of the child to continue with the programme, then he/she should contact the psychologist involved for advice, or if not available, the nurse in charge at the Medical Centre.

26 Medication incidents procedure

26.1 When a medication administration error occurs the two most important things to establish are:

- Will the person who uses the service have suffered any harm?
- How do Young Epilepsy minimise the chance of the error occurring again?

26.2 If a mistake occurs, staff members must IMMEDIATELY report this to their DSL to prevent any harm to the young person. The DSL must contact the nursing team for advice. The nursing team will contact the medical team/nurse consultant where necessary.

26.3 The DSL must establish a root cause for each incident and discuss any concerns with the medication quality team for guidance around mitigating actions.

26.4 Medication safeguarding Incidents must be reported as concerns on the MyConcern reporting system via the DSL and the Medication Quality notification group informed.

26.5 In line with NICE guidelines, medication administration errors will be reported to the young person, their family and/or carers as appropriate.

26.6 Incidents involving young people on the residential houses will be investigated by the manager of the respective house.

26.7 Incidents involving Day Placement young people in school/FE will be investigated by the Principals/Extended Leadership Teams (ELT) in school or FE college.

26.8 The house manager/Principals/ELT will work with the Medication Quality Team and any staff members involved in the incident, to learn any lessons, change any systems, and spread the learning from the incident to other staff members and senior managers to ensure continuity of best practice and recording procedures.

26.9 To minimise the chance of the error occurring again, Young Epilepsy wishes to create a culture where staff members feel able to report all errors and near misses. This ensures we learn from as many incidents as possible. The individual manager is responsible for keeping a log of all errors which is used as a learning resource.

26.10 Any error in dispensing must be immediately reported to the dispensing pharmacy. The Medication Quality Team must also be informed.

Who to notify when a medicines-related incident is identified

26.11 The thresholds for reporting medication errors in the Children's service to the Local Authority Designated Officer (LADO) applies to errors involving a controlled drug and/or any medication error which has caused significant harm to a child.

26.12 The thresholds for reporting medication errors for young people over 18 years to Surrey MASH include any errors involving prescribed medications as noted on

the MAR. A section 42 enquiry is likely if there is reasonable cause to suspect that the adult

- has needs for care and support arising from a physical or mental impairment or illness, AND
- is being abused or neglected, or is at risk of being abused or neglected, AND
- is unable to protect themselves due to their care and support needs.

Section 42 enquiries trigger notification to CQC.

26.13 **CQC and OFSTED** should always be notified when any medicines-related incident has caused either:

- **Harm or potential harm** to a young person. By harm we also include significant distress.
- **Intent**: If the staff member intended the adverse consequences to occur because of the incident.

Grading incidents

26.14 Each incident must be graded according to the level of harm that could be caused for the purposes of reporting to the Board.

26.15 The Medication Quality Team will assign the necessary grading.

27 Medication storage procedure

27.1 All medicinal products must be kept in locked trolleys which (when not in use) must be attached to the wall with a fixing bracket.

27.2 Cabinets can also be used if they are secured to a wall or floor.

27.3 Cupboards may be used for storing food supplements only. A risk assessment must be in place if this is not lockable.

27.4 A room thermometer should be kept in trolleys and cabinets and the temperature checked daily.

27.5 If there are any storage problems (lack of space, queries regarding suitability of storage etc.) the Pharmacy Advisor/Medication Quality Assistant must be contacted for advice.

27.6 Lockable drug fridges or locked containers within refrigerators must be used if medicines need to be stored between 2-8ºC. Maximum/minimum temperature readings must be taken using maximum/minimum thermometers and recorded daily on the Fridge Max-Min Temperature Log on Sharepoint. Fridge Max-Min Temperature Log. Drug fridges have inbuilt thermometers.

27.7 The medical centre must be contacted for advice if temperatures are outside the 2-8°C guideline.

27.8 In the event of a young person's death, their medication must be quarantined on the house until any investigations have been completed. After this time they may be returned to Boots.

