Evaluation of the Management of Medicines in Domiciliary Care Agencies

September 2010

informing and improving health and social care
www.rqia.org.uk

The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT
Tel: (028) 9051 7500
Fax: (028) 9051 7501

Contents

		Page
i	**Acknowledgements**	**ii**
ii	**Overview**	**iii**
iii	**Executive Summary**	**v**
1	**Context of Evaluation**	**1**
2	**Methodology**	**4**
2.1	Methodology Employed	4
2.2	Terms of Reference	4
3	**Profile of Regulated Domiciliary Care Provision in Northern Ireland**	**9**
4	**Findings**	**10**
4.1	Contractual Arrangements	10
4.2	Management and Training	12
4.3	Record Keeping	15
4.4	Administration of Medicines	17
5	**Summary of Key Findings**	**20**
Appendix A	Evaluation Team Members	25
Appendix B	Records Made Available to RQIA	26
Appendix C	Definition and Description of Key Terms	27
References		29

i Acknowledgements

RQIA wishes to thank the chief executives, responsible persons, registered managers and members of staff for their contribution to and cooperation with this evaluation of the management of medicines in domiciliary care.

ii Overview

The Regulation and Quality Improvement Authority (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1]. We are sponsored by the Department of Health, Social Services and Public Safety (DHSSPS) and are responsible for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and promoting improvements in the quality of those services.

As part of its corporate strategy, RQIA aims to deliver independent assurance about the safety, quality and availability of health and social care (HSC) services in Northern Ireland, encourage continuous improvement in those services and safeguard the rights of service users.

The Order also placed a statutory duty of quality on health and social care organisations for the services they commission, and requires RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland. The legislation is supplemented by both the Domiciliary Care Agencies Regulations (Northern Ireland) 2007[2] and the Domiciliary Care Agencies Minimum Standards (Northern Ireland) 2008[3] which were designed to specify the arrangements and procedures required to ensure the delivery of a quality service.

Medicine incidents are reportable to RQIA under Standard 7.13 of the Domiciliary Care Agencies Minimum Standards (Northern Ireland) 2008[3]. Statistics recorded from April to August 2010 indicated that 81 of the 286 incidents of this nature which were reported to RQIA originated from the domiciliary care sector.

This evaluation was initiated by a number of factors:

- the number of medicine incidents reported by domiciliary care agencies
- the concerns raised by the Health and Social Care Board regarding the increased reliance in community settings on Monitored Dosage Systems (commonly referred to as blister packs) (see Appendix C for description)
- informal discussions with domiciliary care providers which highlighted difficulties in relation to the achievement of standard seven of the minimum care standards

In order to gather further evidence, we sampled a small number of domiciliary care agencies across Northern Ireland drawn from the statutory and independent sectors. The focus was on the management of medicines in accordance with the Domiciliary Care Agencies Minimum Standards[3].

By undertaking this evaluation of domiciliary care, we hope to address the four core strands of RQIA's corporate strategy:

- Improving care: we encourage and promote improvements in the safety, quality and availability of services through the regulation and review of health and social care.
- Informing the population: we publicly report on the safety, quality and availability of health and social care.
- Safeguarding rights: we act to protect the rights of all people using health and social care.
- Influencing policy: we influence policy and standards in health and social care.

iii Executive Summary

Since the regulation of domiciliary care agencies by RQIA commenced, there has been a growing awareness of the challenges facing the sector in relation to the management of medicines. This short evaluation is an initial attempt to assess the current practices in place against The Domiciliary Care Agencies Regulations (Northern Ireland) 2007[2] and the Domiciliary Care Agencies Minimum Standards[3].

In many instances the domiciliary care worker is one of the few people who the service user may see and they provide a vital service which is often undervalued.

It was encouraging to note that all those who took part in the evaluation were aware of the standards and of the challenges they presented to the sector. We found that there were varying degrees of compliance with regard to the management of medicines across Northern Ireland; within trust areas and across different sectors.

There were positive examples of managers attending annual governance meetings. In one Trust a specialised medicines management nurse had been appointed to support training for non-nursing staff. However, some of the evidence examined appeared to suggest a lack of understanding by, and involvement from, some senior managers within the trusts who did not seem to fully understand the roles and responsibilities of the registered managers in relation to their registration with RQIA.

The terms being used to describe staff involvement in the administration of medicines appeared to be open to interpretation and flexibly used in order to deliver the required level of service. RQIA would take the view that the following definitions apply:

- When a care worker assists someone with their medication, the service user must indicate to the care worker what actions they are to take each time.
- If a service user is not able to do this or if the care worker gives any medicines without being requested (by the service user) to do so, this is defined as administration.

The lack of formalised training in the administration of medicines for care workers was notable. There was also a variation in the amount of training received in parts of the trusts. One of the challenges for trusts is to deliver training across large geographical areas. Creative methods of accessing such training were observed, for example some of the independent agencies had researched internet based learning packages. On a more positive note this lack of training was partly compensated for by the care workers' clear understanding of their roles and responsibilities and by the dedicated support from their managers.

The discussion with the trust managers of domiciliary care highlighted the difficulties that the status of the staff group posed when trying to access training especially when compared with those who administer medicines in residential care homes.

While there was good communication within each of the agencies evaluated, all of those involved in the evaluation spoke of the limited communication from the referral agents especially in respect to medicines and any changes to them.

