**WSCC Policy: Medication in WSCC Children’s Homes**

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

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| **Section** | **Subject** | **Page no** |
| 1. | Overview and Principles | 2 |
| 2. | Liability Insurance | 2 |
| 3. | Principles of managing medication | 3 |
| 4. | Staff Roles and Responsibilities | 4 |
| 5. | Consent and capacity | 5-7 |
| 6. | Confidentiality and sharing of information | 7 |
| 7. | Transferring information about a child’s medication | 7 |
| 8 | Medication Reviews | 8 |
| 9 | Assessing and recording what type of support is required | 9-10 |
| 10. | Principles of the level of support | 10-14 |
| 11. | Training requirements | 14-15 |
| 12. | Ordering and receiving medication into the children’s home  Collecting or receiving medication from the pharmacy | 15-16 |
| 13. | Storage and security of medication | 16 |
| 14. | Disposal of Medication | 17 |
| 15. | Record Keeping | 18-21 |
| 16. | Administering medication at Levels 2 and 3 | 21-23 |
| 17. | Controlled Drugs | 23-25 |
| 18. | Refusal of medication | 25-26 |
| 19. | Giving medication to a child without their knowledge(Covert administration of medication) | 26 |
| 20. | Adverse Effects | 27 |
| 21. | Medication-related Incidents | 27-28 |
| 22. | Audits | 28 |
|  | Review / Contacts /References | 29 |
|  | Glossary | 30-31 |

1. **Overview and Principles**

* This policy applies to all West Sussex County Council (WSCC) children’s homes and all its employees. It intends to clarify the range of duties to be carried out by staff in relation to medication and how they can be undertaken safely and in accordance with best practice.
* For the purpose of this policy, and in line with the Children Act 1989, a child means anyone below the age of 18 years. For those aged 18 years and over, refer to the adult policy.
* WSCC will ensure children receive their medication safely by appropriately trained and competent staff.
* Medicines should be administered in a way the child finds acceptable without detracting from their human rights. This policy challenges discrimination based on age, gender, disability, sexuality, faith, religion, culture, ethnic or national origin, trans-gender, marital status, and HIV status.
* Implementation of this policy is dependent on close collaboration between Health and Social Care and with agreement of children using the service and their parents, carers or legal guardians.
* This policy has been developed as best practice and considers the Medicines Act 1968. It also embodies the principles of the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001. It is based on the latest National Institute for Health and Care Excellence (NICE) good practice guidance and quality standards (QS) that underpin safe handling of medicines in social care e.g. Managing medicines in care homes (SC1) (March 2014), Medicines management in care homes (QS85)(March 2015) and Managing medicines for adults receiving social care in the community (NG67) (March 2017).
* This policy considers Article 3 of the Human Rights Act 1998, the right not to be subjected to torture or to inhuman or degrading treatment or punishment and the UN Convention on the Rights of the Child (UNCRC).

1. **Liability Insurance**

* WSCC liability insurance covers the personal liability of employees working with medication and related tasks. The County Council also indemnifies care staff regardless of the nature of their duties, whilst carrying out official duties, in respect of the financial consequences of negligent acts or omissions committed in the course of their duties.
* The indemnity does not apply where care staff act outside their contract of employment or authorised duties (e.g. by ignoring instructions or this policy), or where there is fraud, dishonesty, criminal or unlawful acts.

1. **Principles of managing medication**

* Every child will be risk assessed to determine their ability to manage their medication safely.
* Medication remains the property of the child to whom it has been prescribed. It should not be shared with others or used on a temporary basis if another child runs out of the same item.
* Staff involved with medication related tasks should not advise children about medication. They should refer queries to the prescriber or pharmacist.
* Every child will have an individual Medication file, which will contain the following documents and information:
* Competence to Consent Assessment for Medication (if over the age of 16)
* Best Interest Plan (as needed)
* Medication Risk Assessment Form
* Medication Support and Education Plan
* MAR chart (last 3 months; current one is held centrally)
* Current photograph
* Child’s full name, date of birth, NHS number and address
* GP’s details
* Details of other relevant contacts and/or their family members or carers
* Children who are looked after on a full time basis where there are concerns about their weight must be weighed frequently in line with recommendations from their Health Care Plan. The prescriber must be informed of any significant weight change.
* Known allergies and reactions to medicines or ingredients, and the type of reaction experienced
* Medicines the child is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication). This should include all non-prescribed medicines.
* 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 child needs to carry on taking the medicine

1. **Staff roles and responsibilities**

* The competency, level of training of staff and the available resources, should determine the ability of the children’s home to respond to the child’s health and medication needs and whether the home is able to accept the placement of a child.
* The Registered Manager has overall responsibility for ensuring systems and procedures around the management of medicines are implemented and followed.

**Registered Manager’s duties:**

* Take overall responsibility for ensuring that this policy is embedded within the children’s home and that the principles of effective medication management are followed by staff
* Be trained and deemed competent in order to coach, assess and advise the staff team on medication management
* Ensure all new staff are trained and competent to administer medicines support to the required level
* Record that all staff have received an annual review of their knowledge, skills and competencies
* Ensure that job descriptions clearly state key responsibilities and the level of support staff are expected to offer around medication management
* The Registered Manager has overall responsibility to ensure that the following are undertaken:
* Monthly process of ordering and booking in the prescribed medication supplied by the community pharmacy against those items ordered.
* Monthly audit of controlled drugs against the register or more frequently if reasonably practicable.
* Monthly audits of the completed MAR charts.
* Monthly audits of homely remedy (ie non-prescription medication) stocks.
* Overseeing the reporting of medication errors and ensuring appropriate action is taken to prevent further errors occurring.
* On admission, ensure that every child has a completed medication risk assessment around the level of support required and a medication review. This should be reviewed at least 3 monthly or sooner if there are changes in the child’s circumstances.
* Ensure that safeguarding concerns are reported as per pan-Sussex policy.
* Reporting to Ofsted any untoward medicines-related incident as per escalation policy.

