the skills network

Level 2 **Certificate in Understanding the Safe Handling of Medication in Health and Social Care**

Unit 4

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Instructions for use

STEP 1:

To get started, you will need to download the EQUAL App from the AppStore or PlayStore and follow the simple tutorial instructions on how to activate your course.

STEP 2:

Look out for this icon in your learning materials.

STEP 3:

Whenever you see the icon, click on the 'lens' in the bottom bar of the app, scan the icon or the image the icon is placed on, and bring your bonus content to life.

Utilising the app to access additional content is not mandatory to successful completion of the course, but allows for an alternative way to access content from within the workbook.

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Disclaimer:

This resource uses real life case studies where specifically stated and referenced. All other references to individuals, groups and companies contained within these resources are fictitious.

Level 2 Certificate in Understanding the Safe Handling of Medication in Health and Social Care

Welcome to this Level 2 Certificate in Understanding the Safe Handling of Medication in Health and Social Care.

We hope you find all of the information contained in this resource pack interesting and informative. This learning resource and the assessment questions have been approved by your awarding body as a great way to meet the learning outcomes for this qualification. (A complete list of the learning outcomes can be found at the back of this workbook.)

This course is made up of **four** books. This is **book four**, which contains **one** unit:

Unit 4: Record keeping and audit processes for medication

As you start to read through each page you will be able to make notes and comments on things you have learnt or may want to revisit at a later stage.

At the end of each section, you will be asked to go to your assessments and answer the relevant questions. Once you have answered the questions, go to the next section and continue studying until all of the assessments have been completed.

Please make sure that you set aside enough time to read each section carefully, making notes and completing all of the activities. This will allow you to gain a better understanding of the subject content and will help you to answer all of the assessment questions accurately.

Good luck with your study. Now let's begin!

Key Skill Activities

Throughout this workbook, you will be asked to complete activities to help with your English and maths skills, and to allow you to stretch and challenge yourself and test your behaviour and attitudes in relation to the safe handling of medication in health and social care. These activities are designed to encourage your development throughout the course and to allow you to extend your knowledge as you progress through the course.

Key Skill: English

Whenever you see this icon, there will be an activity which encourages you to demonstrate your English skills. Completing these activities will allow you to practice literacy components and may stretch you beyond your existing skills which will then improve your general abilities.

Key Skill: Maths

Whenever you see this icon, there will be an activity which encourages you to demonstrate your maths skills. These activities will help you with your personal and professional development. Completing these activities will allow you to practice mathematical components and may stretch you beyond your existing skills which will then improve your general abilities.

Key Skill: Stretch and challenge yourself

Whenever you see this icon, there will be an activity which encourages you to stretch and challenge yourself in relation to the safe handling of medication. These activities will help you with your personal and professional development and encourage you to think about certain situations and scenarios in more detail.

Key Skill: Behaviour and attitudes

Whenever you see this icon, there will be an activity which encourages you to consider your own behaviour and attitudes in relation to the safe handling of medication. These activities will help you with your personal and professional development and will help you to evaluate the skills you already have, and think about how you approach various situations in the workplace.

Key Fact: British Values

You will also come across this British Values icon throughout the course. Whenever you see this, it represents an area of learning that emphasises British Values. Your understanding of these values is crucial as you look to grow and develop as an employee and member of your wider community.

Section 1: The audit process

This section will explore the following:

- The audit process in relation to medication transactions and stock levels
- Recording medication.

The audit process in relation to medication transactions and stock levels

All health and social care workers have a duty to provide high standards of care to service users. However, the quality of care can vary between service providers. News reports have exposed unacceptable conditions and treatment of service users being cared for in health and social care organisations. This is particularly true of errors associated with medication, including:

- Doctors who were not accessible, did not know the service users and lacked information in the homes when prescribing
- High workload within the care homes, lack of medicines training and drug round interruptions
- Lack of teamwork between the home, practice and pharmacy
- Inefficient ordering systems
- Inaccurate medicine records and prevalence of verbal communication
- Medication administration systems that are difficult to fill out.

Medication errors can occur at any stage in the process of medication management; from the prescribing and dispensing of medication, through to the administration and monitoring of medication. It is therefore essential to highlight that everyone involved in the handling of medicines, including care home managers, health and social care professionals, and staff, have a duty to ensure high standards are maintained at all times.

Your organisation must therefore ensure systems are in place for monitoring and addressing standards associated with the handling of medication. This is achieved through a system known as the ‘audit process’.

What do you know?

Before you start this unit, it is important that you take some time to think about what you already know about record keeping and audit processes for medication. Please take some time to answer the questions below and rate your confidence in each topic area.

Use the following key to complete your answers to questions 1 to 5. You can then write out your answer in full for Question 6.

At the end of the unit, you will be asked to take another look at these questions so that you can rate your confidence again and identify how you have progressed throughout the unit and how your knowledge and awareness in each area has developed.

1 – Not confident at all 2 – A little confident 3 – Confident
4 – Very confident 5 – Confident enough to share my knowledge with others

1.	How confident do you feel in your understanding of the audit process in relation to medication transactions and stock levels?	
2.	How confident do you feel in your ability to record information and maintain confidentiality?	
3.	How confident do you feel in your understanding of the importance of a medication review process?	
4.	How confident do you feel in your understanding of accountability and responsibility in a care setting?	
5.	How confident do you feel in your ability to safeguard individuals in relation to medication use?	
6.	What are you hoping to learn in this unit?	

The audit process is a well-established procedure within health and social care, and is used to examine and monitor standards associated with planned activities – for example, medicine management. All medication entering and leaving the organisation is auditable.

Through careful handling and accurate record keeping, every item of medication must be accounted for at every stage throughout the prescription cycle.

The audit process must therefore cover every aspect of medication management; from the ordering and prescribing, through to the dispensing, receiving, storage, administration and disposal of medicines.

The aims of a medication audit are to:

- Promote and ensure compliance with regulatory body requirements and the law
- Promote safer handling of medication at every stage of the prescription cycle
- Identify trends in medication management standards and areas where attention must be focused
- Reinforce the principles of accountability and responsibility.

An audit is a form of quality control. It follows a structured process which provides a means of measuring the practices and processes within the organisation. The results of the audit process are then measured against agreed standards. This provides a platform upon which modifications can be made as indicated.

The audit process consists of **four** stages:

Stage 1	**Assessment**	Assessment involves looking at certain situations and setting aims and objectives.
Stage 2	**Implementation**	This stage looks at the ways in which the aims and objectives are going to be met. It identifies what needs to be done and the actions that need to be taken.
Stage 3	**Measurement (monitoring and recording)**	This identifies whether or not the aims and objectives have been met and any areas where improvements can be made.
Stage 4	**Reviewing (monitoring and actioning)**	This is an essential stage in the process as it ensures that aims and objectives continue to be met. If the aims and objectives are not being met, the situation will need to be reassessed.