In February 2004 the DHSSPS published Making it Better. A Strategy for Pharmacy in the Community[4]. Action 5.4 states:

"DHSSPS will undertake to work with HSS Boards, Trusts and other key agencies to increase the support provided to carers to encourage the safe, effective administration and use of medicines."

There appears to have been limited success in addressing this action point in relation to how medicines are being managed in domiciliary care. Commissioners and staff are unaware of what support might be available from the community pharmacy, apart from the supply of medicines in a blister pack.

Those involved in delivering domiciliary care are willing to develop and improve the practice in order to make it safer for both service users and care workers. However, they do not necessarily have the expertise or knowledge of medicines management. For this improvement to happen, input from all of the healthcare professionals involved in the delivery of care including general practitioners and community pharmacists will be required.

Overall this evaluation found that the standard is partially achieved with agencies meeting few of the 14 supporting criteria. The challenge for agencies is to develop their systems to ensure that the minimum standards are met. The challenge for RQIA as the regulator will be to develop methods of support for domiciliary care in order to build on the appetite for change within the sector and to improve the standards in place.

A list of the recommendations from this evaluation may be found in section 5, Summary of Key Findings (page 23).

1 Context of Evaluation

Management of Medicines Policies
As part of the pre-registration procedures for domiciliary care agencies RQIA pharmacist inspectors undertook a desk top evaluation of the submitted medicine policies. It has been noted that these varied in quality and understanding of the minimum care standards for domiciliary care. As a result, in January 2009 RQIA published Guidelines for the Control and Administration of Medicines - Domiciliary Care Agencies[5] for the providers on the management of medicines. Since then, the pharmacist inspectors have continued to review policies and answer any queries on the management of medicines within the sector. Care is delivered in the service user's home and this means it is not possible for the pharmacist inspectors to inspect the arrangements in place in the same manner as they do for other registered facilities. It has been recognised through RQIA inspections that this is an area where medicines are being administered and managed by a workforce with limited knowledge of the management of medicines.

Incidents
Medicine incidents, no matter how minor, are routinely reported to RQIA. Of the 286 incidents reported from 1 April 2010 to 31 August 2010, 81 (28 per cent) happened in domiciliary care settings. These are broken down as follows:

Type of incident	Occurrences
A - wrong dose	12 (15%)
B - wrong frequency	5 (6%)
C - wrong time of administration	12 (15%)
D - wrong medicines administered	6 (7%)
F - omissions	32 (40%)
H - discrepancy/loss	4 (5%)
L - medicines administered to the wrong person	4 (5%)
P - other	6 (7%)

Table 1: Type and frequency of medicine related incidents in domiciliary care reported to RQIA 1 April - 31 August 2010

The most common type of incident reported was the omission of a dose of medicine by a care worker. A number of incidents also involved medicines being administered at the incorrect time from a blister pack, despite the widespread belief that the use of these systems improves compliance and safety.

Monitored Dosage Systems
In Northern Ireland the use of monitored dosage systems (also known as blister packs) and compliance aids to facilitate the self management of medicines has grown over the years. Increasingly, they are also the preferred method for care workers to use to administer medicines to service users in

receipt of domiciliary care. The HSC Board has raised concerns with RQIA about the increasing demand for monitored dosage systems in the community and the corresponding impact on the prescribing budget. The Assistant Director of Integrated Care - Head of Pharmacy and Medicines Management at the HSC Board is planning to review the current medicines management arrangements for older people in the community and in particular, those that are in receipt of domiciliary care. This will aim to identify the pharmaceutical need for such systems and propose options for future service delivery under the new pharmacy contract.

Compliance Aids

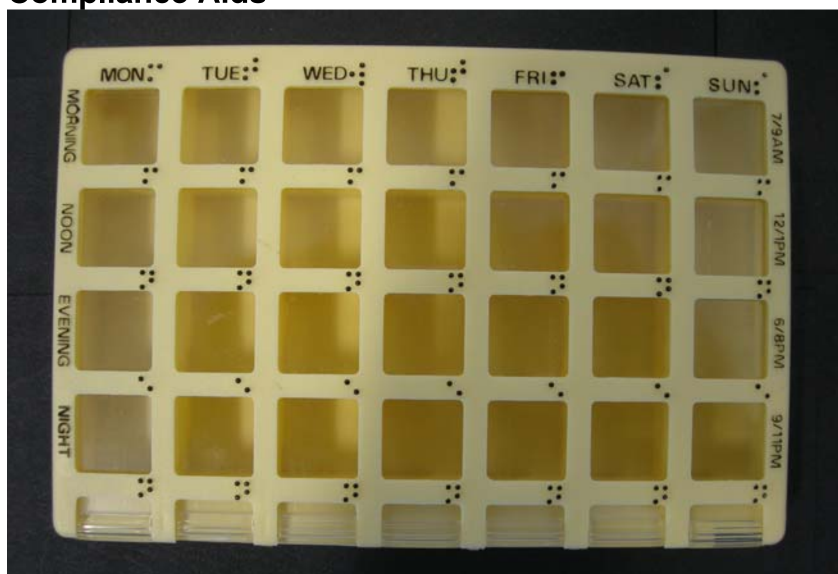

Diagram 1: Example of a weekly medicines compliance aid

Compliance aids are designed to promote the safe self-administration of medicines by people living in their own home. However, they are not suitable for all medicines thus service users may be able to manage some medicines for themselves but require help with others, for example, eye drops or liquids. This type of compliance aid will not benefit all service users and they are not helpful if service users:

- have a significant memory loss or confusion
- are poorly motivated to take their medicines
- have frequent changes to their medicines
- take medicines on an as required basis
- have a physical or mental disability
- have difficulty in opening the compliance aid

In order to ensure that a service user would benefit from the use of a compliance aid a thorough risk assessment should be undertaken. Compliance aids should not be used by care workers to administer medicines as, even if they are filled by a pharmacist, they are not tamper proof. There can also be a lack of space for labelling and some of the directions cannot be read. Similarly it is not always possible to positively identify each tablet/capsule and it is difficult to keep any identification chart up-to-date as

their appearance may change frequently. These devices are only suitable for some medicines and many other medicines including liquids and external preparations have to be supplied in traditional and/or original containers.

