Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

All Wales Guidance to Support Integrated Medicines Management in Community Settings



October 2025

This document has been prepared by a multiprofessional collaborative group including the Association of Directors of Social Services, Care Inspectorate Wales and Social Care Wales, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC). It has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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Glossary

Anaphylaxis	A life-threatening allergic reaction, triggered by insect bites, stings, medicines, food, or other allergens.
Carer	A carer is anyone who cares, unpaid, for a friend or family member who, due to illness, disability, a mental health problem or an addiction, cannot cope without their support. Anyone can become a carer; carers come from all walks of life, all cultures and can be of any age.
Care and support plan	A written statement, regularly updated, and agreed by all parties, setting out the health and social care and support that an individual requires to achieve specific outcomes and meet the needs of the individual.
Care co-ordinator	This person is responsible for planning and reviewing the care of the individual.
Care provider	Can be regulated, unregulated, funded, and self-funded.
Care manager	The person, from the local authorities social services department, responsible for undertaking the assessment of need, developing and coordinating the care and support plan and for monitoring and reviewing its progress.
CDAO	Controlled drug accountable officers
CHC	Continuing NHS healthcare
CIW	Care Inspectorate Wales - the regulator for social care and social services in Wales, from child minders and nurseries to homes for older people. For more information about CIW, see: Home | Care Inspectorate Wales
Covert administration	The discreet giving of medicines to an individual without their knowledge or consent, for example by mixing it into food or drink.
Delayed dose	The administration of a medicine that occurs two hours or more after the prescribed time.
DoLS	Deprivation of liberty safeguards
DisDat	Disability distress assessment tool
Dispensing contractor	A pharmacy or dispensing doctors responsible for dispensing prescribed medicines to individuals.
eMAR / electronic MAR	electronic medicines administration record
Homely remedies	Non-prescription or over the counter (OTC) medicines used in care homes for the short-term management of minor, self-limiting conditions.
IMCAs	Independent mental capacity advocates
IMHAs	Independent mental health advocates
ISPC	Independent second practitioner check
Individual	In this document, the term refers to the person the health or social care professional supports or cares for in their work, whether that be a child, young person, or adult.

Medicine	A substance used to diagnose, cure, treat, or prevent disease or to enhance physical or mental well-being.
Medicines administration	Involves the act providing a person with a medicine, whether prescribed or purchased.
Medicines reconciliation	The process of identifying an accurate list of an individual's current medicines (including over the counter and complementary medicines) and carrying out a comparison of these with the current list in use, recognising any discrepancies, and documenting any changes.
Medicines support	Assistance provided to individuals in managing their medicines, which can include reminders, help with administration, or other forms of guidance.
MAR	Medicine administration record
MCA	Mental Capacity Act
Micro-care providers	Small-scale care providers that offer personalised care services, often focusing on specific communities or individual needs.
MCCAs	Multi-compartment compliance aids
NHS and local authority commissioners	Organisations responsible for planning and purchasing health and social care services on behalf of the public.
Non-prescription medicines	Non-prescription medicines, also known as over the counter (OTC) medicines, can be purchased without a prescription from a doctor or other healthcare professional. Pharmacy-only medicines are a subset of non-prescription medicines that can only be purchased from a registered pharmacy, with or without the supervision of a pharmacist.
Omitted dose	A situation where a medicine is not administered or not taken before the next dose is due. A missed dose is considered one that was not given or taken before the next dose is due.
OTC	Over-the-counter medication
Personal assistants	Individuals employed to assist a person with daily activities, often providing support tailored to the individual's needs.
Personal plan of support	A written plan which specifies how the individual's needs/outcomes are to be met, in terms of tasks and activities. The personal plan must be consistent with any care and support plan/medication care plan developed by the assessor for the individual.
PRN / 'when required' medications	Latin phrase for 'pro re nata' meaning 'when required'. This medication is usually prescribed to treat short term or intermittent medical conditions and is not to be taken regularly.

