**West Sussex – Practice Guidance**

IROs are qualified social workers with at least five years’ experience, and who have acquired the right skills to carry out this role.

**First Aid and Medication**

*Please also refer to the WSCC Children’s Residential Service ‘Medication Policy’ and Practice Guidance relating to ‘Homely Remedies’.*

* Staff will receive training in either ‘Paediatric First Aid’ (staff who work with children aged 10 and under) or ‘Emergency First Aid’.
* Staff who are nominated First Aiders must attend ‘First Aid at Work’ training and undertake refresher training every 3 years.
* Fully stocked first aid kits must be available in the home; in the main office, kitchen and in ‘sleeping in’ rooms.
* Each home must have a qualified First Aider on duty at all times.
* First Aid boxes should have a white cross with a green background must be held in each home and should be carried in each of the vehicles used for the transportation of children.
* Each box has an inventory that must include the full quantity of each item stipulated in the box. When an item has been used, then it should be replaced as soon as possible.

**Recording of first aid:**

* Each child should have permission for staff to administer first aid and non-prescription medication from a person with Parental Responsibility for them recorded in the relevant plan. Permission should be sought and arranged by the child’s social worker.
* The administration of first aid must be recorded in the HSW3 report and/or Incident report and the individual child's Daily Record and Medication Administration Record (MAR) where required.

**When first aid is needed:**

* Staff should always assess the situation and in a medical emergency, send for medical help and an ambulance or the Police if this is needed.
* Before help arrives:
* Do not move the person other than to remove them from immediate danger or place them into the recovery position;
* Try to find out what has happened;
* Collect any drugs or spillages (e.g. vomit) for analysis;
* Do not try and make them sick;
* Observe the child/young person; keep them calm, warm and quiet.
* If the person is unconscious:
* Ensure they can breathe and place them in the recovery position;
* Do not move them if they are likely to have spinal or other serious injury which may not be obvious;
* Do not give anything by mouth;
* Do not attempt to make them sit or stand;
* Do not leave them on their own.
* When medical help arrives, pass on any information available, including samples of vomit and any drugs.

**Medication – Storage**

* All medication will be stored in a locked medicine cabinet in the medicine room.
* Access to the medicine cabinet will be restricted to the Shift Leader.
* Within the medicine cabinet, each child will have an individually labelled box for their medication, which will only contain medication for that specific child.
* All medication will be stored in original packaging with a fully visible and legible pharmacy label identifying the child’s name, dosage and instructions for administering the medication.
* The Shift Leader and/or a trained Medication handler will check stock levels and expiry dates of medication on a weekly basis and take responsibility for re-ordering and replenishing stock as required.

**Staff responsibilities**

* All permanent staff will be trained in the administration of medication. Only trained members of staff will be permitted to administer medication to children. Night staff who are medication trained will be permitted to administer medication on a case by case basis.
* All medication must be fully checked and signed for on delivery and a Medication Administration Record (MAR) completed and signed at the point of administration by the person who has administered the medication.
* Any child has the right to refuse medication; no staff member will conceal or covertly administer medication to a child who has withheld their consent, unless there is a current (within 2 years, or the child has turned 16 years of age) Covert Medical Consent form on the child’s medical file. In this situation, the staff member will seek medical advice dependent on the necessity and individual health needs of the child.
* Covert Medical Consent must be provided by an individual with parental responsibility for the child and only be used in situations where the child is assessed to lack capacity to provide informed consent. All those involved in supporting the child must be in agreement of the clinical necessity for the medication concerned and act in the child’s best interests.