Blister Packs

Diagram 2: Type of pharmacist filled sealed blister pack

If care workers are to be responsible for the administration of medicines to a service user they should use a blister pack filled by a pharmacist. These types of systems are subject to the labelling and leaflet requirements of 'dispensed medicinal products' and must be labelled in accordance with the legislative requirements. This can prove difficult as not all may have sufficient space on which to attach a label. In order to administer medicines safely from these aids, care workers must be able to positively identify each medicine.

It would appear that compliance aids and blister packs are increasingly the first choice when deciding on how to manage the administration of medicines in domiciliary care. There is little evidence to suggest that any thought has been given to alternatives, for example, winged tops on bottles for those with arthritis; a medication chart to identify when medicines should be given; and large print labels to help those with poor sight. This may be as a result of the apparent lack of full involvement of the professional expertise of community pharmacists in the process.

Training

The minimum care standards state that care workers must be trained and competent if they are to administer medicines to service users. Providers regularly advise RQIA that suitable training is difficult to access. If care workers are suitably trained and competent they should be able to administer medicines from either a blister pack or traditional packaging.

2 Methodology

RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems, which can identify performance standards and support the learning necessary for improvement. The evaluation operated within the principles which underpin the Quality Standards for Health and Social Care[6].

2.1 Methodology Employed

Using the minimum standards and the guidance produced by RQIA for the management of medicines in domiciliary care a series of questions were formulated for use in semi-structured interviews across the sector.

Domiciliary care agencies or providers were purposively selected in keeping with fiscal efficiency and expediency, given the current economic constraints within the public sector. The sample selected was designed to incorporate each trust area and include a statutory and independent provider within each trust area. Consideration was given to consulting with service users but it was decided that this was not possible within the constraints of this evaluation.

2.2 Terms of Reference

1. Evaluate the extent to which standard seven (management of medicines) of the Domiciliary Care Agencies Minimum Standards[3] is being met in a sample of agencies.
2. Provide RQIA with information on the management of medicines in domiciliary care settings to enable targeted approaches to continual quality improvement in this setting.
3. Identify examples of good practice and areas for improvement.

In doing so, this evaluation will examine a number of key issues:

1. Evaluate the extent to which standard seven (management of medicines) of the Domiciliary Care Agencies Minimum Standards[3] is being met in a sample of agencies.

    - the level of conformity with the minimum standard and sub-criteria for the management of medicines
    - the arrangements in place to ensure minimum standards are met
    - identify the level of consistency in practice across the sector as to how medicines are managed

2 Provide RQIA with information on medicines management in domiciliary care settings to enable targeted approaches to continual quality improvement in this setting.

- the arrangements in place for how service users take or are given their medicines in domiciliary care settings in their own home
- the communication and procedures in place regarding the management of medicines between the service user (or carer if appropriate), domiciliary care agency, care worker, trust, GP and other health professionals
- the level of understanding by care workers of the requirements of the individual care plans and the instructions contained in them
- the level of information given to domiciliary care agencies by the contracting trust and then to care workers about the level and type of assistance required
- identify variations in practice

3 Identify examples of good practice and areas for improvement.

- the procedures in place for training, monitoring and advising care workers on medicines management and interpretation of care plans
- the procedures and practices for recording required medicines, dosages and frequency and changes to these
- good practice and areas for improvement in relation to the minimum standard for the management of medicines and to general recognised good practice

The following will not be assessed as part of this evaluation:

- domiciliary care provision for service users living in supported living settings
- service users who do not have assistance with medicines management identified in their care plan (the evaluation may, however, identify any incidents where medicines are being assisted or administered although not being identified in the care plan)
- community pharmacy procedures
- agencies not yet registered by RQIA

The evaluation process consisted of four main stages:

- consideration of the appropriate standards and relevant best practice
- electronic consultation with the pharmacist regulators in England, Scotland and Wales regarding the standards in place for the management of medicines within domiciliary care
- a desktop review of the policies provided by the agencies visited as part of the evaluation
- semi structured interviews with the registered managers and staff in the selected domiciliary care agencies in each trust area

The evaluation team assessed how the medicines management arrangements in place for a sample of domiciliary care agencies and their commissioning trusts were in line with expected minimum standards and best practice.

In this evaluation the following legislation and standard was used to benchmark practice and inform the findings of this evaluation:

The Domiciliary Care Agencies Regulations (Northern Ireland) 2007[2]

Reg 15 (6) The registered person shall ensure that where the agency arranges the provision of prescribed services to a service user, the arrangements shall -

(b) Specify the circumstances in which a domiciliary care worker may administer or assist in the administration of the service user's medication, or any other tasks relating to the service user's health care, and the procedures to be adopted in such circumstances.