The role of the pharmacist in supporting the audit process

Pharmacists play an integral role in supporting organisations throughout the process of auditing policies and procedures associated with medication. Through what is known as an **enhanced service**, community pharmacists can provide organisations with:

- Day-to-day practical advice and guidance surrounding all aspects of handling medication
- Medication training for care staff
- An auditing service to ensure the organisation is meeting fundamental standards of quality and safety.

Effective auditing is dependent upon the pharmacist and the organisation working in partnership with each other.

How manufacturers' instructions apply to the audit process

It is essential that manufacturers' instructions are always followed throughout the process of handling medication.

Manufacturers' instructions should always be supplied with medication and will indicate the way in which it should be stored and the requirements for safe administration. Checks must be made to ensure medication is being stored in a clean and orderly environment, which is maintained at the correct temperature for the medication being used. The stability of a medicine can become compromised if it is not stored under the right conditions, and, as a result, can become less effective, develop harmful bacteria, or become out of date more quickly.

When auditing medication, it is therefore essential to check that medication is being stored and administered as the manufacturer has instructed.

There is a need for staff to have knowledge about the medications they are administering, and it is also a regulatory body requirement to ensure that service users can access information about their medicines. For these reasons, it is essential that manufacturers' instructions are available in the form of Patient Information Leaflets (PIL).

Policies

The process of handling medication is very tightly regulated at a national level. However, at a local level, your employer must have in place an organisational policy to ensure you have very clear guidelines and procedures to work within. Workplace policies must take into account the current national legislation, standards and guidelines. The policy should detail what you need to do to ensure you are working in line with legislation, and should cover all aspects of handling medication.

If all members of staff adhere to this policy, it will ensure that medication is handled in a safe manner. It will also ensure that incoming and outgoing medicines can be reconciled with the stock held on the premises, and that any discrepancies can be accounted for. In order to achieve this, organisations must:

- Undertake regular stock checks of all prescribed medication
- Keep records of all medications received
- Keep records of all medication administered to service users, including any medications which have been spoiled, refused or intentionally withheld
- Keep records of medication which has been returned for disposal.

STOP AND THINK!

Familiarise yourself with the internal audit requirements for your organisation or a care setting you are familiar with. Have any areas of concern been highlighted? If so, have measures been put in place to improve practices?

What are external audits?

The Care Quality Commission (CQC) is integral in carrying out external audits (inspections) within health and social care establishments.

The Care Quality Commission is the independent regulatory body for health and social care within England.

The Care Quality Commission has a responsibility to register, review, inspect and report on all health and social care services throughout England. The CQC has published the **Fundamental Standards**, the standards against which care providers are measured when an external audit (inspection) takes place. These audits can take place unannounced at any time of day or night, and the auditor (inspector) will undertake the audit in line with the regulatory body prompts.

The external audit (inspection) will observe and scrutinise procedures for:

- Accessing up-to-date policies
- Staff training
- The ordering of medication
- The receiving of medication
- The appropriate storage of medication
- The administration of medicines, including self-administration
- Evidencing that manufacturers' instructions are being followed
- The giving of information when administering medication
- All records associated with medication
- Whether transactions and stock levels correspond
- The disposal of medication.

Following the audit, the auditor will publish a report relating to the standards observed within the visit. This report will set out what the organisation does well and any areas where improvements are needed.

If the CQC has concerns that the care provider is not meeting the Fundamental Standards, it will work with commissioners to establish a course of action. In some circumstances, the CQC will use powers of enforcement to ensure appropriate action is taken. This may include issuing warnings, imposing certain conditions, issuing a penalty notice and suspending or cancelling registration.

A

Activity 1: Audit inspections

Take a look at the last external audit (inspection) carried out by the regulatory body which is responsible for your organisation. What does the report indicate about the way medication is handled within your organisation?

Legal requirements

The introduction of the Fundamental Standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 brings about several changes with regards to medication. Notably, there is no longer a specific regulation for medication management, as the Fundamental Standards cover all aspects.

Regulation 17: Good governance of the Health and Social Care Act 2012 states:

'...providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice'.

In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.'

Providers of health and social care have a legal responsibility to comply with these regulations. In order to ensure compliance with this legislation, health and social care organisations must ensure they monitor these processes in order to make sure safe practices are being maintained.

The CQC's Fundamental Standards cover all aspects of medication management, and by following these standards, providers will be complying with the legislations and guidelines that are in place to ensure the audit process is being adhered to, and that safe practice is being followed.

The Royal Pharmaceutical Society (RPS) has published guidelines which identify **eight core principles** relating to the safe and appropriate handling of medicines in health and social care settings. These principles cover the:

1. Availability of medicines
2. Importance of access to advice from a pharmacist
3. Competency of staff in handling medication
4. Storage of medication
5. Privacy and dignity of individuals receiving medication
6. Appropriate use of medication
7. Importance of keeping accurate records
8. Freedom of choice of service users in relation to their provider of pharmaceutical care.

Key Fact

The Care Quality Commission emphasise that their guidelines must be followed by organisations which are responsible for the handling of medication.

Recording medication

Within the United Kingdom there is a statutory requirement to keep records of all medications within health and social care organisations. Record keeping is an essential aspect of handling medication, as these records provide evidence of medicines which have been:

- **Received**
- **Administered**
- **Sent for disposal.**

These records are auditable documents and must provide a clear account of what has been done with medication that has entered and left the care facility. If these records are not accurate, the audit trail will be compromised.

In addition, your organisation must maintain a list of all staff who are involved in the handling of medicines. This list must detail each individual's signature and initials. This requirement will ensure the identity of staff administering medicines can be established at any time.

Recording the receipt of medication

The procedure for receiving and booking in medication was discussed in Unit 2. This section will explore the requirement for recording the receipt of medication.

Each time medication is received within your organisation, evidence of this receipt must be provided in the form of a record. The record must indicate the:

- Date of receipt
- Name of the service user
- Name, strength and dose of the medicine
- Quantity received
- Signature of the member of staff receiving medicines.

The quantities of the prescribed medicines received must be entered into the appropriate box on the service user's Medication Administration Record (MAR) chart when they are checked off.