Reconciliation	The process of verifying and ensuring that an individual's medicine records are accurate and complete, especially during transitions in care.
Regulated services	Care services that are governed by specific laws and regulations to ensure safety and quality of care.
Representative nominated by the by the individual	This may be a family member, or other non-paid carer. For the purposes of this policy a representative cannot be a care worker employed to provide medication administration.
Responsible Individual	A responsible Individual (RI) must be designated in relation to a service as part of the provider's application. See Regulation and Inspection of Social Care (Wales) Act 2016.
RISCA	Regulation and Inspection of Social Care (Wales) Act 2016
Service providers	Organisations or individuals that offer care and support services to individuals.
Sharps	Sharps in this context refer to medical items that can puncture or cut the skin, such as needles, syringes, and lancets. Safe handling and disposal of sharps are crucial to prevent injuries and the potential spread of infections.
SRPC	Single responsible practitioner check
Social care workers	Professionals who are employed to provide care and support to individuals, often in their own homes or care facilities.
Social services	Government agencies responsible for providing social care services, including support for individuals in need.
SALT	Speech and language therapists
Supported living arrangements	Housing options that provide support for individuals to live independently while receiving assistance as needed.
Support workers in health and social care	Healthcare support worker or social care support worker or Assistant Practitioner
Time-critical medicines	Medicines where early or delayed administration from the prescribed time may lead to harm, suboptimal therapy, or inadequate pharmacological effect.
Unpaid carers	Family members or friends who provide care and support to individuals without financial compensation.
Unregulated services	Care services that are not subject to government regulation or oversight.
*	Applicable in care home settings
†	Applicable in domiciliary care

1.0 Background

Ensuring the safe and effective use of medicines in community settings is fundamental to enhancing individuals' well-being and social interactions. The All Wales guidance to support integrated medicines management in community settings aims to address the unique needs of service providers, encompassing regulated, unregulated, commissioned and self-funded services, thereby promoting a consistent approach to medicines management that is tailored to individual requirements.

In accordance with The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1], service providers must implement safe and effective management practices when such support is referenced in an individual's care plan and commissioned according to the principles of the Social Services and Well-being Act and The NHS (Wales) Act 2006.

Service providers must have robust medicine policies and procedures in place. Managers should have clear oversight of the robust procedures and ensure that medicine policies are implemented and followed[1]. This guidance supports the development of these local, integrated policies by establishing consistent standards across health and social care settings for the safe handling, storage, administration, and disposal of medicines. Additionally, it emphasises the importance of supporting individuals to manage their own medicines independently whenever possible, and outlining expectations for staff training, oversight, and covert administration procedures.

By adhering to this guidance, service providers ensure that medicines management aligns with regulatory requirements and best practices. This approach supports a safe, proactive, and holistic care environment, promoting individual well-being while minimising the need for restrictive measures.

2.0 Scope

This guidance assumes that medicine support responsibilities have been collectively agreed upon by NHS and local authority commissioners, supported by regional policy, with collaboration focused on ensuring the safe and appropriate delivery of support within a clear governance framework. It is intended to strengthen the safety and consistency of medicine support through improved coordination and clearly defined roles. Collaborative arrangements should be formalised through partnership agreements or shared principles that set out clear commissioning and contractual responsibilities ensuring clarity around decision-making, accountability, and the division of responsibilities. Clinical responsibilities will remain solely within the remit of health services.

The principles outlined in this guidance apply to a wide range of regulated and unregulated community-based services, including those working with individuals in their own homes, care homes, and supported living arrangements. This guidance is relevant to both adult and children's services.

Regulated organisations, including health boards, local authorities, and service providers including privately funded as well as commissioned services, should integrate the content of this national guidance into their internal medicines policies to

uphold the highest standards of medicines management. Unregulated services, such as personal assistants, micro-care providers and day opportunity services, should strive to incorporate these principles while adapting them to their specific operational contexts. Similarly, unpaid carers are encouraged to adhere to the relevant aspects of the provided guidance to ensure safe and effective medicines management.

3.0 Collaborative governance

This guidance prioritises supporting individuals to manage their medicines independently, with initial support from unpaid carers where appropriate and as needed. In cases where short-term support from a social care support worker is necessary to aid recovery towards independence, this should be incorporated into care planning. The need for longer-term involvement of social care support workers in medicines support should only be considered after a thorough review by healthcare professionals, including efforts to simplify regimens, utilise adherence aids, and implement other enabling measures. Where ongoing support is deemed necessary, it must be formally agreed upon, with clear governance arrangements and defined accountability in place. A collaborative working approach and effective communication between health and social care colleagues will enable individuals to receive the support they need, optimise their medicines, and reduce the risk of avoidable medicines-related harm and admissions.