Reg 15 (7) The registered person shall make arrangements for the recording, handling, safe keeping, safe administration and disposal of medicines used in the course of the provision of prescribed services to service users.

Reg 16—(1) Where an agency is acting otherwise than as an employment agency, the registered person shall, having regard to the size of the agency, the statement of purpose and the number and needs of the service users, ensure that -

(a) There is at all times an appropriate number of suitably skilled and experienced persons employed for the purposes of the agency.

Domiciliary Care Agencies Minimum Standards (July 2008)[3]

Standard 7: The agency has arrangements in place to ensure that care workers manage medicines safely and securely.

Criteria:

7.1 Where a service user has difficulty in managing his or her medicines, a mechanism is in place to ensure that there is a referral to the community pharmacist for medicines management scheme, and advising the HSC Trust as appropriate.

7.2 Administration of, or assistance with, medication is facilitated when requested by the referral agent, in situations where the service user is unable to self-administer and there is no other carer available, with the informed consent of the service user (or where the assessment indicates he or she is not able to give informed consent, his or her representative) and the agreement of the care worker's line manager, and not contrary to the agency's policy.

7.3 Where packages of care may be provided on a multi-agency basis, policies and procedures on the management of medicines are agreed between the agencies and followed.

7.4 The agency ensures that the administration or assistance with medication is detailed in the care plan (Standard 3.3) and forms part of the risk assessment.

7.5 The policy and procedures cover each of the activities concerned with the management of medicines.

7.6 The policy and procedures identify the parameters and circumstances for care workers administering or assisting with medication. They identify the limits and tasks that may not be undertaken without additional training.

7.7 Care workers who administer medicines are trained and competent. A record is kept of all medicines management training completed by care workers and retained for inspection (Standard 12.7).

7.8 The impact of medicines management training is evaluated as part of the quality improvement process, and through supervision and appraisal of care workers.

7.9 When necessary, training in specific techniques (e.g. the administration of eye/ear drops or the application of prescribed creams/lotions) is provided for named care workers by a qualified healthcare professional.

7.10 The agency ensures that the care worker documents, on each occasion, the administration or assistance with medication.

7.11 The agency ensures that, where care workers are involved, records are kept of all requests for, receipt and disposal of medicines.

7.12 The agency ensures that all those involved in the management of the service user's medication agree the arrangements for the safe storage within the service user's home.

7.13 Medication errors and incidents are reported, in accordance with procedures, to the appropriate authorities.

7.14 Practices for the management of medicines are systematically audited to ensure they are consistent with the agency's policy and procedures and action is taken when necessary.

3 Profile of Regulated Domiciliary Care Provision in Northern Ireland

Regulation of domiciliary care agencies commenced on 30 April 2007, following the enactment of The Health and Personal Social Services (Quality, Improvement and Regulation) (2003 Order) (Commencement No. 4 and Transitional Provisions) Order (Northern Ireland) 2007[7]. At the time of this evaluation there were 316 domiciliary care agencies in total, of which 146 were providing conventional home care in the community rather than providing care to service users located within supported living. Within both these types of service, there are services run by statutory providers (trusts) and independent sector providers.

Levels of provision provided within domiciliary care vary across as well as within the agencies concerned e.g. service users may receive the assistance of one care worker or of two care workers depending upon their assessed level of need. Similarly the range of tasks identified within the care plan may range from direct personal care through to support and supervision with daily living activities.

The HSC trusts (through their relationship with DHSSPS) are responsible for the provision of care to the population of Northern Ireland in accordance with several pieces of legislation. However, the trusts are also involved in both the commissioning and the actual provision of care through their provider agencies and the independent sector agencies.

4 Findings

The 14 criteria contained within Standard 7 (Management of Medicines) of the Domiciliary Care Minimum Standards[3] were used to inform the following findings of this evaluation. The findings have been grouped into four themes – contractual arrangements, management and training, record keeping and administration of medicines.

4.1 Contractual Arrangements

Trusts commission domiciliary care for service users from either their own in-house provider or from the independent sector. Evidence gathered during the visits suggested that the same contractual arrangements are followed irrespective of who is providing the service. The only aspect of the commissioning contract examined, was that regarding the provision of help in the administration of medicines. It would appear that in the first instance, the in-house provider is requested to provide the service and if this is not possible it is offered to independent providers. Within the area of domiciliary care, involvement in the administration of medicines is clearly defined by providers and is usually only offered when all other alternatives have been considered, for example family or carer involvement. In some trust areas referral forms or decision making trees have been developed to identify whether assistance with medicines is required.

All agencies interviewed advised that little information is initially provided by the referral agent. In some of the trust areas referral forms have been developed to include specific details in relation to the service required including, in some instances, a medicine consent form; risk assessments; and details regarding the medicine storage location. However, it is not routine practice for agencies to be provided with a list of the medicines that have been prescribed for a service user. All of the agencies visited were conscious of the lack of information and the difficulties that this posed. Many are actively working to improve the quality of the information received. For example, referral documentation has been developed to include trigger questions regarding the arrangements required in relation to medicines such as what containers they are to be administered from; the level of assistance required; the administration of any medicines not supplied in a blister pack; and whether creams are to be applied. In the best practice seen during this evaluation, community nurses are involved in completing a medicine form which details the tasks to be undertaken. This will list the individual medicines (usually liquids and external preparations) that are to be administered but which are not supplied in the blister pack. No details are included of the medicines packed in the blister pack, and care workers rely on the information supplied by the community pharmacist on the label.