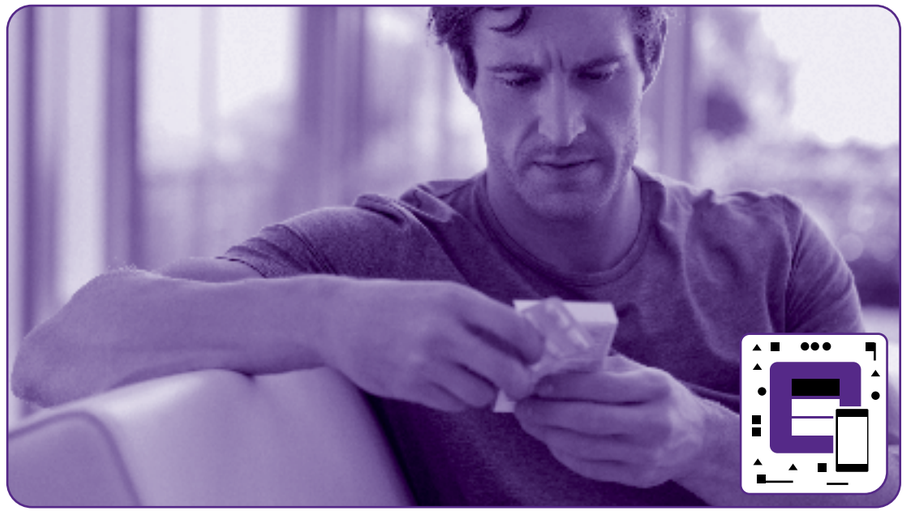
Key Skill: Maths

Tariq receives four packets of medication to last him four weeks. Each packet contains 14 tablets. How many tablets does Tariq receive? Use the space below to make notes.

You can find the answer to this activity at the end of the workbook.

Some ‘as and when required’ (PRN) medicines may be carried over from one month to the next. If this happens, and a new supply has been received, the quantity received should be added to the quantity carried over so that the total number of tablets in stock at the beginning of the 28-day period is recorded. This will ensure an accurate audit trail of medication usage is maintained.

On receipt of controlled drugs, the designated person, along with a competent witness, must check the contents of the container with the quantity on the container label. If correct, the designated person must enter the quantity into the Controlled Drugs Register (CDR) on the appropriate page. The balance of the stock must then be calculated, checked and entered at this time. The designated person and the witness must then sign the register.



Here’s your first video. Point your lens at the whole image to unlock the video content!

Where service users are responsible for their own medication, the MAR chart must indicate the date the medication was received by the individual. This information is important in order to help staff assess whether or not self-administering service users are accurately taking their medication.

Are you using the Equal App?

Please wait patiently to watch your videos as some may buffer while they are loading.

Recording the administration of medication

All medicines must be recorded on the MAR chart, the working document for recording the administration of medicines. It is this document which contains all of the information about the medication each service user has been prescribed.

Every dose of medication administered to a service user must be recorded on the MAR chart. Before the administration can be recorded, the person who administered the medication must be sure that the service user has taken it.

The record must indicate the name, dose and strength of the medicine, the date and time of administration and the initials of the member of staff who offered the dose. The record must also indicate if a medicine was not taken and the reason for this (using the appropriate code). If there is an option to give one or two tablets, the record must show how many were administered. The Medication Administration Record (MAR) must provide an accurate account of exactly what has happened to all medication throughout the process of administration.

Key Fact

An MAR chart is a legal document. If any problems occur in relation to a service user’s medication, the MAR chart will be called upon as it should provide an accurate record of all medication administered.

In addition to providing protection for service users, these documents also provide protection for staff. It is therefore in the interests of both that MAR charts are always completed accurately and at the time of administration.

STOP AND THINK!

Do you know exactly how to accurately record information about the administration of medication on an MAR chart?

In addition to the procedures relating to the administration and documentation of other medicines, there are additional procedures which must be carried out following the administration of controlled drugs. The administration of a controlled drug must be witnessed by a second, suitably trained member of staff.

Following administration, an entry must be made on the MAR chart and in the Controlled Drugs Register (CDR). The CDR must be completed to detail the:

- Date and time of administration
- Name of the service user
- Dose administered
- Full signatures of the person who administered the medication and the witness
- Remaining balance of stock, which should be checked on the returning of stock.

A separate page must be used for each drug and variation of strength.

If service users are responsible for administering their own medication, there are no statutory requirements for staff to sign the MAR chart.

Read the case study below and have a go at the activity on the next page.

C

Case Study: Errors in administration

Sally has just been employed as a healthcare worker at Newberry Park Care Home.

As part of her induction, she is assigned a senior member of staff to work with. Sally shadows the senior member of staff who has been given the responsibility of administering the morning medication. Sally observes that the senior member of staff picks up each MAR chart and signs it prior to popping out the required medication. She then takes the medication to the service user, gives them the medication and walks away.

A

Activity 2: MAR

Read the case study on the previous page and explain why the Medication Administration Record (MAR) chart should not be signed in this way.

Recording the disposal of medication

There are many reasons why medication needs to be disposed of, which have been covered in Unit 2. Some of the reasons for disposal will initially be recorded on the MAR chart – for example, where medication has been refused. However, when medication is prepared for disposal, the designated person must make a record to evidence the medication was sent to be disposed of in line with current legislation. Medication is often returned to the pharmacy for safe disposal.

A record of the return must be made on the MAR chart and within the medication returns book. On preparation for return, the following information should be recorded:

- Date of return
- Name and strength of medicine
- Quantity returned
- Name of service user for whom the medication was prescribed
- Signature of the member of staff arranging the disposal.

When returning controlled drugs for disposal, this must be witnessed by a competent person and the details must be recorded in the register and in the returns book. The following details must be recorded:

- Date of return
- Name of the service user
- Controlled drug name and strength
- Number of tablets or volume of liquid
- Full signature of the designated person and the witness.

A signature of receipt is always required for the disposal of controlled drugs.

Accurate records are essential in order to ensure:

- Medication is not misused
- Medication is not stolen
- Errors in administration do not occur
- Medication is being handled in line with legislation.

Activity 3: Your organisation's internal audit

Using the procedure as highlighted within your organisation's internal audit, take a look at five Medication Administration Records within your organisation. Undertake a mini audit on the charts and explain your findings in the space below. Imagine that your supervisor is going to check the notes you make, so make sure that your spelling, grammar and use of punctuation are correct.

Let's Summarise!

Take a few moments to answer the following questions to help you summarise what you have learnt in this section. This will help you answer the upcoming assessments.

1. State the <u>four</u> stages of the audit process.

1.

2.

3.

4.

2. What <u>three</u> stages of handling medication are evidenced through record keeping in health and social care organisations?

1.

2.

3.

3. Medication records are not auditable documents.

True ○ **False** ○

Check your answers by looking back over this section.

Congratulations, you have now completed Section 1.
Please now go to your assessment and answer Q1 to Q12.

Section 2: Recording information and confidentiality

This section will explore the following:

- Record keeping
- The requirements of the regulatory authorities in relation to medication record keeping
- Medicines reconciliation
- The importance of a medication review process
- The importance of keeping records up to date
- Confidentiality.

Record keeping

The Care Quality Commission recognises that good record keeping is crucial to the delivery of high standards of care. In fact, when the Care Quality Commission undertakes an inspection, they will scrutinise an organisation's documentation in order to assess whether or not it is compliant with the Fundamental Standards. The overall aim of this quality assurance is to ensure the needs of service users are being met to the highest possible standard.