3.1 Primary responsibilities of healthcare professionals

Primary responsibility for diagnosing and managing an individual's clinical condition lies with their relevant healthcare professional (e.g. GP, consultant, nurse, pharmacist, dentist). Healthcare professionals must conduct regular medicines reviews (See Section 13 – Supporting medicines reviews) and reconciliation to ensure appropriateness of medicines regimens, educate individuals about their medicines and monitor treatment effectiveness through follow-up assessments. Additionally, they should identify and address barriers to adherence to enhance the overall optimisation of the individual's medicines. The supply of medicines resides with the dispensing contractors, who are also required to assist individuals in managing their medicines in accordance with the Equality Act 2010.

A regulated service can be commissioned by social services, health boards (e.g. for Continuing NHS Healthcare [CHC] or medicines-only support), or privately by individuals and their support networks. Additionally, some unregulated micro-care providers may also be engaged to provide medication support.

Health boards maintain joint governance responsibilities for medicines management in the community when social services are the primary providers of the individual's overall care and support. Health boards should take a leading role in promoting safe medicines practices, supporting the development of regional policies, and facilitating collaborative care strategies that enhance medicines safety and quality of care across all services.

Healthcare professionals must ensure that all individuals prescribed regular or long-term medicines are reviewed regularly and ensure that reviews are conducted effectively and align with best practice expectations (see Section 13 – Supporting medicines reviews).

They must provide education to individuals about their medicines and monitor outcomes through timely follow-up assessments.

Additionally, they should identify and address barriers to adherence, to enhance the overall optimisation of the individual's medicines.

3.2 Medicines support under the Social Services and Well-being (Wales) Act, 2014

Under section 47 of the Social Services and Well-being (Wales) Act 2014, a local authority may provide support to individuals in administering or managing their medicines when it is viewed as a minor or supportive part of other care services. This ancillary and incidental support is delivered in partnership with the health board, who hold the primary responsibility for medicines management in the community including safe prescribing, dispensing, and advising on the use of medicines.

Offering the necessary support to ensure individuals are able to take their medicines safely and effectively, also known as ancillary medicines support, enhances the holistic approach to care, improves service continuity, and promotes overall well-being, in line with the ethos and core principles of the Social Services and Well-being (Wales) Act 2014. Taking medicines as prescribed is often essential to an individual's health, well-being, and ability to carry out daily activities. By integrating medicines support into broader care services within the scope of their statutory duties, local authorities can significantly improve quality of life for individuals. This approach supports the vision of A Healthier Wales by fostering an integrated, preventative health and social care system that makes prudent use of resources. Adhering to the Sustainable Development Principle of the Well-being of Future Generations (Wales) Act, this approach encourages more effective collaboration and addresses long-term challenges, ensuring that services remain person-centred, sustainable and resilient.

In situations where administering medicines demands enhanced skills or presents greater complexity (see Section 4.5 – Enhanced skills), the local authority may still decide to support by involving or enlisting personnel to assist in the administration of medicines if it is in the best interest of the individual. However, this must only be done under a delegation agreement such as a contractual or joint partnership arrangement, to ensure clear accountability and robust oversight in the administration of medicines. The ability to deliver a safe service under the regulations also needs to be considered.

In situations where support with medicines falls outside the incidental and ancillary definition outlined in the Social Services and Well-being (Wales) Act 2014[2], health and care professionals must seek to meet this need for individuals while ensuring overall public sector cost-effectiveness.

For example, if medicines administration support is required outside scheduled personal care activities, such as during a dedicated medicines-only call, it should be commissioned through a collaborative approach led by the health board. Healthcare professionals should prioritise exploring all viable alternatives, including proactive medicines reviews, implementing adherence aids, and utilising technology to effectively support individuals.

3.3 Compliance with regulatory standards

When a local authority or health board agrees to support an individual with their medicines within the broader context of the Social Services and Well-being (Wales) Act 2016[2] or Continuing NHS Healthcare: The National Framework for Implementation in Wales, the regulated service must ensure compliance with Regulation 58 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1].

This regulation promotes the responsible handling of medicines to safeguard the health and well-being of individuals receiving care. It ensures that assistance with medicines adheres to safe practices, regardless of whether enhanced skills are required, thereby facilitating effective care that prioritises individual safety.

This guidance expands on Regulation 58 and statutory guidance, ensuring consistency with regulatory requirements. All providers, whether regulated or unregulated, including micro-care providers and those delivering care through personal payments or direct payments under CHC should follow the guidance within this document to ensure adequate support for individuals managing their care.