Without exception all of these agencies require medicines to be packed in a blister pack. This is seen by all as the safest option for the administration of medicines (further discussed in section 4.4). One of the factors influencing this choice of packaging is the amount of time (typically 15 minutes) allocated

within the care plan to the administration of medicines. Registered managers and care workers alike, highlighted that it would be impossible to safely administer medicines traditionally dispensed in bottles or containers, in the allocated time especially when service users might have up to ten prescribed medicines in the morning. Family or carer filled compliance aids are still in use in some parts of Northern Ireland but in most cases these are being replaced by a blister pack filled and labelled by a community pharmacist. Service users availing of the service for the first time are more likely to have a blister pack in place compared to those that have received support for a number of years who may still have a family filled compliance aid. In some instances staff advised that compliance aids may also be filled and labelled by the community pharmacist. Managers providing domiciliary care were unaware of any viable alternatives to the use of blister packs and expressed unease about any alternatives discussed during the visits. There appears to be little proactive involvement of community pharmacists through the medicines management scheme although it is acknowledged that one trust makes reference to this scheme in their policy.

Recommendation 1:	Trusts should consider procedures for ensuring that domiciliary care agencies are provided with an initial up-to-date list of prescribed medicines.

Recommendation 2:	Community pharmacists should consider how they can actively promote their expertise in medicines management to those in receipt of domiciliary care.

4.2 Management and Training

Medicine Policy
All agencies reviewed were found to have a medicine policy in place as this was a pre-requisite for registration. These varied in detail and many agencies are in the process of reviewing and developing them. In many cases the policies are also supplemented by staff handbooks which may give specific details on administration techniques e.g. for the application of eye drops. One of the difficulties highlighted by all the statutory providers was the difference in policy and practice in the previous trusts which existed until 2007. These difficulties are being addressed through the development of trust wide policies which are at varying stages of progress.

Within the statutory sector, providers indicated that the lines of accountability and layers of management in place could at times hinder the speed of progress and associated changes in practice.

Training
The arrangements in place for staff training varied across Northern Ireland. Registered managers, especially those with large numbers of care workers spoke of the cost and practical difficulties associated with arranging training for the staff group. One trust has appointed a specialist medicines management nurse whose remit is to develop training and competency tools for non-nursing staff in community settings within the trust. In other trusts formal training is provided in some areas and plans are being discussed to roll this out.

Induction training for care workers regarding the administration of medicines appeared to be quite limited within some of the agencies sampled. One registered manager has tried to overcome the lack of training by including pertinent reminders in a news sheet which he produces periodically. He felt that it was particularly important until the trust medicine policy was fully developed and implemented.

Within the statutory sector there were comparisons between the status and skills set of staff employed in the domiciliary setting as opposed to residential homes. The view of RQIA from the evidence seen during the visits and from our experience in relation to residential care is that in many instances both sets of staff are undertaking the same tasks. The difference in the domiciliary care setting is that at present the same level of documentation is not available to back up the practice. As a result staff are in a vulnerable position. This is acknowledged by the registered managers within the sector who are actively working to minimise the risks. Some of the care workers in the statutory sector commented that they felt disempowered on a visit to a home when a care worker from an independent agency visited at the same time to administer medicines which they were not permitted to do.

Specialised training for specific techniques is usually provided to non-nursing staff in the community by the community nursing team. However, difficulties are experienced in identifying who is responsible for deeming care workers competent. Registered managers reported that although community nurses may provide the training, they are reluctant to deem care workers competent as they have no clinical oversight of their continued practice.

In one area of a trust the community nurses are actively involved in the management of medicines within domiciliary care. Prior to the care commencing, care workers meet with the nurse in the service user's home and the required tasks are discussed and agreed. The managers of this service were currently examining if this could be developed across the remainder of the trust.

Those interviewed in the independent sector advised that training is provided in-house with some managers exploring the possibility of using e-learning e.g. Social Care TV online training and the use of cascade training. Some less well established providers are developing medicine specific roles within care plans.

Throughout the sector many care workers have received nationally recognised training. For example, some had obtained NVQ Level 2 while others are working towards it. Two of the care workers interviewed had also acquired NVQ Level 3 which includes a specific module on medicines.

It was good to note that the care workers spoken to during the visits were all aware of their roles and responsibilities and those of their line managers. All of the care workers reported the good communication channels that were in place. All without exception advised that they would contact their manager if they had any queries, no matter how small. In the area with the most community nursing input, the care workers would also regularly contact the community nurse for information and advice.

Medicine Incident Reporting
Medicine incidents, no matter how minor, should be reported to RQIA. Discussion with the registered managers confirmed that the vast majority of them were aware of the procedures that should be followed. One considered that there would be no medicine incidents as care workers only supplied a prompt. Care workers advised that they would automatically ring their line manager for advice. One spoke of a recent incident where on a Sunday visit it was noted that all the medicines had disappeared from the Sunday section of the blister pack. One manager was able to provide evidence of the learning that had been disseminated to care workers after an incident. All were aware of the need to encourage a no blame and open culture in relation to incidents.

Audit
Auditing processes are at an early stage of implementation across the entire sector. Registered managers described how they review the records returned to the agency from the service user's home to ensure that they had been completed. In one instance where these records were reviewed during this

evaluation, it was noted that there were a number of omissions in one record. These were readily explained and it was suggested that the care workers should add an explanatory note at the earliest opportunity.