27.9 The following personnel are responsible for ensuring the storage procedures are complied with and will be audited by the Pharmacy Advisor/Medication Quality Assistant:

- NCEC Medical Centre: the designated nurse in charge of the shift
- House: the designated care staff member in charge
- School: Principal/Assistant Principal/Designated medication trained staff member
- Further Education: Principal/Assistant Principal/Designated Medication trained staff member.

27.10 Each of these storage areas will have two sets of keys. One set must be kept in the building that contains the storage area by the medication-trained staff member in charge of the shift/delegated staff member or in the security coded safe. The spare set of keys will be held in the Medical Centre, as a central resource.

27.11 The following personnel are responsible for storage area keys:

- Medical Centre: the designated nurse in charge of the shift
- House: the designated medication trained shift manager

- School/FE: Medication trained staff

27.12 Spare keys must be signed out only on the authority of the nurse in charge of the shift. Registered/House Managers are responsible for supplying the spare set of keys to the medical centre whenever new storage cabinets/trolleys are acquired.

27.13 When a new key is provided, a Health Care Assistant must visit the house to check the spare keys against the cabinets, removing those that are no longer used on the house. The patency of the spare set of medication cabinet keys for the houses must be checked by a Health Care Assistant at least termly.

27.14 Where non-medication trained night staff are in charge of a shift, the keys must be placed in a secure locked place (e.g. the security coded safe held on the houses).

27.15 Should nursing staff need to access medicines during these times the spare keys held in the medical centre must be accessed. If EFA bags are stored in cabinets containing other medication, they can be transferred to a separate locked storage area (e.g. safe/filing cabinet/office cupboard) overnight which allows access by EFA trained staff in an emergency.

27.16 When houses are unoccupied, medication keys should be left in the house key safe. The nursing/Medication Quality team must be updated when codes for key safes are changed.

27.17 The loss of a key for medication storage on the houses must be immediately reported to the Senior Care Manager/Duty Officer who is responsible for informing the Nurse in Charge of the Medical Centre. Any staff members who are not on duty should be contacted to discover if they have any knowledge of the matter.

27.18 If the NCEC medication keys are lost this should be reported to the Director of Integrated Care. If medication keys in school/FE are lost the Principal/Assistant Principal must be informed.

27.19 Should the key not be discovered within a 24-hour period, arrangements must be made to have new keys cut or to acquire replacement locks. A letter of authority must be obtained from the Pharmacy Advisor/Medication Quality Assistant in cases where keys need to be cut.

27.20 The Department head must instigate an independent investigation into the disappearance of the medicine storage keys and take appropriate action regarding staff and policy. The results of the investigation must be disclosed to the Pharmacy Advisor/Medication Quality Assistant.

28 Steroids medication procedure

28.1 Before starting steroids, the medical consultant responsible for the young person must carry out the following:

- Discuss the possible risks and benefits fully with the parents and child.
- Provide parents, teacher, Registered/House Manager with the product information
- Baseline urinalysis and blood pressure.
- Blood test for zoster immunity status.

28.2 The Doctor must inform nursing staff when steroids are commenced

28.3 The young person must attend the Medical Centre's steroid clinic weekly to check blood pressure and urinalysis.

28.4 Any signs of infection in the child must be reviewed immediately.

28.5 Particular vigilance must be exercised with regard to possible contact with chicken pox if the young person is non-immune and the Medical Centre must be informed. Staff and parents should refer to the information sheet.

28.6 Young people should have a steroid card filed with their MAR sheet on the house. (available from Boots).

28.7 The steroid card must accompany the young person to any dental or urgent medical treatment off-campus.

29 Medication training

29.1 All health professionals employed or contracted to Young Epilepsy must be professionally qualified and registered with the appropriate professional body and continue to meet the professional registration requirements.

29.2 Before any member of staff can be assessed to administer medication they must:

- Have been in post for at least 3 months, although the Residential Management Team has authority to vary this in conjunction with the Head of Residential Services/Operations Managers.
- Be nominated by their line/registered manager (e.g. Registered/House Manager)
- Be able to identify each young person that they regularly work with and meet their daily care needs, as judged competent by their line manager.

29.3 Staff meeting these criteria will be offered training to ensure that the care provided to all young people is of a consistently high and safe standard.