3.4 Alignment with national guidelines and policies

This guidance should be utilised in accordance with established guidelines provided by the National Institute for Health and Care Excellence (NICE) and other national guidance, including:

- NICE Managing medicines in care homes, social care guideline (SC1[3])
  NICE has developed a helpful checklist for health and social care staff involved in the development and updating of a care home medicines policy[3].
- NICE Managing medicines for adults receiving social care in the community, NICE Guideline (NG67)[4].
- UK Government. Mental Health Act 1983[5]
- UK Government. Social services and well-being (Wales) Act 2014[2]
- UK Government. The Regulated Services (Service providers and responsible individuals) (Wales) Regulations 2017[1]
- Welsh Government. The Well-being of Future Generations Act 2015[6]
- Welsh Government. National framework for Continuing NHS Healthcare[7]
- Welsh Government. A healthier Wales: long term plan for health and social care[8]
- Welsh Government. The Regulation and Inspection of Social Care (Wales) Act 2016 statutory guidance[9].
- Welsh Government. Regulation and Inspection of social care (Wales) Act 2016[10]
- AWMSG. Care home medicines optimisation toolkit[11].
- AWMSG. All Wales guidance for health boards/trusts and social care providers in respect of medicines and care support workers[12].
- AWMSG. Polypharmacy in older people: A guide for healthcare professionals[13]
- AWMSG. Welsh national standards for medication review[14]
- Health Education and Improvement Wales (HEIW). All Wales social care medicines management training framework (Medicines management – social care)[15].
- HEIW. All Wales Guidelines for Delegation[16].

- Association of Directors of Social Services (ADSS) Cymru. National guiding principles for medicines support in the domiciliary care sector[17].
- Royal Pharmaceutical Society. Professional guidance on the safe and secure handling of medicines[18].

4.0 Medicines assessment

In any health or social care assessment, including hospital discharge, addressing an individual's medicines support needs is essential. The NHS holds overall responsibility for ensuring that medicines are safe and appropriate, including how they will be administered.

Healthcare professionals should conduct thorough assessments during medicines reviews (See Section 13 – Supporting medicines reviews), focusing on optimising medicines and deprescribing when necessary. This is particularly important when social care support workers are involved, as it can influence prescribing decisions and overall medicines management.

Social care assessments must evaluate medicines-related support to ensure all aspects of the individual's care are considered, resulting in more effective and personalised support. Health boards, local authorities and social care providers must collaborate to develop an integrated assessment process.

Under the Social Services and Well-being (Wales) Act 2014[2] and the Mental Health (Wales) Measure 2010, the NHS and social care services are responsible for assessing medicines support needs. When agreed, regulated providers must evaluate their capability to meet the needs specified in the care or treatment plan, as outlined in The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1]. This includes assessing their capacity to deliver adequate medicines support (Regulation 14) and developing personalised, co-produced plans that detail tailored daily medicines support and risk management strategies to promote independence (Regulation 15).

In privately funded domiciliary care, the contracted private care provider should utilise the care and support plan to assess an individual's medicines management needs, with active participation and consultation from the supported individual and/or their family and involving health and social care professionals, as necessary.

When assessing an individual's medicines support needs, considerations should include:

- The individual's needs, preferences, and understanding of their medicines, including why they take them.
- Their capabilities and required level of medicines support, i.e., assistance or administration, including considerations related to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Any challenges they face in obtaining, storing, using, and disposing of their medicines.
- Support from unpaid carers and contact information for medicines-related queries.

- Regular reviews to assess changes in the individual's ability to remain independent in their medicines administration.
- Integration with existing assessment and commissioning protocols.

In cases where care and support are commissioned by the local authority, the assessor—such as a social worker—must evaluate the individual's ability to manage their medicines and collaborate with relevant health or social care professionals when there is a need for a more comprehensive assessment. The process for assessment must be incorporated into admission or commencement policy as set out in the RISCA Regulations[10].

This assessment should identify potential risks and determine the necessary level of support. While assessors are not required to have clinical knowledge, they can leverage their expertise in holistic assessments and understanding of individual needs to identify barriers to effective medicines management. The primary objective is to promote the individual's independence by considering various support options, including the use of technology. This approach aims to reduce reliance on statutory services while ensuring that individuals receive the necessary assistance tailored to their unique circumstances. Those responsible for conducting medicines support assessments should have received appropriate training in line with respective regulators or service providers. This practice is integral to maintaining a standardised and high-quality approach, preventing variability in the assessment process.