Good record keeping, whether at an individual, team or organisational level, has many important functions, such as:

- Helping to improve accountability
- Demonstrating how care-related decisions have been made
- Supporting the delivery of services
- Ensuring continuity of care
- Providing documentary evidence of services delivered
- Promoting better communication between members of the team
- Helping to identify risks
- Supporting the requirements of audit
- Helping to address complaints or legal processes
- Being respectful to the service user.

The principles of good record keeping apply to all records, regardless of whether they are electronic or held on paper. If documentation is not legible, or it is inaccurate, incomplete or confusing, it will be of limited value. It is therefore essential that all records are maintained to a high standard because this is an indicator of the quality of care being delivered within the service. If record keeping is to be effective and worthwhile, the records you maintain must be:

- Clear, concise and accurate
- Up to date
- Signed
- Free from jargon
- Legible
- Written as soon after the event as possible – for example, as soon as you have administered medication.

In order to ensure best practice when completing records, there are **three** fundamental points that should always be followed:

1. If an error is made, a single line should be drawn through the error. It should then be initialled and dated. In order to ensure the audit trail is not compromised, correction fluid should NEVER be used to correct errors.
2. Entries must have a record of the time and date, and must always be signed where appropriate.
3. All entries must be legible and written in black ink. Pencil can be erased and must NEVER be used.

All records must be completed in line with your organisational policies and maintained in line with the **General Data Protection Regulation 2016**.

Don't forget to point your lens at this icon!

Scan for your Virtual Tutor

Scan the icon here to listen to a handy tip from your Virtual Tutor.

A

Activity 4: Mini audit

Randomly select <u>five</u> service users' care records in which you have recently documented entries, and complete a mini audit. (Alternatively, you and a colleague may wish to audit each other's record keeping.)

Are all your entries legible?

Have they all been dated and timed?

If mistakes have been made, how have they been rectified?

Has black indelible ink been used throughout?

The Medication Administration Record (MAR) chart is the working document for the administration of medication. It is this document which contains all the information relating to medications prescribed for each service user.

The MAR chart must detail:

- The service user's name
- The service user's date of birth
- The generic name of the prescribed medication
- The dose to be administered
- The strength of medication
- The dates, frequency and time at which the medication should be administered
- The route by which the medication should be administered
- Any special instructions or precautions
- The start date of the medication
- The completion date of the medication (if applicable)
- Any known allergies
- Page numbering (for example, 1 of 1 or 1 of 2).

These charts can be supplied preprinted, or may be supplied as a template. If the organisation takes responsibility for transferring the information onto a template MAR chart, extra vigilance and care will need to be taken.

When writing information on the MAR chart, it is important to refer back to the original prescription to ensure the directions prescribed are the same as those on the medication label.

It is essential to ensure the MAR chart is kept up to date and entries are made at the earliest opportunity. This means ensuring the chart is signed following each administration by the person who administered the medication. Equally, if a service user refuses medication, or medication is not administered for a specific reason, this must be recorded on the MAR chart using the appropriate code.

It is never acceptable to leave a box blank when medication has not been administered.

Key Fact

If you sign a record, for example, an MAR chart, you are accepting responsibility for the administration of medication and are immediately accountable for the outcome of that administration.

The requirements of the regulatory authorities in relation to medication record keeping

As of April 2010, it became a requirement that all adult health and social care providers must register with the Care Quality Commission (CQC) in order to provide their services. In order to continue to be registered with the CQC, all health and social care services must comply with the regulations as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There is no longer a specific regulation for medication record keeping, with the Fundamental Standards covering all aspects of medication management. As discussed in Unit 1, there are several key regulations that support the medication process and management, with the following regulations lending themselves to medication record keeping:

Regulation 11: Need for consent

This regulation requires that all people using the service have given their consent before any care or treatment is provided. The consent must be gained lawfully and that the person who obtains the consent has the 'necessary knowledge and understanding of the care and/or treatment that they are asking consent for'.

Regulation 17: Good governance

This regulation includes the requirement to 'maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided'.

Regulation 17: Good governance states that the setting must:

> ***...assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice.***

As guidance and best practice, service providers must ensure that:

- Records about the care, treatment and support of people who use services are updated as soon as is reasonably practicable
- Verbal communications about care, treatment and support are documented within personal records as soon as is practicable
- Records about care, treatment and support are clear, factual and accurate and maintain the dignity and confidentiality of the people who use the services.

There is a legal requirement to maintain and handle all records to a high standard. Documentation in relation to medication will include:

- Order requisitions
- Receipt books
- Medication Administration Record charts
- Medication profiles
- Running records
- Care plans
- Stock check sheets
- Controlled drugs registers
- Returns books
- Fridge temperature charts.

All of these documents provide a medication audit trail and will be required to provide evidence to the Care Quality Commission that the service is being run in line with the regulations and Fundamental Standards set by the government. The standard and continuity of the record keeping will then be interpreted to ascertain whether or not service users are being properly cared for.

Medicines reconciliation

Medicines reconciliation is the process of creating and obtaining an up-to-date and accurate medication list, including any new medicines being prescribed and administered, as well as being removed.

Key Fact

The medication profile document must be kept up to date and any changes in medication, or any new medicines being prescribed and administered, must also be included.

Two recent and reliable sources of information should be used to undertake the medicines reconciliation. These could be:

- A GP record or repeat prescription
- A hospital discharge letter
- A residential/care home medication chart
- A community hospital (electronic or paper)
- An outpatient record.

The information must include:

- Each drug taken by the patient prior to admission, including over-the-counter medicines, herbal remedies and supplements
- Dose, frequency, formulation and route of all medicines
- Duration of treatment
- Breaks in medication
- Any special arrangements
- Any allergies
- Any additional information.

The importance of a medication review process

Medication reviews were briefly covered in Unit 3. As noted in the ***National Service Framework for Older People***, the medication needs of individuals must be reviewed and discussed on a regular basis. Medication reviews are an examination of a person's medications, ideally with the person themselves if possible, carried out by an expert in medicines; usually the GP, pharmacist or nurse. If the person is in a care home setting, the service user's family may also be present, as well as a member of the care home staff.

Reviews should take place annually for people who are aged over 75, who take regular prescription medication, take medication for a long-term illness, or if there have been any recent major changes to the person's medicines. For those who take four or more medications, this reduces to every six months.

During the review process, the following will be discussed:

- The purpose of the medication review
- What the person and/or their family members/carers think about the medication, and how much they understand about the medication
- Any queries, worries or concerns regarding the medication
- All medication, be it prescribed, over-the-counter or complementary medicines that the person is taking or using, and what these are used for
- The safety of the medication, how well it works, how appropriate the medication is, and whether it is being used in line with guidelines that are in place nationally
- The monitoring tests that are required to ensure the medication is working as it should be, and having no adverse effects on other areas of the person's life
- Any problems that have been experienced with the medication, such as side effects, reactions, difficulty in taking the medication independently or difficulty with swallowing the medication
- The support requirements necessary to help the person to take their medication as prescribed
- Any additional information or support that may be needed.

