**Activity: Medication Administration; Minimising Risk**

What failsafe systems do you have in your medication procedures at your service?

Identify some areas of potential weakness in your services’ medication procedures….

How do you support your staff in your service with medication administration.. what processes do you have in place

Do you involve your service user(s) in the review process?

How do you do this…?

**Toolkit: Medication Incidents and Accident: For use with observees**

1. You are carrying out a meds check when you come on shift at 5pm. When you look at the medication administration records (MAR) you realise that a client was not given their medication at 1 pm that day. The medication is still in the pack and the MARR sheet is not signed.

* What would you do in this situation?

2. A staff member comes to you for advice and explains that they were to administer medication at 9 am to a service user as directed and they suddenly realised that they had given them medication belonging to another service user. They immediately checked what they have given them and some medications are similar to the ones they are prescribed anyway.

* What do you do?
* How could this situation be avoided?

3. A staff member comes to you at 1pm on a Saturday and tells you that they are to administer a client’s medication and it has ran out.

* What do you do?
* How do you think this incident may have happened and how do you think it could have been prevented?

4. A staff member tells you that they went to visit John, (a service user who lives in the community), for their usual planned weekly support session. When they went to the toilet they noticed 2 blister packs of medication which still contain some tablets discarded in the bin. (You know that the blister packs contain a week’s worth of medication in each pack).

* What would you do about this and what are your responsibilities as the manager?

5. You come on duty for a late shift when one of your workers asks you to countersign the MAR sheet. This is because the worker who should have signed it didn’t and has had to go off early. You did not witness the service user taking their medication.

* What should you do and what further action should you take?

6. You work in a service for highly dependant service users. On one shift a staff member asks you to crush a service user’s tablets and put them in her mashed potato. You are told this is because she has problems swallowing the tablets and the other manager they work with does this….

* What issues does this raise? What should you do?

7. You visit Mary for her usual weekly support visit. While there you notice that she has a large amount of medication boxes in her cupboard. When you ask Mary about them, she says she “Doesn’t know what most of them are for”. But she’s keeping them “Just in case”.

* What could you do about this? What concerns does it raise?

8. Michael has a severe learning disability and has just moved into supported accommodation. Due to his anxieties he is prescribed PRN 10 mg Diazepam “as required, up to 3 times daily”

* What issues does this raise? What other support should Michael receive?

9. Claire buys some Lemsip Max, as she feels she’s getting a cold. Claire is already prescribed 1000 mg Paracetamol as and when she needs them. The staff come to you for advice about this.

* How could this be a problem?
* What is Creative Support’s policy on homely remedies?
* How should service users be supported with homely remedies?

10. When Michelle goes home to visit her parents at the weekend, staff dosette up her medication. She often comes back with a few that she hasn’t taken.

* What would be the problems with this? How could this problem be overcome?