**Designated persons**

* Designated persons are members of staff, deemed by the Registered Manager to be competent to carry out medicines management duties. These members of staff must have completed the full medication training and be deemed competent prior to being given this responsibility.
* The responsibilities of the designated person on duty include:
* Assisting with the ordering of medicines
* Assisting with the monthly process of receiving and checking prescribed medication from the community pharmacy against ordered items
* Liaising with healthcare professionals where necessary
* Accurately recording each child’s medicines on admission, transfer or discharge
* Safe storage of medicines
* Monitoring supplies and appropriate levels of stock
* Undertaking the administration of medicines
* Accurate record keeping
* Completing a medication risk assessment and undertaking regular reviews as per policy
* Safely managing the disposal and return of medication

1. **Consent and Capacity**

* Consent must be obtained and recorded to ensure that the child and their parents and carers are in agreement with the identified interventions. This consent should be recorded on a Medication Risk Assessment form.
* A child’s competence to give consent must always be considered. For those children aged 16 and over, who are unable to make a decision about their treatment, the prescriber(s) must document through an assessment of the child’s competence to consent that it is in their best interests that the medication should be prescribed. If a child refuses to take their medication, see Section 18 – Refusal of Medication.
* A child under 16’s refusal of their medication can in some circumstances be overridden by a parent, someone with parental responsibility or a court. Residential staff have an overriding duty to act in the best interests of children who are refusing their medication. These circumstances would include where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.
* If there is any concern that a young person between the ages of 16-18 is not competent to give consent then the Mental Capacity Act must be used. A capacity assessment must be completed using information that maximises the young person’s understanding.
* If it is determined that the young person does not have capacity then a Best Interest (BI) decision must be made as to how they should receive their medication using the least restrictive means. The BI will require a discussion involving all relevant parties.

**Gillick Competency – Children under 16 years**

* The right of children under 16 years of age to provide independent consent is proportionate to their competence. The ‘Gillick test’ must be used to judge capacity in children to consent to medical treatment. If a child under 16 years of age is determined to have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including purpose, nature, likely effects and risks, chances of success and the availability of other options, they are considered Gillick competent to consent to medical treatment or intervention. This consent is only valid if given voluntarily and not under undue influence or pressure by anyone else.
* If a child is not deemed to be Gillick competent, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment. Staff still have a duty to keep the child’s best interests at the heart of any decision, and the child should be involved in the decision-making process as far as possible.
* Staff must carry out an assessment of Gillick competence with each individual decision as a child may have the capacity to consent to some treatments but not others e.g. the understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions.

**Fraser guidelines**

* The ‘Fraser guidelines’ specifically relate only to contraception and sexual health advice and treatment, which can be given as long as:
* The child has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
* The child cannot be persuaded to tell her/his parents or to allow the doctor to tell them
* The child is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
* The child’s physical or mental health is likely to suffer unless he/she receives the advice or treatment
* The advice or treatment is in the child’s best interests.
* Health professionals should still encourage the child to inform their parent(s) or get permission to do so on their behalf, but if this permission is not given they can still give the child advice and treatment. If the conditions are not all met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.
* There is no lower age limit for Gillick competence or Fraser guidelines to be applied. However, it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent/carer’s involvement. When it comes to sexual health, those under 13 are not legally able to consent to **any** sexual activity, and therefore any information that such a person was sexually active would need to be acted on, regardless of the results of the Gillick test. Please refer to the Pan Sussex Child Protection and Safeguarding Procedures Manual.

**Complex Health Needs, consent and competency**

* Children who are Gillick competent but who are physically unable to sign may authorise a parent or carer to sign on their behalf.
* For children who are unable to communicate consent, every possible step should be taken to assist the child to make a decision and to communicate that decision. This may require the use of other communication tools and methods.
* If the child still cannot communicate their decision, the prescriber must document this through an assessment of the child’s competence to consent and then establish that the treatment is in the best interests of the child using the service. If the child is over the age of 16 then the Mental Capacity Act applies.

1. **Confidentiality and sharing of information**

* Information about a child must be treated confidentially and respectfully.
* Staff should only share confidential information about a child on a need to know basis, with the health and social care professionals and other professionals (i.e. police, firemen, transport staff etc.) when it is required for the safe and effective care of an individual child.
* Consent to share any information must be obtained as part of the Medication Risk Assessment form.
* Records that contain confidential information about a child must be held securely (see Section 15) and must be accessed only by those persons who need to have access to them.

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

* Staff must check that complete and accurate information about a child’s medication has been obtained and recorded in the child’s individual medication file.

**Permanent Transfer**

* When a child permanently transfers, into or out of a children’s home, the core documents of a child’s individual medication file (ie Current medication list, Health Assessment etc) must be photocopied and transferred to the new provider. The original file must be securely archived within West Sussex County Council storage facilities.
* The staff member responsible for collating this medication information must 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 ie. The GP, lead Paediatrician or dispensing Pharmacist

**Temporary Transfer (e.g. respite/return home for the weekend/short stay)**

* 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
* If a child is going on holiday, their original dispensed medicines should be sent with them.

* All medication must be transferred in its original packaging with pharmacist label that is fully legible. Controlled Drugs must be placed in an Envopak and not be placed in envelopes or other types of temporary containers. All medicines must be handed over in person to the person receiving it and signed out by residential staff.
* Quantities of the child’s medication when leaving or entering children’s homes must be recorded in the Medication Transfer Log Book, so they can be accounted for. This also applies if medicines are transferred to hospital with the child.
* Where a child using the service is regularly away from the children’s home such as at school or with relatives, the designated member of care staff must ensure the continuity of supply.