Key Fact

If there is an urgent problem with any medication, then it is not necessary to wait for a medication review. If any of the following occur or are observed, a doctor or pharmacist should be contacted immediately:

- **Too much of the medication is taken**
- **An allergic reaction to new medication, such as wheezing, rash, swelling or fainting occurs**
- **Any side effects or unusual symptoms**
- **Any major changes to personal health.**

The importance of keeping records up to date

It is often noted that the quality of a care worker's record keeping is a direct reflection of their approach to care. Therefore, where care workers maintain accurate, neat and timely records, it is very likely that they will adopt the same meticulous approach when providing care for service users.

Similarly, where record keeping is 'sloppy', for example, when it is illegible, full of gaps, not dated or signed and difficult to interpret, this can be an indication of an equally 'sloppy' approach to the provision of care. If medication records are not accurately completed, this could increase risks associated with medication errors.

The Health and Social Care Act 2012

This act places legal obligations on health and social care environments to ensure records relating to medication are kept up to date.

These records can be requested by the Care Quality Commission at any time of day or night. Remember: an inspector can make an unannounced visit at any time. If records are not up to date, this will result in an inaccurate audit, meaning that individuals will be held to account for inaccuracies or omissions associated with the records. It must also be remembered that records can be called upon as evidence in a court of law, or could come under close scrutiny if a complaint is made at a local level.

Accurate and up-to-date records are required in order to ensure continuity of care. Other appropriate healthcare professionals may need to access information relating to medication already taken, for example in the case of a medical emergency or a sudden deterioration in the service user's condition. Visiting healthcare professionals may not know the service user very well, and may need to check their records in order to assist in making a diagnosis or deliver appropriate treatment.

Key Fact

Remember, an inspector from the CQC could make an unannounced visit to check files and audit processes at any time.

Activity 5: Keeping records up to date

a) Write down what you were doing this time yesterday.

b) Write down what you were doing this time last week.

c) Do you know what you were doing at this time last month?

d) Can you remember what you were doing on this date last year?

e) Now try and remember what you were doing five years ago.

The previous activity demonstrates the importance of keeping records up to date, as you cannot recall every detail accurately from memory. It is essential that records are completed as soon as possible after an event. You may be required to rely on your records to support your actions and the decisions you make in providing care. You may have to rely on records based on care you gave to a service user several years after an event has taken place.

Confidentiality

The concept of confidentiality is an integral part of health and social care delivery, which is enforced through various documents and guidelines. These include:

- Policies and procedures
- Codes of practice/conduct
- Contracts of employment
- Common law (the decisions of the court)
- Statute law (passed by parliament).

Confidentiality arises where a person disclosing personal information expects his or her privacy to be respected. It is also an underlying part of practice that protects human rights, as detailed in the European Convention of Human Rights.

The General Data Protection Regulation 2016 is a key piece of legislation which governs the management of all records, including access, storage and the sharing of information. The regulation applies to all types of records, including paper and computer-generated records.

The General Data Protection Regulation 2016 works in two ways. Firstly, it gives people the right to know what information is held about them, and secondly, it ensures that information is handled properly. Anyone who handles personal information must comply with the following **six** enforceable principles, which state that information should be:

1. Processed fairly, lawfully and in a transparent manner in relation to the data subject.
2. Collected for specified, explicit and legitimate purposes and not further processed for other purposes incompatible with these purposes.
3. Adequate, relevant and limited to what is necessary in relation to the purposes for which data is processed.
4. Accurate and, where necessary, kept up to date.
5. Kept in a form that permits identification of data subjects for no longer than is necessary for the purposes for which the personal data is processed.
6. Processed in a way that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

The main purpose of the principles listed on the previous page is to protect the interests of the individuals whose personal information is being processed. If your organisation handles personal information, it must meet the requirements under the General Data Protection Regulation 2016. Under the regulation, service users have a right to access their personal or medical records.

The Data Protection Act 2018 was also introduced in May 2018, to modernise UK data protection laws and implement General Data Protection standards.

The Access to Health Records Act 1990 applies to the health records of deceased people. This means that when a service user has died and there is reason to believe that negligence is to blame, a personal representative or a person who may have a claim arising from the person's death (for example, a relative) has the right to apply for access to the individual's health records. However, only information relating to the death may be released.

The right to confidentiality is also enforced through the **Human Rights Act 1998**. This Act identifies the rights and freedoms of people as set out in the European Convention on Human Rights. It is **Article 8 of the Human Rights Act** which identifies that all people have a right to privacy. Confidentiality is an essential part of health and social care practice aimed at protecting this human right.

All health and social care workers are in a privileged position in that they have access to highly sensitive information about the people in their care. This information is always given in trust and it must always be remembered that this information remains the property of the service user.

Key Fact: British Values

The Human Rights Act 1998 also provides individuals with the right to individual liberty. This is one of the core British Values and allows individuals to freely exercise their rights, including their right to confidentiality.

The common law of confidentiality states that people have a right to expect that any information they give to a health or social care worker will only be used for the reason it was given. Information will not be disclosed without the person's permission. People have the right to control access to their own personal health information, which means as a health or social care worker you cannot discuss matters relating to service users outside your work setting. In addition, you must not discuss confidential information in a public place where you could be overheard. In relation to documentation, you must not leave records unattended where they may be read by others. Good standards of care are based on trust between service users and service providers.

Activity 6: Accessing care records

What is the policy within your organisation if a service user expresses a wish to access his or her medical/care records?

Disclosure of confidential information

Disclosure is the giving of information. Disclosing information is only lawful or ethical if the service user has given permission for the information to be passed on. If the service user is unable to give permission, for example, due to loss of consciousness, permission can be sought from a senior member of staff, a relative or someone with lasting power of attorney.

It is important to remember that any decisions made on behalf of the individual must always be made in their 'best interests'.

If a service user withholds consent, or if consent cannot be obtained, disclosures may be made under certain circumstances.

For example:

- When the information is required by law or a court order is issued
- When a person is at risk to themselves or others
- When the information is considered to be given in the best interests of the individual
- When a criminal offence has taken place
- When the information is considered to be given in the best interests of the public.

Access to confidential information

Although all care workers have a duty to respect confidentiality, there are some individuals who have a right to access confidential information. However, this right of access can only be granted for very specific reasons. It is important to know which individuals can access confidential records, and under which circumstances. The following groups of people may at some stage need to access confidential information concerning the service users within an organisation. However, access to service users' confidential records can only be accessed for very specific reasons.

Medical professionals

Medical professionals may include people such as doctors, pharmacists, community nurses, physiotherapists, social workers and other care professionals.