Supervision
Care workers all advised that they would receive spot supervision checks from their line managers. Quality assurances systems are being developed and some providers have developed questionnaires to seek the opinion of the service users as to the quality of the service being provided and in all cases these were very positive.

Multi-agency Care
More than one agency may be involved in the provision of care to a single service user. From the discussion it was evident that each agency works independently and in many cases does not officially know who else is providing care. For example, care workers from one agency would not routinely examine other agencies records, though some stated that they would if they noticed a change in the service user's behaviour or mood. This apparent lack of communication is concerning.

Recommendation 3:	Trusts should work together to develop suitable training for care workers.

Recommendation 4:	Trusts and registered managers of domiciliary care agencies should ensure that all care workers involved in domiciliary care receive the appropriate training in the management of medicines.

Recommendation 5:	Where packages of care are provided on a multi-agency basis the commissioning trust should ensure that there are communication systems in place.

Recommendation 6:	Care workers should record why medicines are not administered as prescribed.

4.3 Record Keeping

The recording systems in place for the management of medicines in domiciliary care were found to be, in the majority of instances, basic and limited in detail in relation to the name and dose of medicine or external preparation administered. However, it was encouraging to note the progress being made in developing record systems across Northern Ireland in both the statutory and independent sectors. Two trusts have developed an extensive range of records for use in the management of medicines. These are at various stages of implementation across the statutory domiciliary care agencies.

As has already been described in section 4.1 little information in relation to prescribed medicines is obtained at the start of the contract. As a result few of the agencies visited maintained a list (personal medication record) of prescribed medicines in the service user's home. One of the smaller independent agencies, which currently provide a medicines only visit, does obtain a list of prescribed medicines from the general practitioner. In another agency a list is obtained on referral and kept in the agency office. This practice is under review with the management of this agency considering the possibility of keeping it in the care plan. However, the logistics of maintaining and updating such a list are challenging and pose the question as to who is responsible for providing the initial information and for updating it when changes in medicines occur.

Warfarin is a medicine where the dosage is regularly monitored and changed. One care worker highlighted the difficulties caused by changes in the dosage of this medicine. On one occasion the service user advised that her dose had changed and the care worker described how she had to make a number of telephone calls to confirm that this was the case before she could assist the service user to take the revised dose. This apparently caused the service user some distress as she felt that she was not believed.

As part of the evaluation a question in relation to personal medication records was posed of the regulators in England, Scotland and Wales who have established systems in place. All of them advised that it would be expected that the domiciliary care agency would maintain and update the record. It is acknowledged that these services have been regulated for a longer period but this is the standard we should work towards.

There is variation in the records maintained of the administration of medicines and external preparations. In some instances this is documented in the daily care records while in others a basic medicine record sheet is completed either using a tick (✓) system or words/phrases such as prompted or assisted with medicines.

Care workers gave one example in relation to multi-agency involvement regarding the administration of antibiotics. If different care workers visit several times a day and an antibiotic is prescribed four times a day it is not

always clear who is responsible for each administration and each agency will usually be completing their own records. This could also be the situation if care workers administer pain relief medicine on an as required basis. Not all care workers are comfortable with reading records maintained by another agency.

Recommendation 7:	Trusts and registered managers should consider how a personal medication record could be maintained in order to improve communication and safe practice across the sector.

Recommendation 8:	The HSC Board should consider arrangements for ensuring that the managers of domiciliary care agencies are informed of any changes to prescribed medicines

Recommendation 9:	Trusts and registered managers should consider how to develop a service user medicine administration record which all care workers complete. This will enable care workers to identify when medicines were previously administered.

4.4 Administration of Medicines

From the discussions during the evaluation visits it was obvious that there is a wide variation in the interpretation of the terms used to describe the involvement care workers have in the administration of medicines. It is acknowledged that within each agency there is clarity as to what each term means but the definition may vary between agencies.

Prompt
It is accepted that this is a reminder to the service user to take their medicines and they may be given their blister pack but that is the extent of the support given. The service user will empty the contents themselves. However, during discussions with some of the care workers they indicated that, in some instances, where they have concerns about the physical skills of the service users they may help service users open the packs in order to avoid the contents being spilled. Many care workers described the difficulties in emptying the contents of the blister pack safely especially if they contained more than three tablets. One of the independent agencies advised that if they had any concerns regarding a service user's ability to manage their medicines, then they would contact the commissioner.

Assist
In some agencies this is when care workers empty the contents of the blister pack onto a plate or into a medicine cup for the service user to take. This would be viewed as administering in a residential or nursing home but care workers felt that they were assisting as they always asked the service user "Do you want your medicines now?" before they opened the blister pack.

Administer
No one interviewed during this evaluation considered that they were administering medicine as this was described by registered managers and care workers as physically giving a service user medicine in their food or mouth. However, as can be seen from the examples below administration of prescribed medicines does occur.

It would appear that these care workers are acutely aware of their vulnerability in the tasks that they undertake and are also knowledgeable about the support that is available to them from their line manager. For example, one care worker shared a recent experience of being requested to apply a cream but when she read the information on the box she noted that it was not to be applied to broken skin and she immediately contacted her manager for guidance.

Discussions with the managers and care workers revealed there is wide variation in the practices undertaken. All will assist service users take their medicines by emptying blister packs or in a few cases compliance aids.