1. **Medication reviews**

* Children’s homes must have a process for ensuring children have their medication reviewed on admission and at least 3 monthly or sooner if there are changes in the child’s circumstances.
* It must be documented in each child’s individual medication file which health professional is responsible for each child’s medication review.
* The children’s home should identify children who may need more frequent review of their medication and highlight this to the Paediatrician and/or GP; for example:
* Children receiving palliative care including end-of-life care with a recent diagnosis of a long-term condition
* Children needing frequent or complex monitoring
* Children who have been transferred to the children’s home (for example, after hospital discharge
* For Children **under** the age of 16, the children’s home should try to involve the child and/or their family or carers, a community nurse or specialist nurse, Paediatrician/GP, residential staff, Social Worker and Pharmacist in the medication review.
* For Children **over** the age of 16 and where capacity is lacking there is a duty under the MCA to involve the people listed above.
* The medication review should identify:
* concerns, questions, side effects or other medication problems
* all prescribed, non-prescribed, vitamins and homeopathic medicines and what these are for
* how well they work, how appropriate they are, and whether their use is in line with national guidance
* any monitoring tests that are needed
* administering medicines with agreed foods
* assessing the need for the continuation of current medication being given covertly or for medication to be given covertly,
* That a young person over the age of 16 who has been determined as lacking the capacity to consent to the administration of medication is still receiving it in their best interests.
* All changes in a child’s medication must be recorded in the child’s individual medication file and their care notes. Such changes should be communicated to all staff members as part of a formal shift handover process.
* All changes to medication must be followed by an updated ‘Current List of Medication’ form being produced and placed on file and the MAR sheet being amended.

1. **Assessing the level of support with medication**

* As part of the admission process, the child must be assessed to establish the level of support that they require to maintain the safe administration of their medication. The child’s competence to consent will also be considered as part of this process, see Section 5.
* Staff must carry out and complete the Medication Risk Assessment Form to establish the level of support the child requires for each medication. The levels of support are defined as follows:
* **Self-administering**: Child has been risk assessed as confident and competent to administer their own medication
* **Level 1 Self-administration with general support tasks**: Child takes responsibility for self-administration of medication with support from care staff
* **Level 2 Administration by care staff**: Care staff take responsibility for administering medication
* **Level 3 Administration by specialist technique (healthcare tasks)**: Care staff administer medication by specialist technique with support from a health professional
* The table below describes the different levels of support and the care staff training and administration requirements.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Level of Support Required** | | |
|  | **Level 1** Self-administration with general support | **Level 2** Administration by care staff | **Level 3** Administration by specialist technique |
| Required level of staff training | Level 1 medicines training | Level 2 medicines training | Specialist training  per task per child |
| Responsibility for child’s capacity assessment | Care staff | Care staff | Care staff and a health professional |
| Responsibility for administering medicine | The child (with general support from care staff may be required) | Care staff | The care worker with ongoing support from a health professional |
| Medicine Administration Records (MAR) chart | Required | Required | Required |

1. **Principles of the levels of support**

* Children’s competencies and /or their physical condition can change during the period of their care and their Medication Risk Assessment form should reflect this.
* It is therefore important that staff understand the different levels of support and who to notify if the needs of the child change. In most cases this would be the Registered Manager, who may refer to the GP or relevant health professional.
* A further Medication Risk Assessment Form must be completed to re-determine the level of support required by the child to manage their medication.

**Self-Administration**

* When the children’s home can provide a system for self-administration, a risk assessment using the Medication Risk Assessment Form must be undertaken as part of the admission process.
* The Registered Manager must ensure the risk assessment is carried out by a member of the care staff who is deemed competent and should include the child, their family or carer (where appropriate), the residential staff team, all relevant health practitioners e.g. GP, Pharmacist, Consultant / Paediatrician, Psychiatrist, Prescriber
* The Medication Risk Assessment Form must be used to determine the child’s ability to self-administer. This form considers a range of factors including:
* Age
* Physical ability to self-administer their medication
* Level of understanding of the child on how to take their medication
* Child’s understanding of the consequences of not taking the medication or not following the doctor’s instructions
* Identify their medicines i.e. confirm that they can identify the right drug, strength, form and dose of medicine to be taken at the right time
* Make choices and communicate them e.g. PRN medication
* Child’s consent
* Risk to other resident children
* History and lifestyle factors
* Responsibility of the care staff
* Medication storage
* When and how the assessment needs to be repeated
* A child’s ability to self-administer should be established with each medication e.g. the child may not be able to use an inhaler device but could self-administer with a cream (see Level 1Self-administration with general support tasks).
* The initial assessment is only the start of the care planning process. Their ability to self-administer may only become apparent as the child establishes a relationship with care staff.

**Self-administration Education and Assessment Plan**

* This may include the following:
* Reviewing the medication to identify whether it can be simplified to support the child with self-administration e.g. the medication can be taken at the same time each day.
* A MAR chart must be used until it has been established that the child is self-administering in a confident and competent way. This may mean initially the child signing the MAR with each self-administration and the care staff checking and countersigning that the medicine has been taken as prescribed (either by seeing it directly or by asking the child). Following on-going review, this may be reduced to a weekly or monthly check by care staff until it is agreed that a MAR chart is no longer required.
* Storage arrangements for medication and risks.
* Action to be taken where concerns arise that a child is not self-administering or storing their medication correctly. This should include completion of a further Medication Risk Assessment Form to re-determine the child’s ability to self-administer.

**Storage arrangements**

* This should be in a lockable cupboard or drawer in the child’s room. The child should be able to get any medication that needs special storage e.g. fridge items at the right time.
* Self-medicating children must be reminded of the risks to others if medicines are left lying around. The risk to others should be taken into consideration and included in an individual risk assessment when deciding if a child is able to self-medicate.
* There are medicines that may be better kept by the child using the service (e.g. asthma relievers). Storing these away from them may delay treatment. This must be included in the individual risk assessment.

**Level 1: Self-administration with general support tasks**

* The degree of self-administration can vary as some children may need extra support at times, to be able to manage their medication e.g. short term or acute illness.
* These are tasks that staff can carry out to help a child using the service to maintain or achieve their independence with medication. This would include children with a physical disability and whose competence to consent is not in doubt.
* The child must be Gillick competent or at 16 years and above, have the competence to consent to direct the care staff member and instruct them what medication is required. (See the principles of self-administering medication).