These people may need to access confidential information, or be informed about changes in a service user's condition, in order to be able to provide specialist care for the individual. Permission should still be sought from the person and an explanation given as to the relevance of passing on this information.

Care colleagues

Care colleagues have a right to access confidential information in order to ensure they are supporting the person in line with the care plan, and to ensure continuity of care.

Relatives/solicitor with Lasting Power of Attorney (LPA)

People who lack the power to make decisions may need another person to manage their legal, financial and health affairs. The Mental Capacity Act 2005 allows people to choose another person, for example, a solicitor or relative, to make decisions on their behalf. This person is known as a Lasting Power of Attorney (LPA). This person may need to access personal information in order to make informed decisions.

Police

Police can access personal records in order to facilitate criminal investigations.

Courts

The court may call upon personal records in order to provide evidence. The court can only request these records on production of a court order.

C

Case Study: Disclosing information in public

An error in the administration of medication had taken place at Maybank Care Home and the staff had been discussing the case whilst on their break in the staff room. The care home manager had also discussed the issues in general at a staff meeting, serving to remind people to record information immediately.

Two care workers continued their conversation in a corridor, commenting on the negligence and the fact that it could have been life-threatening for the service user if the medication had been a higher dose.

A

Activity 7: Disclosing information in public

Read the case study about Maybank Care Home above. Explain what could be a consequence of the staff discussing the error in this way.

Your own role in maintaining confidentiality

It is essential that your organisation has a policy relating to confidentiality. As with all workplace policies, you must ensure you are familiar with all aspects of it and you must abide by it.

If you are in a position where you have a responsibility to keep information confidential, you must ensure you protect the rights of service users by:

- Maintaining the security measures for handling confidential information within your workplace
- Ensuring confidential information is only accessed by people who have a right to access
- Ensuring confidential information is only communicated on a need-to-know basis
- Reporting any concerns in relation to breaches of confidentiality.

Under no circumstances must you ever:

- Chat or gossip about service users with friends, colleagues or other service users
- Leave confidential information where others might see it
- Disclose confidential information to people who do not need to know it
- Disclose confidential information without the consent of the service user or the lasting power of attorney.

Scan the image

Let's Summarise!

Take a few moments to answer the following questions to help you summarise what you have learnt in this section. This will help you answer the upcoming assessments.

1. It is good record keeping practice to write all entries in pencil.

True ○ **False** ○

2. Which organisation must all health and social care providers be registered with?

3. Explain the term 'medicines reconciliation'.

4. If there is an urgent problem with a service user's medication, it is not necessary to wait for a medication review to assess their needs.

True ○ **False** ○

5. All record keeping should take place as soon as possible after an event.

True ○ **False** ○

6. Which piece of legislation governs the management, access, storage and sharing of all records?

- ○ **The Misuse of Drugs Act 1971**
- ○ **The General Data Protection Regulation 2016**

Check your answers by looking back over this section.

Congratulations, you have now completed Section 2.
Please now go to your assessment and answer Q13 to Q27.

Section 3: Accountability and responsibility

This section will explore the following:

- The meaning of accountability and responsibility
- The importance of accountability in relation to medication
- The responsibilities of people involved with storing or administering medication
- Potential consequences of not following agreed ways of working
- The importance of working within your own limitations.

The meaning of accountability and responsibility

Accountability

Accountability means that you are liable or answerable for the outcomes of your actions. Being accountable for the outcomes of your actions therefore means that you must be able to provide answers for what you do and for what you do not do.

For example, if you acted outside of your organisation's policy for handling medication and something went wrong, you would have to explain why you did not follow the policy.

Being accountable, however, does not only relate to your actions. It is important to realise that you are also accountable to certain people within your organisation. The people to whom you are accountable should be clearly set out in your contract of employment and could include any of the following:

- Individual service users
- Manager(s)
- Colleagues
- Employer(s)
- Members of the general public
- Regulatory body/bodies.

In addition, there are different types of accountability:

Moral accountability is where you are expected to treat people equally and with respect and dignity.

Legal accountability is where you are accountable for any professional actions you undertake – for example, handling medication.

Key Fact

Being accountable is best explained as being able to account for the result or outcome of your actions and answering to it.

Case Study: Joseph

Joseph is responsible for the administration of medication on his shift.

He knows the service users well and is used to the medication they normally take. He feels that he doesn't really need to check the MAR chart prior to administering the medication, and just administers from memory. Consequently, he forgets to sign some of the MAR charts.

Another member of staff sees what Joseph is doing, but she just ignores it and carries on setting the table for lunch.

Activity 8: Accountability

Who is accountable in the case study above? Why are they accountable? Make notes in the space below.

Check your answer at the end of this workbook.

Responsibility

Responsibility is different from accountability in that it does not require you to be answerable for the results of your actions. Responsibility refers to your obligation or duty to act in a certain way, carry out certain actions and conduct yourself appropriately.

Responsibility arises when your employer delegates a set of tasks or functions to you. When tasks are delegated, you have a responsibility to carry them out to the best of your ability.

In order to be responsible, it is necessary to have some degree of knowledge. If responsibility to handle medication is delegated to you, your employer has an obligation to ensure you receive training in all aspects of handling medication, and that you are supervised until you are deemed competent.

Some examples of your responsibilities include:

- Reporting any changes to your manager
- Co-operating with other members of the care team
- Ensuring the health and safety of everyone within your workplace
- Ensuring service users receive care in accordance with their care plan
- Carrying out your duties in line with your organisation's policies and procedures.

The importance of accountability in relation to medication

In order to be fully accountable for your actions throughout the process of handling medication, it is essential that you:

- Have received training to prepare you for this role
- Keep your knowledge up to date
- Only work in line with your organisational policies
- Never undertake procedures for which you have not received training.

Accountability also ensures that employers:

- Have policies and procedures in place for the safe handling of medicines
- Ensure staff are trained prior to delegating responsibility to them
- Ensure staff are provided with further training to keep their knowledge up to date
- Do not delegate tasks to staff who have not received training.

Accountability is important in all aspects of a care worker's role, however it is particularly important when you have a responsibility to handle medication. All medicines have the potential to cause harm, and, if handled incorrectly, could put lives at risk. Accountability places responsibility on every health and social care worker to be answerable for their actions. It ensures that health and social care workers:

- Only work within their sphere of competence
- Acknowledge their limitations
- Follow approved procedures
- Work in line with their organisational policies
- Continually update their skills through training
- Report any areas of concern.

Accountability should ensure that the responsibility for handling medication is not delegated to staff unless they have received adequate training and supervision and are deemed competent in the safe handling of medication.

The responsibilities of people involved with storing or administering medication

The overall responsibility for the safe storage and administration of medication lies with the registered manager. The registered manager must ensure an adequate and up-to-date policy is available which sets out the procedures for the safe handling of medication within the organisation.