In addition:

- Some will administer prescribed medicines which are not packed in the blister pack but that are listed on the care plan/task sheet while others will not.
- Some will make up food thickening agents but will not mix up laxative powders
- Eye drops will be applied in some instances if care workers have been shown by the community nurse or have directions located in their staff handbook to follow.
- A few agencies will assist with the application of medicated patches. For example, one care worker described in detail how she renewed a patch on a service user. Her description revealed that she knew exactly the procedure to follow and how to safely dispose of the patch which had been removed.
- Most of the agencies visited allowed care workers to apply cream if it was specified in the care plan.

These examples all highlight the variety of situations that arise on a daily basis for the care workers and their managers and the challenges they face in managing medicines in domiciliary care.

Some of the risks identified by this evaluation included:

- Two service users in one house and both with medicines in blister packs.
- Families leaving notes attached to cough bottles etc requesting that the care worker gives their relative a dose when they visit.
- The administration of bedtime medicines. Some agencies will not administer these medicines unless the service user is in bed. Some service users indicate that they will take their night time sedation when they are in bed and the rest of their medicines are given (if care workers can identify the sedation) and the sedative left in the bedroom.
- The administration of antibiotics or other newly prescribed medicines. Care workers highlighted that they would first know about these medicines during a visit or via a note from a relative. They then have to contact their manager who has to obtain clarification prior to the medicine being administered. Some will administer from the original container while others will not.

Managers and care workers were asked why they preferred blister packs as opposed to medicines supplied in traditional/original containers. Their responses included:

- The safety of the system and the fact that they had been prepared by a community pharmacist.
- It would be difficult to accurately administer the number of medicines from traditional/original packaging in the allocated time.
- Their limited knowledge and training in the administration of medicines.

However, a number of disadvantages of the use of blister packs were also highlighted:

- The different types of blister packs in use.
- The lack of adequate labelling. Many are not labelled in such a manner as to enable positive identification of each medicine. Two of those spoken to suggest there should be a photograph to identify each medicine.
- The number of tablets in each compartment and the possibility for spillage or tablets becoming stuck.
- The risks where there are more than one service users with a blister pack in the home. It was suggested that it would be useful if the blister packs were colour coded in these instances.

The arrangements in place in service user's homes for the storage of medicines vary depending on the risks and pose little difficulty for care workers. In some instances they may be stored in safes with care workers knowing the code for access.

Recommendation 10:	The HSC Board should remind all community pharmacists of the labelling requirements for all forms of monitored dosage systems.

Recommendation 11:	The HSC Board should consider how community pharmacists might reduce the risks identified in the use of blister packs.

5 Summary of Key Findings

This evaluation took place to assess the management of medicines against standard 7 of the Minimum Care Standards for Domiciliary Care Agencies.

Standard 7: The agency has arrangements in place to ensure that care workers manage medicines safely and securely.

7.1	Where a service user has difficulty in managing his or her medicines, a mechanism is in place to ensure that there is a referral to the community pharmacist for medicines management scheme, and advising the HSC trust as appropriate.

We found that there was no evidence to suggest that any referral was made to the community pharmacist for the medicine management scheme. Registered managers were unaware of the scheme though all agencies expected medicines to be packed in a blister pack.

7.2	Administration of, or assistance with, medication is facilitated when requested by the referral agent, in situations where the service user is unable to self-administer and there is no other carer available, with the informed consent of the service user (or where the assessment indicates he or she is not able to give informed consent, his or her representative) and the agreement of the care worker's line manager, and not contrary to the agency's policy.

The referral agents will identify the level of assistance required but there is little evidence to support that any informed consent is obtained from the service user specifically with respect to assistance with medication. It was generally accepted that consent was implied by the use of the service.

7.3	Where packages of care may be provided on a multi-agency basis, policies and procedures on the management of medicines are agreed between the agencies and followed.

We found no evidence to support that there had been any communication between agencies when more than one agency was involved in the care of a service user.

7.4	The agency ensures that the administration or assistance with medication is detailed in the care plan (Standard 3.3) and forms part of the risk assessment.

The administration or assistance with medication is detailed in the care plan. However, there was little evidence to suggest that it was included in the risk assessment. This is being progressed in some areas.

7.5	The policy and procedures cover each of the activities concerned with the management of medicines.

Domiciliary care agencies have policy and procedures in place. These are at varying stages of development.

7.6	The policy and procedures identify the parameters and circumstances for care workers administering or assisting with medication. They identify the limits and tasks that may not be undertaken without additional training.

The tasks undertaken by care workers are clearly defined in the policy and procedures and are clearly understood by them.

7.7	Care workers who administer medicines are trained and competent. A record is kept of all medicines management training completed by care workers and retained for inspection (Standard 12.7).

This area is one of the challenges within the sector. Registered managers are proactively working to overcome the obstacles identified in the evaluation.

7.8	The impact of medicines management training is evaluated as part of the quality improvement process, and through supervision and appraisal of care workers.

Supervision systems are in place and quality improvement systems are being developed.

7.9	When necessary, training in specific techniques (eg the administration of eye/ear drops or the application of prescribed creams/lotions) is provided for named care workers by a qualified healthcare professional.

The availability of this resource varies across Northern Ireland. Registered managers are aware of the importance of specific training.

7.10	The agency ensures that the care worker documents, on each occasion, the administration or assistance with medication.

Basic recording systems are in place. However in many instances these lack specific details as to the medicine administered.

7.11	The agency ensures that, where care workers are involved, records are kept of all requests for, receipt and disposal of medicines.