**Which tasks are considered Level 1 – Self-administration with support**

* **Physical assistance:** For example: unscrewing lids, popping tablets out of a blister pack (only if the child using the service tells the care staff which tablets to pop out). These remain general support tasks when the child or young person using the service (not care staff) takes responsibility for confirming that they are taking the right medicine at the right time.
* **Occasional infrequent verbal reminders:** verbal reminders may sometimes be required. The occasional need for a verbal reminder does not mean a child isn’t capable of self-administering.
* However, if regular verbal reminders are needed or if the child becomes reliant on verbal reminders then their ability to self-medicate needs to be re-assessed using the Medication Risk Assessment Form.

**Level 2: Administration by care staff**

* Staff are considered to be providing level 2 support when they take responsibility for administering medication e.g. by using the ‘6Rs’
* Right child
* Right medicine
* Right route
* Right dose
* Right time
* Right to refuse
* Level 2 tasks may include some or all of the following tasks:
* Administration of oral medication including tablets, capsules and liquids (including all controlled drugs)
* Administering inhaler devices
* Applying external medicated creams/ointments/gels/lotions etc (including those applied to intimate areas in accordance with the intimate care policy)
* Applying transdermal patches (including controlled drug patches)
* Applying medication to the eye, nose or ear
* Staff should only give a medicine to a child if the following criteria are met:
  + The child has been assessed as needing level 2 or 3 support
  + There is clear instruction on the MAR chart to give the medicine
  + The staff member has been trained and assessed as competent to give the medicine

**Level 3: Administration by care staff using a specialist technique (Delegated task)**

* Level 3 support are healthcare tasks that require instruction and care planning from a healthcare professional. Where both Health and social care staff are involved in delivering support with medication there will be an agreed care package between both parties. Level 3 tasks may include some or all of the following:
* Rectal administration e.g. suppositories, enemas
* Administration into the vagina e.g. pessaries
* Injections e.g. Insulin
* Administration through a Gastrostomy device
* Giving oxygen
* Nebulised medication
* Buccal midazolam
* Injections such as an Epi-pen®
* Where a child has been assessed as requiring emergency medication e.g. buccal midazolam, the Registered Manager must liaise with the prescribing practitioner or health professional to ensure a detailed Emergency Medication Treatment Plan is completed with a support plan for medication administered using a specialist technique.

1. **Training requirements**

* The Registered Manager must ensure that there are sufficient numbers of suitably trained and competent staff in the children’s home to deliver the required level of medication support for all children.
* To undertake this role, the Registered Manager must be trained to level 2 with additional training in competency assessment (see Competency Check and annual review).
* Staff must only undertake medication tasks they feel they are confident and competent to complete. Where there is an identified learning need, the staff member must inform the Registered Manager who will support the staff member to access additional learning and development.

**Training for Level 1 - Self-administration with general support tasks**

* West Sussex County Council requires all staff to be trained for level 1 as part of their induction programme. Details for level 1 training and annual review are available on the WSCC Learning and Development Gateway.

**Training for Level 2 - Administering medication**

* All care staff must receive medication training at level 2. This training must cover the learning outcomes as advised by Learning and Development.
* Care staff must undertake training updates at least 2 yearly and have an annual review of their skills, knowledge and competence.

**Competency check and annual review for Level 2**

* The Registered Manager is responsible for ensuring there is a formal system in place to assess care staff competency and annual reviews for administering medication.
* Staff must be signed off as competent, using a competency assessment framework by the Registered Manager or approved deputy, before they can administer medication. This must include observing care staff carrying out the administration of medication and the key actions outlined in this medication policy.
* The Registered Manager must be trained to an appropriate level to carry out competency training. If they choose to delegate this role, they must ensure the approved deputy has undertaken additional competency training.
* WSCC suggests the competent person should have a minimum qualification equal to that of the Level 3 Diploma Support Use Medication in Social care Settings unit. It is expected that competency is checked annually as a minimum.

**Training for Level 3 Administration using a Specialist Technique (delegated task)**

* These types of medicines would normally be administered by a health professional. In agreement with the Registered Manager, the health professional may delegate these tasks to care staff provided they are satisfied that the care staff member has received and understood the appropriate training.
* When a task has been delegated, staff hold the responsibility to carry out that task in accordance with their training. The health professional holds accountability for the training. The health professional should offer ongoing support for the delegated task as required.

**The Training Provider for Level 2 Administration**

* The training provider for level 2 support must be a suitably qualified and competent trainer e.g. someone knowledgeable in the subject with relevant, current experience of handling medication.
* WSCC suggest the trainer should have a minimum qualification equal to that of the Level 3 Diploma Support Use of Medications in Social Care Settings (or have equivalent occupational competence) and suitable experience in delivering training.

1. **Ordering and receiving medication into a children’s home**

* The Registered Manager must ensure that the WSCC standardised process is followed for ordering and receiving medication into the home.
* To ensure continuity of care, staff must ensure that the child does not run out of their medication and sufficient time has been allowed to obtain a prescription and for it to be dispensed.
* Where non-prescription and over-the-counter products (homely remedies) are used, staff must ensure that they have enough stock in place.
* Staff should have protected time for ordering and checking medication delivered to the children’s home.
* Each children’s home should have at least 2 competent members of care staff who are responsible for ordering medication.
* Only one competent care staff member is required to order medication at any one time.
* Children’s homes should retain responsibility for ordering medication from the GP practice and should not delegate this to the supplying pharmacy in order to control stock levels locally.
* Children’shomes should keep a record of which medicines they have ordered and received (see Medication Ordering and Collection Form for details).
* When prescribed medicines are collected, care staff may be required to show the pharmacy proof of identity and sign the back of the prescription.

1. **Storage and security of medication**

* Where medicines are stored on behalf of children, a suitable lockable cupboard must be used.
* This should be in a lockable room where access is only available to care staff who administer medication.
* When the cupboardis unlocked, it must never be left unattended.
* The medication cupboard keys must be properly managed by the Registered Manager or the designated officer. The care staff that are trained and competent to handle and administer medicines should be the only care staff able to access medication.
* Keys must be kept by the Registered Manager (or designated officer) and a procedure for handing over keys should be clearly understood by all care staff. Medication storage keys should be kept on a separate key ring from other keys and the number of duplicate keys available should be restricted and logged.