The registered manager, however, may delegate the responsibility for handling medication to other members of staff. These members of staff are usually known as **designated staff**.

Where this responsibility has been delegated, the registered manager must ensure these members of staff have received full training and that their practice is observed on an ongoing basis. This ensures that skills are being maintained through providing support and reviewing levels of competence.

Any members of staff who are delegated responsibility for the storage and administration of medication must ensure they undertake this role to the best of their ability. The handling of medication is governed by the law and the responsibility for storing and administering medication must always be undertaken in line with legislation.

When members of staff are responsible for the administration of medication, they must ensure they administer the right medication to the right person, by the right route, at the right dose and at the right time.

When staff are responsible for the administration and storage of medication, they must ensure:

- They have received adequate training in the safe handling of medication
- Medicines are stored and administered in a secure and safe manner
- Stock is rotated to ensure medication is not stored beyond its shelf life
- There is adequate ventilation in the storage area
- Key safety is maintained at all times
- They complete any documentation in relation to the administration of medication – facilitating a robust audit trail
- They know the actions to take if a spillage occurs
- The storage area is kept clean and tidy
- They are aware of their policies and procedures
- They are aware of any relevant risk assessments
- They update any necessary documents
- They comply with any instructions that have been issued
- They use Personal Protective Equipment (PPE) where required
- They report any concerns to their manager
- They maintain a safe environment
- No harm is caused to service users by their actions
- They respect service users' dignity, choice, privacy and confidentiality.

Don't forget to point your lens at this icon!

Scan for your Virtual Tutor

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Potential consequences of not following agreed ways of working

The potential consequences of not following agreed ways of working can have an impact on:

- Service users
- The organisation
- Yourself.

Your organisation will have policies relating to the action that will be taken if members of staff fail to adhere to agreed ways of working. It is important that you are aware of the sanctions that will be taken should these circumstances arise.

In general, a failure to follow agreed ways of working will call for you to be able to account for your actions. If you are unable to account for your actions, sanctions may be taken against you. These could include:

- Warnings
- Disciplinary actions
- Suspension
- Criminal prosecution and, if found guilty, fines or imprisonment
- Deregistration if you work in a professional role.

If you fail to adhere to agreed ways of working, this will impact on the standard of care received by service users.

Service users could be put at risk from unsafe practices. This could result in harm or even death.

If you choose not to adhere to agreed ways of working, this will affect overall standards within your workplace. This could lead to complaints from service users and their families. Poor standards will also be picked up during periods of inspection.

If the CQC has concerns that a provider is not meeting the Fundamental Standards, they will act quickly. They work closely with commissioners and others and if necessary will use powers of enforcement. This could lead to investigations, sanctions, prosecution and, if found guilty, fines and imprisonment. Ultimately, this could lead to closure of the care facility.

A Activity 9: The consequences

Think about the consequences of not following agreed ways of working within your workplace. What could the consequences be for you, the service users and the organisation?

Are you using the Equal App?

Pressing the refresh icon in the top right hand corner of your lens will allow you to scan another image and icon without exiting camera mode.

The importance of working within your own limitations

There are a number of reasons why it is important to ensure that you work within your own limitations – it is important that you are aware of your limits, and that you are not afraid to ask for help and support if you are ever unsure.

Unit 1 explored care workers' various roles and limitations with regard to medication – working within your job description, the level of experience that you have, the training that you have received, and the qualifications that you hold will all dictate your role and limitations in regards to medication.

There are several key reasons why it is important to be aware of your limitations, and the role you play in regards to medication:

- Accountability, both moral and legal
- Responsibility
- Prosecution
- Illness/death.

Appropriate training is required – training courses such as this can be useful in providing the theory behind the medication process, but careful observation to ensure competency is also required.

Scan the image

Key Fact

The 2009 Care Homes' Use of Medicines Study (CHUMS) found that staff in care homes spend around half their time dealing with medication-related activities.

The CHUMS research also identified a level of 'unacceptable' errors in care homes where older residents resided, with 7 out of 10 residents experiencing errors with their medication on any one day. (Source: *NICE*, 2013)

STOP AND THINK!

Working outside of your limitations can have a number of serious consequences for a service user, including:

- **Hospitalisation**
- **Illness**
- **Disability**
- **Death.**

How do you know if you are competent when dealing with medication? What should you do if you come across something that you are unsure of?

Let's Summarise!

Take a few moments to answer the following questions to help you summarise what you have learnt in this section. This will help you answer the upcoming assessments.

1. State the <u>two</u> different types of accountability.

1.

2.

2. Accountability ensures that employers do not delegate tasks to untrained staff.

True ○ **False** ○

3. Within health and social care settings, who is responsible for ensuring an up-to-date policy for the safe handling of medication is in place?

4. State the ultimate consequence for a care facility where staff do not follow agreed ways of working.

5. If you are unsure of the limitations of your role regarding medication, you should ask for help and support.

True ○ **False** ○

Check your answers by looking back over this section.

Congratulations, you have now completed Section 3.
Please now go to your assessment and answer Q28a to Q32.

Section 4: Safeguarding individuals in relation to medication use

This section will explore the following:

- What a 'medicines-related safeguarding incident' is
- How medicines-related safeguarding incidents are reported and recorded
- How practice can alter following a medicines-related safeguarding incident
- How adverse reactions are reported.

What a 'medicines-related safeguarding incident' is

Q. What is a medicines-related safeguarding incident?

A. 'Medicines-related safeguarding incident' is a term that is used to cover several different issues that could occur with regards to medication. This could be:

- **Deliberating withholding medicine(s) without a valid reason for doing so**
- **The incorrect use of a medicine(s) for reasons other than the benefit of a service user**
- **A deliberate attempt to harm a service user through the use of a medicine(s)**
- **Accidental harm to a service user through incorrect administration or a medication error.**

STOP AND THINK!

Medicines-related safeguarding incidents have regularly been hitting the headlines with service users being given incorrect medication, having their medication tampered with, or being given medications that have not been prescribed.

The Shipman Inquiry brought about rigorous changes to the legal structure surrounding healthcare and medicine, including the introduction of better controls in the use of Schedules 2, 3 and 4 drugs by doctors and pharmacists.

Key Skill: Behaviour and attitudes

Imagine that a medicines-related safeguarding incident has occurred as a result of your actions. How would this make you feel? How would you work to ensure that a similar incident doesn't happen again in the future?
Make notes in the space provided.

How medicines-related safeguarding incidents are reported and recorded

Within your setting, there will be a process in place for identifying, reporting, reviewing and learning from medication errors that involve service users. This also includes 'near misses', whereby an error has been avoided, or no harm has come to the service user. This process will form a key part of the medication policy that is in place within the setting, and should clearly state the following:

- When the Care Quality Commission (CQC) should be informed of the medication error
- Which medicines-related safeguarding incidents should be reported under local safeguarding processes
- That accurate details of medicines-related safeguarding incidents are recorded as soon as possible to ensure the information is available for any investigation and reporting.