During this evaluation there was no evidence to suggest this occurs. However, examples of appropriate documentation are being developed by some agencies.

7.12	The agency ensures that all those involved in the management of the service user's medication agree the arrangements for the safe storage within the service user's home.

We found that this was the practice within the service and the arrangements are usually detailed in the care plan.

7.13	Medication errors and incidents are reported, in accordance with procedures, to the appropriate authorities**.**

Medicine incidents are reported to RQIA.

7.14	Practices for the management of medicines are systematically audited to ensure they are consistent with the agency's policy and procedures and action is taken when necessary.

We found that audits systems are at an early stage of development.

Recommendations

Recommendation 1:	Trusts should consider procedures for ensuring that domiciliary care agencies are provided with an initial up-to-date list of prescribed medicines.

Recommendation 2:	Community pharmacists should consider how they can actively promote their expertise in medicines management to those in receipt of domiciliary care.

Recommendation 3:	Trusts should work together to develop suitable training for care workers.

Recommendation 4:	Trusts and registered managers of domiciliary care agencies should ensure that all care workers involved in domiciliary care receive the appropriate training in the management of medicines.

Recommendation 5:	Where packages of care are provided on a multi-agency basis the commissioning trust should ensure that there are communication systems in place.

Recommendation 6:	Care workers should record why medicines are not administered as prescribed.

Recommendation 7:	Trusts and registered managers should consider how a personal medication record could be maintained in order to improve communication and safe practice across the sector.

Recommendation 8:	The HSC Board should consider arrangements for ensuring that the managers of domiciliary care agencies are informed of any changes to prescribed medicines

Recommendation 9:	Trusts and registered managers should consider how to develop a service user medicine administration record which all care workers complete. This will enable care workers to identify when medicines were previously administered.

Recommendation 10:	The HSC Board should remind all community pharmacists of the labelling requirements for all forms of monitored dosage systems.

Recommendation 11:	The HSCBoard should consider how community pharmacists might reduce the risks identified in the use of blister packs.

Appendix A Evaluation Team Members

Steering Group
Phelim Quinn (Lead Director)
Dermot Parsons (Supervising Head of Programme)
Frances Gault (Supervising Senior Officer)

Evaluation Team
Frances Gault (Senior Pharmacy Inspector)
Lorna Conn (Domiciliary Care Inspector/Quality Reviewer)
Other RQIA staff as necessary where advice in their specific area of responsibility was required.

Facilitated by
Louise Hunter (Project Manager)
Jenny Stainsby (Pharmacy Team Administrator)

Appendix B Records Made Available to RQIA

Medicine policies from each of the agencies visited.

Samples of the current medicine recording systems in use in each agency.

Sample of care plan or task sheets.

Appendix C Definition and Description of Key Terms

Care Management
Care management is a process of assessing needs; developing a care plan based upon those needs; coordinating services to meet the assessed needs and monitoring and reviewing those needs to ensure the continued appropriateness of the care provided.

Care Plan
The Domiciliary Care Agencies Minimum Standards (Northern Ireland) 2008[3] define a care plan as "a written statement, regularly updated and agreed by all parties, setting out the health and social care and other support that a service user requires in achieving specific outcomes and meeting the particular needs of each service user".

Compliance Aid
A compliance aid is an aid to help a person self manage their medication. It is usually a compartmental device filled by the person, their relative or a carer. They are unsealed and usually have no or limited written details regarding the medicines in them.

Domiciliary Care Agency
Article 2(2) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1] defines a domiciliary care agency as "an undertaking which consists of or includes arranging the provision of prescribed services in their own homes for persons who by reason of illness, infirmity, disability or family circumstances are unable to provide any such service for themselves without assistance".

Medicines Management
The Audit Commission's study A Spoonful of Sugar[8] states "medicines management encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care".

Monitored Dosage System
A monitored dosage system is a medication storage device designed to simplify the administration of oral solid dose medication by a formal carer to a service user. They are prepared and labelled at the point of dispensing in a community pharmacy. The contents can be positively identified. They are also called blister packs in domiciliary care.

Personal Medication Record
Personal medication record is an up-to-date record of all prescribed medicines and external preparations with specific dosage directions.

Referral Agent
The Domiciliary Care Agencies Minimum Standards (Northern Ireland) 2008 define a referral agent as "the HSC Trust representative who commissions services from a domiciliary care agency on behalf of a service user, usually a care manager"[3] .

References

[1] The Office of Public Sector Information (2003). The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

[2] Department for Health, Social Services and Public Safety (2007). Domiciliary Care Agencies Regulations (Northern Ireland) 2007

[3] Department for Health, Social Services and Public Safety (2008). Domiciliary Care Agencies Minimum Standards (Northern Ireland) 2008

[4] Department for Health, Social Services and Public Safety (2004). Making it Better. A Strategy for Pharmacy in the Community.

[5] Regulation and Quality Improvement Authority (2009). Guidelines for the Control and Administration of Medicines - Domiciliary Care Agencies January 2009.

[6] Department for Health, Social Services and Public Safety (2006). The Quality Standards for Health and Social Care: Supporting good governance and best practice in the HPSS.

[7] Health and Personal Social Services (2007). (Quality, Improvement and Regulation) (2003 Order) (Commencement No. 4 and Transitional Provisions) Order (Northern Ireland) 2007

[8] Audit Commission (2001). A Spoonful of Sugar. Medicines management in NHS hospitals.