**Children who are self-administering medication**

* Children within the home should be provided with a personal lockable drawer or cupboard that only they and designated care staff have access to, with the permission of the child. Medication must be kept in the locked drawer or cupboard.
* Children who are self-administering medication must keep medication safe and not accessible to any other children. Should children refuse to do this, then their ability to self-administer should be re-assessed due to the risk this may present to themselves and the other children within the home.

**Medication storage and monitoring principles**

* All medication should be stored under conditions which ensure that their quality is maintained e.g. in a hygienic and clean environment, not prone to extreme temperature changes or moisture. Medication must not be stored in a bathroom, toilet or sluice room.
* Medication must be stored in accordance with the manufacturer’s storage requirements, which can be found on the medication package or patient information leaflet (PIL).
* The majority of medication requires storage at 25°C or below (room temperature) OR cold storage (between 2°C and 8°C).

**Room Temperature** - 25 degrees Centigrade (25°C) or below

* Where the manufacturer’s storage requirement is 25°C or below, the medicine can generally be stored at room temperature. Where there is any doubt about the temperature of the room, daily temperature readings should be recorded for a sustained period (e.g. 2-3 months) to ascertain if the temperature is consistently above 25°C. If the main storage area is found to be consistently above 25°C, measures such as the introduction of an air conditioner may be required. The supplying pharmacist should be contacted for advice.

**Cold Storage** - between 2 and 8 degrees Centigrade (2°C and 8°C)

* For medication requiring cold storage (between 2°C and 8°C), a separate, dedicated, lockable refrigerator (medicines fridge) should be available. This refrigerator should be used exclusively for the storage of such medicines and should be kept locked at all times. Medication should be stored away from the internal walls of the refrigerator.
* A record of the fridge temperature must be recorded daily using a minimum/maximum temperature monitoring device to ensure temperatures are maintained within the accepted temperature range of between 2°C and 8°C. Care must be taken to ensure the device is reset after each reading.
* Where the temperature reading is outside the recommended range, staff must immediately report this to the Registered Manager. Measures should be taken to rectify the situation e.g. defrosting the fridge and a pharmacist should be contacted to discuss if the medicines need to be replaced.
* The refrigerator should be cleaned and defrosted (where required) monthly.
* It is also acceptable for medicines requiring refrigeration to be stored within a lockable box in a normal use fridge dependent on a risk assessment.

1. **Disposal of medicines**

* A designated member of care staff should check the medication cupboards and fridge on a monthly basis to ensure that all prescribed medication is currently in use, within its expiry date (use by date) and prescribed to the current resident children.
* All non-prescribed medication should also be checked on a monthly basis to ensure they are within their expiry date (use by date).
* Medication should not be disposed of within the home; under no circumstances must any medication be disposed of in the refuse bin, flushed down the toilet or sink or by any other means.
* All expired, unwanted or unused medication should be disposed of immediately. It should be returned to the pharmacy for safe disposal in accordance with current waste regulations.
* Medication waiting for disposal should 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 must be clearly documented. When staff are responsible for the disposal, a complete record of medication should be made usinga Disposal of Medication Log form.
* In the event of the death of a child, their medication becomes the property of the child’s estate and therefore is the responsibility of the executors to dispose of it safely with the exception of controlled drugs which **must** be returned to a local pharmacy for appropriate destruction. However, it is recommended the medication should be retained for seven days (or until informed that they are no longer needed) following the death, in case the Coroner’s office or courts require it.
* Syringes and needles should be disposed of in a rigid sharps box and disposed of in accordance with local clinical waste disposal arrangements. When syringes and needles are used, they should be safely disposed of by the person using them.

**When a child permanently leaves the children’s home**

* A child’s medication is their property and should be given to them or their parent/carer on discharge. If the medication is no longer required, then consent must be obtained from the child or their parent/carer prior to disposal.

1. **Record Keeping**

**General Principles**

* A Medication Administration Record (MAR charts) should be accurate and kept up to date and include:
* the child's name, date of birth and NHS number, if available
* the name, formulation and strength of the medicine(s)
* how often or the time the medicine should be taken
* how the medicine is taken or used (route of administration)
* the name of the child's GP practice
* stop or review date
* additional information, such as specific instructions for giving a medicine and any known drug allergies.
* Using a MAR chart, care staff must record the medication support or activity for each child and each individual medication on every occasion including:
* reminding a child to take their medication
* giving the child their medication
* recording whether the child has taken or declined their medication
* non-prescribed and homely remedies
* using the appropriate MAR chart when administering medication from a monitored dosage system – MDS (Blister packs or pods
* using a separate MAR chart to record items not in the Monitored Dosage System-MDS (e.g. liquids, eye drops etc).
* Care staff must record details of general medication support tasks in the child’s Support Plan.
* If the child has a MAR chart then care staff should sign next to the medication that the child has had support with. This should be reviewed as per the Medication Risk Assessment form.
* An additional copy of the child’s Medication Risk Assessment Form must be stored in the child’s Main file.
* On receipt of medication from a pharmacy and where a MAR chart has been supplied, a competent member of the care staff must check and sign that the MAR chart has been prepared correctly and accurately against the prescribed medication.
* In addition to the above, a second witness (level 2 trained) needs to certify and sign that the MAR chart has been prepared correctly and accurately.

**Verbal orders from a prescriber**

* Verbal orders to stop, add or amend medicines should only be accepted in an emergency, when the child’s health would be put at risk if the order was not acted upon immediately.
* When taking a verbal order, staff must make a written and signed record of the following:
* child’s name,
* date of birth,
* the time and date of the call,
* the name of the prescriber they are speaking to,
* and the new instructions

* The instructions must be repeated back to the prescriber to confirm that they have heard them correctly, spelling out any drug names if they are unsure. It is best practice that a witness be present to confirm the information. The verbal order must be recorded in the child’s care notes.
* Written confirmation (via fax, email or letter) must be obtained within 24 hours from the prescriber (or within 72 hours at weekends or bank holidays). The written confirmation must be kept in the child’s individual Medication folder alongside the MAR chart.
* Where possible, the prescriber is encouraged to amend the MAR chart themselves. If this is not possible then the MAR chart should be amended by the member of staff taking the verbal order and again checked by a second staff member following the guidance below. Care staff must record the reason for administering the new medication in the child’s care notes.