29.4 Staff are expected to comply with training requirements and it will be their responsibility to ensure they have a good level of understanding of all aspects of this Medication Policy and will be aware of the implications of failing to follow procedures.

29.5 Records of this training and approval to administer medication must be maintained by the Learning and Development and HR departments.

29.6 Staff should also undertake the following types of training:

- Awareness of Epilepsy
- Administration of Epilepsy First Aid (this may already have been undertaken before being medication trained. See Epilepsy First Aid Training in section 30)

29.7 All staff who are required to administer medication to residential young people on the houses must complete the training programme comprising theoretical training, the Medication Administration Pre-Test, 10 practice rounds and the Medication Test.

29.8 Theoretical training should involve the following approved personnel:

- Pharmacy Adviser
- Any other member of staff or external professional deemed competent by the Director of Integrated Care/Head of Health

29.9 To administer regular medication, staff must successfully undertake theoretical and practical training, which should cover:

- The law relating to medications
- The Young Epilepsy Medication Policy and Procedures

- Responsibility and accountability
- Knowledge and understanding of the limits/boundaries involved in their role
- Different types of medication
- Methods of administration
- Drug Administration practices
- Adverse Drug Reactions
- Where to get information about medicines
- Storage
- Medicine Supply chain
- Record Keeping
- Putting the policy and procedures into action
- Safe practice, including checking processes
- Actions to be taken if problems arise (e.g. dropping a tablet, what to do in case of error etc.)
- Communication
- The administration of external preparations
- Routes of administration of medicines
- Incident Reporting

29.10 Practical training may be provided by the following approved staff:

- Registered/House Manager and/or Care Co-Ordinator/Team Leader
- Trained nurse (e.g. Key Nurse)

29.11 The Key Nurses will review practice on the houses at least annually to ensure a consistent approach.

29.12 The theoretical training involves one 2½ hour session led by the pharmacy adviser. A Medication Training Workbook is issued at this session and must be retained and kept safe by the candidate since it serves as a training log for medication training.

29.13 After the theoretical training, a written medication pre-test must be taken and passed to proceed to the practice sessions. This will be communicated via email to the candidate and their house manager/supervisor by the Pharmacy Adviser.

29.14 If the pre-test is not passed, the candidate will have the opportunity to re-sit the test. If it is failed a second time, the theoretical training must be attended again. The house manager may decide whether to support the candidate through this additional training.

29.15 Practice rounds must not be carried out until the pre-test is passed and the trainee has read the Medication Policy and Procedures and signed the declaration in the Training Workbook.

29.16 Practice rounds can only be supervised by Registered/House Manager/Care Co-Ordinator/Team Leader or a registered nurse using the set criteria for assessment.

29.17 All medications given must be signed for by the Registered/House Manager/Care Co-Ordinator/Team Leader/Nurse assessing the trainee and the trainee. Responsibility for medication given and any errors on a practice round remain with the Registered/House Manager/Care Co-Ordinator/Team Leader/Nurse.

29.18 The trainee should complete at least 10 practice rounds with 2-3 different supervisors where possible

29.19 For a practice round, ideally at least 5 young people must require medication within the shift period. If fewer young people than this require medication on a given house, the Pharmacy Adviser will assess the complexity of medication regimes of the existing young person population and decide whether assessed rounds must be completed on a different residential house.

29.20 During the assessed rounds, the practice of checking the MAR sheets and accurately administering medication must be demonstrated, using the Medication Round checklist in the Medication Training Workbook

29.21 The 5th round will be supervised by a qualified nurse or House Manager trained for the role. The 10th round will always be supervised and signed off by a nurse/member of the Medication Quality Team. Once the 10th round is passed a medication test paper must be taken

29.22 If the trainee does not demonstrate competence during these 10 rounds then he/she must continue being supervised until such time as he/she is deemed competent or referred for further training. Additional Medication Round checklist sheets will be provided for this purpose by the Pharmacy Advisor/Medication Quality Assistant. A nurse must sign off final competency.

29.23 Trainees are assessed to give medication for the young people in the houses on which they work. However, the Head of Residential Services/Operations Managers have the discretion to approve staff to administer medication to young people other than those on the house on which they regularly work.