**Controlled drugs**

* Unlike other prescribed medicines, Controlled Drugs (CD) have additional safety and legal requirements for storage, administration records, disposal and prescribing because of their ability to cause dependence and misuse.
* They are usually used to treat severe pain, treat insomnia, and induce anaesthesia, treatment of attention deficit hyperactivity disorder (ADHD) or to treat drug dependence.
* CDs are classified into five different schedules according to the different levels of control required by the governing regulations, with Schedule 1 being the most tightly controlled schedule and Schedule 5 the least tightly controlled.
* In line with legal and national best practice guidelines, the controls outlined in this section must apply to the following controlled drugs:
* All schedule 2 controlled drugs (CDs)
* Just these schedule 3 CDs: temazepam, buprenorphine, flunitrazepam and diethylproprion
* Just this schedule 5 CD: Oramorph 10mg/5ml solution
* Hence when using the term ‘controlled drugs’ (or ‘CDs’ for short), we are only referring to these drugs listed above.
* Care providers may wish to apply controls to CDs not listed if they feel that there is a risk these CDs would go missing, or be more safely stored or accounted for e.g. buccal midazolam.
* In children’s homes, CDs must be prescribed for individual children and must not be kept as stock. Once the child no longer requires the medication, the remainder of the medication should be returned to a pharmacy.
* If a care worker collects CDs from a pharmacy on behalf of a child, they must provide identification.
* CDs must be stored securely in a CD cupboard, as specified in the Misuse of Drugs (Safe Custody) Regulations 1973 (<http://www.legislation.gov.uk/uksi/1973/798/made>). This specifies the standard of the CD cupboard and its fitting, which in brief are:
* Metal cupboard of specified gauge
* Specified double locking mechanism
* Fixed to a solid wall or a wall that has a steel plate mounted behind it
* Fixed with either Rawl or Rag bolts
* The CD cupboard must only be used for the storage of controlled drugs and not for general medication or valuables and must be kept locked at all times when not in use.
* The CD cabinet key must be kept separately from the keys for other medicines and must be kept in the possession of the designated person or their deputy. The CD cabinet key must never be removed from the premises. The Registered Manager has overall responsibility for the CD key and should know where it is at all times and approve of its use. The CD key should be returned to the Registered Manager or delegated senior member of staff, immediately after use.
* All CD’s received into the home must be immediately stored within the CD cupboard and an entry made into the CD register (see below).
* The Home must have a controlled drug’s register, which must be a bound book with numbered pages.
* A record of the receipt, administration and disposal of controlled drugs must be kept in this CD register. This is in addition to usual recording of the administration of the controlled drug on the MAR chart.
* Each child using the service must have a separate page for each CD prescribed. The quantity left should be recorded on the sheet following each dose administered and checked with the actual amount of controlled drug remaining. Each record should be countersigned by another witnessing designated member of care staff.
* CDs should be administered by appropriately trained and competent staff. The staff member responsible for administering the CD must book the CD out of the CD register each time it is given and record the administration on the MAR chart and sign and date both. The balance of the CD remaining in the cabinet must be recorded and checked each time. An appropriately trained witness should also sign the CD register and the MAR chart. The use of a witness is intended to reduce the possibility of an error occurring.

**Audit process**

* The Registered Manager will carry out quality assurance audits to record and monitor the effectiveness of the medication arrangements as follows:
* Monthly audit of every MAR chart and individual Medication folder
* List of care staff who have received training with the date of training and what level of training obtained.
* List of care staff signatures is up to date
* List of care staff competency assessments
* The child’s medication review date
* Monthly audit of medication incidents to establish themes and outcomes
* Ensure that medication stock levels are monitored weekly

**Disposal of medicines**

* A designated member of care staff will check the medication cupboards on a monthly basis to ensure that all medication currently in use is within its expiry date (use by date) and prescribed to the current resident children.
* Medication will not be disposed of within the home; i.e. placed in the refuse bin, flushed down the toilet or sink or by any other means. All expired, unwanted or unused medication will be returned to the pharmacy for safe disposal in accordance with current waste regulations.
* Medication waiting for disposal will be labelled as such and kept in a locked cupboard, separate from all current medication being used to prevent incidents of wrong medication being used.
* All disposal of medication will be clearly documented. When staff are responsible for the disposal, a complete record of medication should be made.
* Syringes and needles will be disposed of in the rigid sharps box and disposed of in accordance with local clinical waste disposal arrangements. When syringes and needles are used, they will be safely disposed of by the person using them.
* When a child permanently leaves a children’s home,their medication is their property and will be given to them or their parent/carer on discharge. If the medication is no longer required, then consent will be obtained from the child or their parent/carer prior to disposal.

**Transferring information about a child’s medication**

* Staff will check that complete and accurate information about a child’s medication has been obtained and recorded in the child’s individual medication folder.
* When a child permanently transfers, in or out of a children’s home, the child’s individual medication folder must be provided e.g. to another children’s home or returns home.
* The care staff member responsible for collating this medication information will use the most recent and up-to-date source of information available e.g.
* Recently dispensed medicines from the pharmacy
* A recent repeat slip
* Medicines administration records from their previous establishment
* The medication information must be verified with the lead health professional such as:
* The GP
* The lead Paediatrician
* Dispensing Pharmacist
* When a child temporarily resides in a different setting the following information (photocopies) should be provided where in use in the home:
* Medication Risk Assessment
* 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 child needs to carry on taking the medicine
* Quantities of the child’s medication when leaving or entering children’s homes will be recorded so they can be accounted for. This also applies if medicines are transferred to hospital with the child.

**Medication errors**

* A medication error is when an incorrect medication or dose has been administered to a child, an incorrect method of administration has been used, or medication has been given at the incorrect time, resulting in a possible overdose.
* In this situation, staff must inform the Registered Manager or senior member of staff on duty who will ensure all necessary documentation and reporting is completed. The incident will also be reported to the allocated social worker and a Safeguarding investigation may be convened in cases where the child is placed at significant risk of harm.

**Medication incidents**

* A medication incident is where there is a spillage of liquid medication or tablets have been dropped, damaged, lost or administration has been unsuccessful (the child has spat the medication out for example).
* All medication incidents will be recorded on the Medication Administration Record which will be supported by additional recording as required. In the event of repeated incidents of failure to ingest the medication, staff will need to seek medical advice as to the need to review the prescription.

**Reference Points;**

West Sussex Partnership Trust Medication Policy (forthcoming)

Medication Stock Check

Covert Medical Consent form