**Altering MAR charts – cancelling, changing or adding medication**

* For all changes to MAR charts a reference should be made in the child’s care notes and on the back of the MAR chart, explaining why the item was cancelled, changed or added and the written confirmation must be attached to the child’s care notes.
* **Cancelling items of medication:** When an item of medication is cancelled, care staff should strike through the item using a diagonal line, to make clear the medication has been changed. Care staff must record the name of the authorising prescriber and sign and date the cancellation.
* **Changing or adding medication (only when authorised by the prescriber and written confirmation obtained)** If changing the medication, cancel the medication item on the MAR chart (as set out above). Add the item as a new entry, with the revised details as provided by the prescriber. Once an item has been added to the existing MAR chart, it must be signed and a competent second member of care staff must check that it has been recorded correctly and then countersign.
* Ensure that this written record is printed in capitals in black ink. The information that is printed on the medication label must be copied directly to the recording chart.
* When making any of the above changes to a MAR chart, the recording must include the following:

* Date of administration
* Time given
* Drug name
* Drug form e.g. tablets, liquid, topical
* Dose required
* Route e.g. oral, topical
* Initials of care staff responsible for administering on the MAR chart

**Intentional Omission of medication**

* If following consultation with the prescriber, a dose of a regularly prescribed medication is intentionally omitted e.g. not giving laxative because the child has developed diarrhoea, the following action must be taken:
* An entry must be made on the MAR chart using the appropriate letter as indicated on the MAR chart.
* A record must be made on the child’s care notes

**If a child refuses their medication**

* If a child refuses their medication, the following action must be taken:
* An entry must be made on the MAR chart using the appropriate letter as indicated on the MAR chart.
* A record must be made on the child’s care notes

**Retention of records**

* Medication records must be kept for seventy five years from the last date of entry. If a child using the service’s care is transferred to another care establishment, copies of the medication records and administration charts will be made available to the new establishment 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 and archived accordingly.
* When records are then destroyed, they must be shredded or destroyed in a way that preserves confidentiality.
* Children’s homes should keep (and allow the child or young person using the service access to) the latest copies of the Patient Information Leaflets for each medicine supplied by the pharmacy.

1. **Administering medication at Levels 2 & 3**

**Crushing tablets and/or opening capsules**

* There may be occasions where tablets or capsules need to be crushed or opened to enable the child using the service to take their medication:
* This should only be done when both a pharmacist and the prescriber have given authorisation (this can be provided verbally and recorded in the child’s notes)
* Where possible this should only be carried out with the consent of the child or their parent/carer or in accordance with a best interest decision.

**Splitting tablets**

* It is always preferable for solid dose forms (tablets or capsules) to be administered as single or multiple units (e.g. one or two tablets) per dose. Occasionally it may be necessary to split a tablet to achieve the required dose. In such cases tablets may be split if they are scored by the manufacturer.
* Non-scored tablets should only be split after confirming with the pharmacist that splitting is safe. Alternatively it may be possible for the medicine to be requested to be prescribed in a liquid form by which the correct dose can be easily and accurately measured using an oral syringe.

**Administering from monitored dosage systems (MDS)**

* If it is appropriate for medicines to be administered from a monitored dosage system (MDS) (sometimes called a blister pack) this must be a sealed, tamper-proof MDS that has been prepared by a pharmacy.
* Staff cannot administer medicines from dossette trays or boxes that have been filled by relatives, neighbours etc. This is because there would be no pharmacy label fixed with details of the medication and the accuracy of the process for filling the dossette tray or box cannot be guaranteed.

**Administering ‘when required’ medication**

* Medication with a ‘when required’ dose is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly but occasionally.
* The ‘when required’ medicine should be clearly recorded in the child’s MAR chart and care plan, including what the medication is expected to do e.g. for pain relief.
* As it is for occasional use the child should be offered the medication at the times they are experiencing the symptoms either by telling a member of care staff or by care staff identifying the child’s need as outlined in the child’s care notes.
* Where the first dose of ‘when required’ medication has not worked e.g. for pain relief, the MAR chart and prescriber’s instructions must be clear when the next dose can be given.If there is any confusion about which ‘when required’ medication or dose to administer , the care staff member must check with the prescriber or out of hours GP service.
* If ‘when required’ medication has been administered regularly for up to 3 days, a consultation with the prescriber or GP must be sought as their medical condition may have changed and the treatment required may need altering. Similarly if the medication is not having the expected effects the GP or prescriber must be contacted. In both cases the response to the medication should be clearly recorded in the child’s care notes.
* ‘When required’ medication that is still in use and in date, should be carried over from one month to the next and not disposed of. (See Section 12)
* ‘When required’ medication must be supplied in an original box rather than a monitored dosage system (MDS).

**Omitted Medication**

* If a dosage of a regularly prescribed medication is intentionally omitted by the responsible person, for any reason e.g. not giving lactulose because the child has developed diarrhoea, the following action must be taken:
* An entry must be made on the MAR sheet.
* A record must be made in the child’s care notes.

1. **Controlled Drugs (CDs)**

* 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.
* 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 apply to the following controlled drugs:
* All schedule 2 controlled drugs (CDs)
* Schedule 3 CDs including: temazepam, buprenorphine, flunitrazepam and diethylproprion, zopiclone, tramadol, phenobarbital, midazolam
* Schedule 4 CDs including: benzodiazepines (e.g. diazepam), Sativex, anabolic steroids, growth hormones
* Schedule 5 CDs including: morphine solution (e.g. Oramorph), codeine, dihydrocodeine
* The government can re-classify controlled drugs at any time, hence care providers should check with a pharmacist to see if any other drugs are added to the schedule 3 CDs which have extra controls placed on them
* 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.