29.24 The residential staff Medication Test paper must be passed for the candidate to be fully medication trained and able to administer medication in accordance with the Medication Policy and Procedures. This will be communicated via email to the candidate and their house manager/supervisor. Failed candidates can ask for a breakdown of areas which caused them to fail and expect to be supported in gaining more experience.

29.25 The Medication Training Workbook serves also as a record of individual training. Progression through the stages of training must be documented in this workbook. The training record log must be completed with dates and signatures of

the relevant supervisors at each stage of the assessment process. The front page must be completed giving dates that each stage of the training is completed/passed. The learning and development department must be sent a copy of the Training Record by the candidate on successful completion. This will be logged on their training record.

29.26 The Managers Training Checklist in the Medication Training Workbook must be completed and signed off by the Manager/Care Co-Ordinator before the 10th round is conducted. The nurse assessing the 10th round must ensure all sections are completed. If they are not the 10th round will not proceed.

29.27 Refresher Training: Medication trained staff must satisfactorily complete a nurse/member of the Medication Quality Team supervised round and a Medication Test annually. This will be recorded on the training record. More frequent supervision may be given if deemed appropriate. Retraining may be required if the annual assessment is failed.

29.28 If prior training competency lapses e.g., due to long-term sickness or a short break in employment the house manager has the discretion to request that the candidate completes the lapsed training programme. Paperwork for this is available from the Pharmacy Advisor/Medication Quality Assistant. This programme has the potential for training to be completed in five assessed rounds. A nurse must always conduct the final assessment to check that the competency standard has been obtained. The medication policy and procedures must be read, and a declaration signed. A Medication Test must be passed before full competency is granted.

30 Epilepsy first aid training

30.1 Epilepsy First Aid training procedures for staff who are able to accompany young people off-campus.

30.2 It is essential that all staff, who are able to accompany young people off-campus should undertake this course but is not a compulsory requirement of any job.

30.3 It is essential that 2 members of staff qualified to administer epilepsy first aid accompany young people off-campus, unless there are no young people with epilepsy in the group. Where this is not possible a risk assessment for one trained staff member accompanying the young person must be written.

30.4 Before any member of staff can be assessed to administer emergency medication they must:

- Have completed First Aid training and been in post for at least 3 months, although the House Managers in conjunction with the Operations Leads/Director of Residential Services ELT in conjunction with Assistant Principals/Principal have authority to negotiate this policy.
- Be nominated by their line/registered manager (e.g. House Manager) or ELT for education staff.

30.5 Epilepsy first aid training delivered by the nursing team will be scheduled to occur once every half term, when possible.

30.6 It is the responsibility of line/Registered/House Managers to nominate staff for attendance at these training sessions.

30.7 A member of the nursing team will provide a lecture on and practical demonstration of the administration of epilepsy first aid. This will include the administration of all types of medication currently used on campus to treat serial or prolonged seizures e.g. buccal midazolam, rectal diazepam, paraldehyde and solid oral dose forms e.g. clobazam, chlormethiazole and psychiatric drug lines for elevated behaviours.

30.8 Training in how to read the Emergency Instruction Document/Emergency Instruction Document, complete the Emergency Medication Audit Sheet and information on sealing the Emergency Medication Kits will also be given.

30.9 Trainees are required to complete a written examination paper at the end of the training session. This paper is marked by a member of the nursing team and must meet the standard deemed competent.

30.10 Proficiency in epilepsy first aid must be recorded in the register maintained by the Learning and Development Department.

30.11 It is the responsibility of Principal/Vice Principals in school and FE and Registered/House Managers to ensure that the staff they line manage have their skills reviewed.

Review of epilepsy first aid proficiency

30.12 Those staff who have successfully completed the epilepsy first aider's course must have their competence reviewed annually. To refresh competency all staff must attend a refresher lecture and take and pass an Epilepsy First Aid test paper annually.

30.13 Failure to sit the annual refresher test within 8 weeks of expiry of competency will result in immediate withdrawal of authority to administer epilepsy first aid and full training will need to be arranged. Any epilepsy first aid administered without Young Epilepsy express authority is done so at that member of staff's own risk and is subject to Young Epilepsy disciplinary procedures.