(Source: *NICE*, 2014)

Key Fact

All medicines-related safeguarding issues, including all 'near misses' and incidents that do not cause harm, should be recorded.

How practice can alter following a medicines-related safeguarding incident

In the event of a medicines-related safeguarding incident, practice will need to alter. Incidents, or even potential incidents (near misses) happen for a reason and need to be dealt with quickly and efficiently. An investigation as to why an incident or near miss has occurred will be undertaken. It may be that staff need additional training or monitoring to ensure practice is correct, that security around medication needs to be reviewed and tightened, or, if a crime has been committed, the police will also need to be involved.

Errors should not be ignored – there must be clear incident reporting systems in place, and all reports should be investigated, leading to reviews of existing procedures. Action taken after this process must be recorded, and serious incidents reported to the Care Quality Commission.

Scan the image

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Once you have unlocked each video, you can access all unlocked videos in the 'My Courses' area of your app and watch them again.

How adverse reactions are reported

The Medicines and Healthcare Products Regulatory Agency (MHRA) is a government agency that is responsible for ensuring that medicines are acceptably safe, and that medical devices work. Adverse reactions to medications can happen to anyone – it should be noted that not all medication is suited to everyone, and adverse reactions can happen at any time. Adverse reactions need to be reported immediately, with medical attention being sought, if necessary. An adverse reaction can be life-threatening.

Not all side effects or possible adverse reactions are known about all medication – this is why it is vital that people who notice side effects and adverse reactions to medications report them immediately. New medications on the market are closely monitored, and this is indicated by a black inverted triangle (▼) in the Patient Information Leaflet (PIL) and the Summary of Product Characteristics (SPC), along with the sentence:

▼ This medicinal product is subject to additional monitoring.

The Yellow Card scheme helps the MHRA to review the way that the medication is used, identify potential hazards, provide additional information to people prescribing the medication, or in extreme cases, where the risk of taking the medication is greater than its potential benefits, remove the medication from the market.

All healthcare workers who suspect side effects or adverse reactions to medication should report these to the prescriber of the medication as soon as possible. This should also be recorded within the service user's care plan.

Key Fact

Find out more about the Yellow Card scheme at https://yellowcard.mhra.gov.uk/. You can also see a paper version in the British National Formulary (BNF) that can be completed and returned to the Medicines and Healthcare Products Regulatory Agency.

Don't forget to point your lens at this icon, to listen to some handy tips from your Virtual Tutor.

Let's Summarise!

Take a few moments to answer the following questions to help you summarise what you have learnt in this section. This will help you answer the upcoming assessments.

1. Give an example of a medicines-related safeguarding incident.

2. Explain the meaning of the term 'near miss' in relation to medication use.

3. There is no reason for practice to change following a near miss incident.

True ◯ **False** ◯

4. Adverse reactions to medication should be reported immediately.

True ◯ **False** ◯

Check your answers by looking back over this section.

Congratulations, you have now completed Section 4 and Unit 4. Please now go to your assessment and answer Q33 to Q36b.

What you know now!

Now you have completed this unit, it is important that you take some time to reflect on what you have learnt about record keeping and audit processes for medication. Please take some time to answer the same questions you answered at the start of the unit, to see how much your knowledge has developed. Please use the same key to answer the first five questions and then write your answer out for Question 6.

1 – Not confident at all 2 – A little confident 3 – Confident
4 – Very confident 5 – Confident enough to share my knowledge with others

1.	How confident do you feel in your understanding of the audit process in relation to medication transactions and stock levels?	
2.	How confident do you feel in your ability to record information and maintain confidentiality?	
3.	How confident do you feel in your understanding of the importance of a medication review process?	
4.	How confident do you feel in your understanding of accountability and responsibility in a care setting?	
5.	How confident do you feel in your ability to safeguard individuals in relation to medication use?	
6.	How do you feel your knowledge has improved since starting this unit?	

Answers to activities

Activity 8: Accountability

By neglecting to consult the MAR chart prior to administration, Joseph will not be aware of any potential changes to medication, and the route of administration of medication, to service users. By neglecting to sign the MAR chart after administration, the next designated person will not have the information they need to administer medication safely and accurately. As Joseph is directly in control of medication administration to service users, he is legally accountable for the outcomes of his actions.

The other member of staff is also accountable, as she recognised Joseph's neglect of the organisational policy but did not report it.

Key Skill Answers

Key Skill: Maths

Page: 11

Answer: 4 x 14 = 56
56 tablets

Learning Outcomes

1. Understand the audit process in relation to medication transactions and stock levels.

1.1 Describe the requirements for medication transactions and stock levels in relation to:

- The role of the pharmacist
- Manufacturers' instructions
- Organisational policies
- Inspection and external audit
- Legal requirements.

1.2 Explain how medication is recorded on:

- Receipt
- Administration
- Disposal.

2. Understand how information is recorded and confidentiality maintained.

2.1 Describe the key aspects of record keeping in an environment where medicine is used in relation to:

- Documentation
- Correct recording
- Signatures.2.2 Outline the requirements of the regulatory authorities in relation to medication record keeping

2.3 Identify the information that needs to be recorded for medicines reconciliation in relation to each individual

2.4 Outline the requirements for the frequency and content of medication reviews

2.5 Explain why all records relating to medication must be kept up to date

2.6 Outline the key points of legislation relating to confidentiality in relation to:

- Who records what, where and when
- Who has access to records
- Individual rights
- Maintaining confidentiality.

2.7 Identify own role in maintaining confidentiality and keeping information secure.

3. Understand own role in relation to accountability and responsibility.

3.1 Define the terms 'accountability' and 'responsibility'

3.2 Explain the importance of accountability in relation to medication

3.3 Describe the responsibilities of different people involved with storage or administration of medication

3.4 Outline the potential consequences of not following agreed ways of working as set out by an employer

3.5 Explain the importance of working within own limitations.

4. Understand the importance of safeguarding individuals in relation to medication use.

4.1 Explain what is meant by a medicines-related safeguarding incident

4.2 Describe the reporting and recording requirements in the event of a medicines-related safeguarding incident

4.3 Give examples of changes in practice that would be implemented as a result of a medicines-related safeguarding incident

4.4 Explain the importance of reporting adverse effects of medication using the 'Yellow Card' system.

Understanding the Safe Handling of Medication in Health and Social Care

Upon successful completion of this qualification, learners will be awarded the following*:

NCFE CACHE Level 2 Certificate in Understanding the Safe Handling of Medication in Health and Social Care (601/3404/5)

TQUK Level 2 Certificate in Understanding the Safe Handling of Medication in Health and Social Care (RQF) (603/3217/7)

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