4.1 Medicines support levels

Promoting individuals' self-care and self-administration of medicines should be a key objective for health and care practitioners. A person-centred approach empowers individuals to manage their own medicines, enhancing their autonomy and engagement in their care. Table 1 provides an overview of the various levels of medicines support.

During the assessment, it is important to evaluate the type of medicines support required. While medicines support levels can serve as a general guide, personalised medicines support should be emphasised, focusing on describing the specific support for individual's medicines needs. Recognising that support may vary for different medicines, fixed levels may not always provide optimal support. A tailored approach ensures that individuals can maintain as much independence for as long as possible, emphasising that support is not an "all or nothing" situation. Flexibility should be built into the plan to allow for changes to reflect the needs of the person at that time. An individual's support requirements may change over time, such as during periods of illness. Regular reassessment should be built into all levels, particularly at Levels 0 and 1, to monitor any changes in an individual's ability to manage their medicines independently.

Health professionals should work closely with social care teams to respond promptly when an individual's health condition or ability to manage their medicines changes. Social care staff should notify the relevant health team if they observe specific indicators such as difficulties with medication adherence, confusion about medication, side effects, or any deterioration in health. The health team should then prioritise timely reassessment and provide clear guidance or recommendations on any adjustments to the individual's medicines or the support they need.

Table 1. Levels of medicines support and responsibilities

Level	Description	Who retains responsibility	Key points
Level 0	Individuals self-administer their medicines independently.	Individual	• No specific support needed for medicines management. Ongoing reviews are necessary to assess any changes in the individual's ability to remain independent.
Level 1	Individuals can make decisions about their medicines but need specific support (e.g. reminders or assistance with opening containers).	Individual	• Support workers are not liable for mismanagement, provided individuals have been assessed as capable and best practice standards are followed. • Detailed documentation of support is crucial to safeguard support workers from liability. • Aligns with the Mental Capacity Act 2005, promoting autonomy and respecting decision-making capacity.
Level 2	Support workers administer medicines for individuals who cannot manage or understand their medicines regimen.	Support worker	• Support workers must fully document medicines administration, including consent and any refusals. • Support workers select and prepare medicines for administration, ensuring the individual's needs are met. • Requires comprehensive training and competency assessment for support workers.
Level 3	Support workers administer medicines requiring enhanced skills or greater complexity.	Support worker	• Requires advanced training and competency assessment. • Ongoing supervision and support from qualified health professionals are necessary to ensure safe and effective medicines administration. • Expectations and responsibilities should be clearly defined, and staff should not undertake activities that exceed the level of support and oversight required. (See Section 5 - Medicines administration)

The statutory guidance[9] accompanying Regulations 21 and 58 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1] emphasises the importance of encouraging individuals to be as independent as possible in their self-care and requires arrangements to support self-administration and independent management of medicines. Additionally, Regulation 15 mandates the implementation of measures to encourage positive risk-taking and independence where appropriate[1].

This process involves reviewing individuals' needs and assessing them within flexible support levels to guide the implementation of tailored strategies, ensuring that they are adapted to meet individual circumstances.

4.2 Self-administration in care settings

Upon admission to a care facility and regularly thereafter, the individual's capability for self-administration of medicines (Level 0) should be evaluated. This assessment should cover the individual's understanding of their medicines regimen and their ability to manage it safely.

It is essential to consider reasonable adjustments and support tools to facilitate effective self-administration. Examples include medicines reminders, medicines organisers, and training on how to use these tools. Community pharmacies and health board pharmacy teams can provide valuable guidance on the suitability of such strategies and tools that may enhance an individual's ability to manage their medicines as independently and safely as possible.

Compliance with the Equality Act 2010[19] ensures that individuals with disabilities have equal opportunities in medicines management, preventing any disadvantages they may face.

4.3 Self-administration of medicines in a care home

*Care organisations should have clear policies and procedures to support self-administration of medicines, tailored to each individual's needs and circumstances, and underpinned by robust risk assessment processes. On admission to a care home, staff should ensure that tailored support arrangements are in place for each individual, with the default assumption that they may be able to self-administer medicines, including controlled drugs, unless the assessment indicates otherwise. This promotes independence and person-centred care, while ensuring safety remains paramount.