**Ordering and collecting Controlled Drugs**

* In children’s homes, CDs must be prescribed for individual children and **must not** be kept as stock.
* Any prescription that does not comply with the legal requirements may have to be sent back to the prescriber for altering before it can be dispensed.
* If a care worker collects CDs from a pharmacy on behalf of a child, they must provide identification.

**Storage of Controlled Drugs**

* Best practice guidelines suggest that 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 security of the location of the CD cupboard also needs careful consideration.
* CD cupboards are available commercially. It is important that when purchasing a CD cupboard, a formal confirmation is obtained from the supplier that the cupboard meets with the requirements.
* The CD cupboard must only be used for the storage of controlled drugs and not for general medication or valuables.
* The CD cupboard must be kept locked at all times when not in use.
* The CD key must be kept separately from all other keys i.e. must not be kept on the same key ring as any other keys.
* The Registered Manager has overall responsibility for the CD key and should know where it is at all times and approve of its use. Only those with authorised access should hold the key to the CD cupboard. The CD key should be returned to the Registered Manager or delegated senior member of staff, immediately after use.
* All CDs received into the care home must be immediately stored within the CD cupboard and an entry made into the Controlled Drug’s Register (CDR).
* If the CD requires safe custody and it has been provided in a monitored dosage system (MDS) the MDS should be stored in a CD safe or cabinet.

**Record Keeping for Controlled Drugs**

* The Home must have a controlled drug register (CDR), which must be a bound book with numbered pages. Registers with specific space for the recording of running balances are available and recommended.
* A record of the receipt, administration and disposal of controlled drugs must be kept in this CDR. 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 designated member of care staff.

**Administration of Controlled Drugs**

* When administering a controlled drug, the same administration procedures should be followed as for any other medicine e.g. the 6 R’s. CDs should be administered by appropriately trained and competent care staff. The staff member responsible for administering the CD must book the CD out of the CDR 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 CDR and the MAR chart. The use of a witness is intended to reduce the possibility of an error occurring.

**Disposal of Controlled Drugs**

* Controlled drugs that are no longer required or have expired must be promptly disposed as per local procedures for prescribed medication e.g. returned to the supplying pharmacist for safe denaturing and disposal. A record of the return should be made in the CD record book and countersigned as outlined above. It is good practice to obtain a signature for receipt from the pharmacist.

**Audit of Controlled Drugs**

* An audit of the controlled drugs should be undertaken and recorded by the Registered Manager at least monthly.
* Controlled drug discrepancies should be immediately reported to the Residential Service Manager to undertake a full investigation and where appropriate inform the NHS England South East Controlled Drug Accountable Officer.

1. **Refusal of medication**

* Staff must record the circumstances and reasons why a child has refused to take their medication, in the child’s individual medication folder and care notes.
* When a child refuses medication, the care staff administering the medication must inform the Registered Manager or delegated Officer. The Registered Manager or delegated Officer must inform the prescriber or if out of hours- call the 111 service as soon as possible.
* When a child refuses their medication, they should be reminded that whilst it is their right to refuse medication, there may be risks to their health and wellbeing.
* When a child aged 16 years or over with competence to consent refuses any medication, this must be respected, however principle 3 of the MCA states that people are entitled to make unwise decisions but the care staff have a duty of care to inform the child of the risks of not having the medication every time it is due to be administered and work with the child to ascertain if there is an alternative treatment available. If medication is refused then the process of reporting and recording must be followed, to ensure the child’s health and wellbeing is maintained (see Section 15).
* An entry must be made on the MAR chart using the appropriate code, for example an ‘X’, to show which medication has been refused.
* If you suspect that medicines are not being taken e.g. not being swallowed, the care staff must record this in the child’s care notes and inform the Registered Manager or delegated officer who must inform the prescriber as soon as possible or if out of hours- call the 111 service as soon as possible.

1. **Giving medication to a child without their knowledge (covert administration of medication)**

* Covert administration of medicines is when medicines are given in a disguised form without the knowledge or consent of the person receiving them. This should only take place in accordance with the requirements of the Mental Capacity Act 2005 and its Code of Practice to protect both the child and care staff.
* A capacity assessment of the child’s ability to decide whether to take a medicine or not should be completed jointly with the prescriber and if it is determined that the child lacks capacity then a formal best interests decision should be made. The process is proportionate to the decision. For example, a formal meeting may not be required for covert medicine as required (ie a laxative when constipation if not problematic and view can be sought remotely) but regular medication affecting mood and behaviour will require a formal process.
* Care staff must not give, or make the decision to give, medicines by covert administration, unless there is clear authorisation and instructions to do this in the child’s care plan, in line with the Mental Capacity Act (2005) or best interest decision for under 16 years.
* Ensure that the process for covert administration clearly defines who should be involved in and responsible for, decision-making including:
* assessing a child's competence to consent to make a specific decision about their medicines
* seeking advice from the prescriber about other options, for example, whether the medicine could be stopped
* holding a best interests meeting to agree whether giving medicines covertly is in the child's best interests
* recording any decisions and who was involved in decision-making within residential records
* agreeing where records of the decision are kept and who has access
* advice from a pharmacist must be sought when planning how medicines will be given covertly
* providing authorisation and clear instructions for care workers in the child’s care plan
* ensuring care workers are trained and assessed as competent to give the medicine covertly (see also the section on training)
* when the decision to give medicines covertly will be reviewed.

1. **Adverse effects**

* Care staff should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional (such as the supplying pharmacist). They should also inform the child parents/carers.
* Staff should record the details of the adverse effect and who was notified and when, in the child’s care plan.
* Staff should tell the supplying pharmacy (if the child using the service agrees that this information can be shared).

1. **Medication-related incidents**

* Medicines-related incidents include any actual errors, errors that do not cause any harm and near misses with medicines. They might be identified by staff involved in the medicines-related incident or subsequently by other people not involved in the incident. They may also come to light after audits.
* If an incident occurs regarding medication, care staff must immediately report this to the most senior person in the establishment who will then contact the on call manager/assistant manager if necessary. This also applies to errors that care staff identify, but have not made themselves – e.g. errors made by prescribers, pharmacists and other care staff.
* When a senior staff member has received information that a child using the service has been harmed, or might have been harmed, or if they have significant concerns about the child, they should seek advice from the GP or pharmacist. If this occurs out of hours, then the NHS 111 service can be contacted if, in the view of the Registered Manager, they cannot wait to tell the GP or pharmacist the day after. Details of the incident should be fully documented using the medicines incident report form.
* A central record of all errors should be kept. This log can be used for monitoring of patterns and to inform training sessions.
* All medicines-related incidents (including near misses) should be investigated to reveal any root causes, be these systems errors or human error. These root causes should be recorded as well as which actions are taken as a result of lessons learnt.
* Any training needs should be identified and appropriate training must be provided if needed.

**Who to notify when a medicines-related incident is identified**

* For registered services, the Residential Service Lead must be notified when any medicines-related incident has caused either:
* **Harm or potential harm** to a child using the service. By harm we also include significant distress.
* **Intent**: If the staff member intended the adverse consequences to occur as a result of the incident.
* If there is any doubt regarding whether a concern should be raised under these procedures this should always be discussed with the Registered Manager of the home.
* Poor practice can result in harm when risks are not identified and no action is taken to prevent further incidents occurring or the concern escalating. Incident logs should always be checked for patterns by those recording incidents and those responsible for monitoring the effective implementation of that organisation's incident policy.
* Managers and staff have a duty to have systems in place that enable them to identify patterns/cumulative incidents and to raise a concern if there are a number of these, even if some are retrospective.

**Incidents where controlled drugs go missing or any suspected abuse of controlled drugs (both by care staff or child or young person using the services)**

* Contact must also be made with:
* West Sussex County Council Safeguarding Children’s Board
* Ofsted
* NHS England South East Controlled Drug Accountable Officer via [www.cdreporting.co.uk](http://www.cdreporting.co.uk). For advice, the Controlled Drug Team can be contacted by email at: [england.southeastcdao@nhs.net](mailto:england.southeastcdao@nhs.net) or on 07917 262609).
* If a criminal act is being committed right now, please contact your local police force via 999. For criminal activity that has already happened or for suspected criminal activity (non-urgent) please contact the police via 101.

1. **Audits**

* The Registered Manager of the children’s home must demonstrate that they have put in place appropriate quality assurance audits systems to record and monitor the effectiveness of the medication arrangements for example (this is not an exhaustive list):
* 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

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| **Review / Contacts /References** |  |
| Document title: | WSCC Policy: Medication in WSCC Children’s Homes |
| Date approved: | TBC |
| Approving body: | Policy and Practice Steering Group |
| Last review date: |  |
| Revision history: |  |
| Next review date: |  |
| Related internal policies, procedures, guidance: | Appendix 1  Medication Review form  Medication Risk Assessment  Disposal of Medication log  Medication Ordering and Collection Log  Medication Transfer form  Risk Assessment for Self-Administration of Medication  Best Interest Plan for Medication  Medication Incident Form  Medication Incident Tracker  Emergency Medication Support Plan  Practice Guidance on Homely remedies  Consent to Administer Homely remedies  Allergy Management Plan  Baseline Body Map |

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| --- | --- |
| Policy owner: | Assistant Director - Corporate Parenting, Children, Young People and Learning |
| Lead contact / author: | Residential Service Lead  Advanced Practitioner (Quality Assurance - Residential Services) |

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| --- | --- |
| **Glossary** | |
|  | |
| **Administration by care staff (level 2)** | When the child or young person using the service is dependent upon care staff to select and/or measure and/or give the appropriate medication from a Monitored Dosage System (MDS) or individual pharmacy labelled container, at the time the medication is due. Care staff are responsible for ensuring it is taken/ applied as prescribed. |
| **Administration by care staff using a specialist technique (level 3)** | These types of tasks will normally be administered by a health professional and include tasks such as giving medicines via nebuliser or injections. |
| **Children’s home** | Means all local authority children’s homes operated in West Sussex. |
| **Care package** | A combination of services designed to meet a child’s or young person’s assessed needs. |
| **Care plan** | A document produced by the Registered Manager following assessment of the needs of the child or young person using the service, outlining how these needs shall be met. |
| **Care establishment** | The service that will provide care to the child or young person using the service to meet their assessed needs. |
| **Carer/s** | People who are supporting a child or young person, who has a physical or mental illness or disability. |
| **Care staff** | A person who is supporting a child or young person using the service who has physical or mental illness or disability. Care staff are paid for the care they provide. |
| **Controlled Drug Accountable Officer** | A named person leading the controlled drug local intelligence network (CDLIN) with an oversight on controlled drug issues within the locality. |
| **County council** | Means West Sussex County Council (WSCC). |
| **General support tasks (level 1)** | Tasks that care staff can carry out to help a person using the service self-medicate and maintain their independence. |
| **Emergency medication treatment plan** | Is an individual plan for a child or young person using the services with specific health needs, written by the person who prescribed the medication or currently responsible paediatrician. |
| **Multi-disciplinary** | Multidisciplinary denotes an approach to care that involves more than one discipline. For example, this include paediatricians, Nurses, Community Pharmacists etc. |
| **Medication administration record (MAR chart)** | Is a recording sheet produced detailing all of a child’s or young person’s medication. |
| **Medication record sheet for monitored dosage system**  **NICE**  **Ofsted** | Is a pre-printed WSCC recording sheet (AS 93) to be used when medication is dispensed in a Monitored Dosage System.  National Institute for Health and Care Excellence  The Office for standards in education – Governing body by which children’s homes are registered. |
| **Registered manager** | Refers to the Manager of the establishment who is registered with Ofsted. |
| **Risk assessment** | Collection and interpretation of data to determine the potential risks to child or young person using the services and staff associated with delivering the care package, before the care staff commences work and is updated annually or more frequently if necessary. |
| **Staff**  **Verbal Reminder** | Means all staff employed by WSCC or employees/self-employees of an independent agency who are providing a service under contract to the County Council.  Care staff are required to remind a child or young person to take their medication. There is **no** physical administration by the care staff. |