The assessment must be documented in the individual’s care record and should consider their preferences, ability to manage medicines, potential risks, storage arrangements, and the responsibilities of staff. It should be reviewed regularly and updated if the individual’s needs or circumstances change. Further details on self-administering medicines can be found in the AWMSG Care Home Medicines Optimisation Toolkit[11].

4.4 Who should undertake the risk assessment?

*This assessment should be documented as a feature of the individual’s care and support plan. The registered manager should review and facilitate a collaborative assessment involving the individual, unpaid carers (if desired), and care home staff.

* Applicable to care homes

In some cases, engagement with the GP, pharmacist, or other healthcare practitioners may be warranted. Care home providers must also document when medicines are provided for self-administration or when reminders are given as part of the personal plan. While individuals who self-administer medicines remain accountable for their actions, care home providers retain the responsibility to ensure that the process is conducted safely and in accordance with the care plan.

Refer to Section 10: Medicines storage.

4.5 Enhanced skills

In the best interest of the individual, a care provider may accept the delegation of administering medicines requiring enhanced skills (Level 3) from a registered nurse, provided that the care worker is appropriately trained and assessed to be competent. Risk assessments, procedures and protocols should also be in place to support the skill. The support worker is encouraged to consider their comfort and competence when deciding whether to accept this responsibility. This process must occur under a delegation agreement agreed with the registered individual/registered manager, such as a contractual or joint partnership arrangement, to ensure clear accountability and robust oversight in medicines administration.

Delegation is contingent upon adherence to established policies and an updated care plan, which should include clear guidelines outlining specific elements, as well as comprehensive training and ongoing supervision. The registered nurse or healthcare professional retains health responsibility for overseeing the delegation, ensuring compliance with local guidance. Whether a care provider can support this delegation depends on the alignment of their registration, policies, procedures, and training to facilitate it.

All Wales Medicines Strategy Group (AWMSG) provides guidance on delegating medicines management to care support workers in nursing homes or community setting where nursing care is involved: All Wales Guidance for Health Boards/Trusts and Social Care Providers in Respect of Medicines and Care Support Workers[12].

The Welsh government document 'Third Party Delegation: The Required Governance Framework'[20] provides guidance on delegating health activities from NHS health professionals to non-NHS health and social care support staff. It emphasises the importance of partners establishing contractual agreements with third parties, like domiciliary care providers, to ensure compliance with the governance framework. Additionally, the Social Services and Well-being Act (2014)[2] stipulates that social services may only deliver healthcare if it is incidental and ancillary to the social care provided.

4.6 Consent

Where an assessment indicates the need for Level 1, Level 2, or Level 3 medicines support, the individual must consent to receive this support. They should be fully informed about the nature of the support provided, including specific activities involved. It is essential that the individual understands that the support worker will require access to their prescribed medicines and the necessary information to ensure safe administration.

To ensure clarity, individuals who do not fully understand Welsh or English should have access to an interpreter to support the consent process.

Individuals must also understand the implications of refusing support and consent to it in accordance with the personal plan. Consent must be recorded. If an individual lacks capacity under the Mental Capacity Act 2005[21], a documented 'Best Interests Decision' within their personal plan is required before support can be provided.

4.7 The use of multi-compartment compliance aids (MCCAs)

All Wales guidance on the use of multi-compartment compliance aids, to support workers in health and social care, is currently in development. Please contact awttc@wales.nhs.uk for further information.

5.0 Medicines administration

Medicines administration is governed by specific legislation and guided by regulatory and professional bodies. According to the law, anyone – including unpaid carers – can administer a prescribed medicines, provided they follow the explicit directions of a prescriber and can do so safely. Support workers in health and social care must receive appropriate training and assessment to ensure competence in this task.

For guidance on non-prescription medicines and over-the-counter products, please refer to Section 5.1 – Non-prescription medicines and over-the-counter products.

Support workers must urgently seek advice from a healthcare professional if an individual experiences acute deterioration or significant changes in health. This should also be reported via the management structure as set out in the Regulation and Inspection of Social Care (Wales) Act 2016[10].

Immediate medical guidance is crucial to prevent the omission of essential, time-critical medicines, especially for conditions like (but not limited to) Parkinson's disease or epilepsy. Medicines should not be withheld or delayed without explicit instruction from a healthcare professional. All advice received, including directives on medicine administration, must be clearly documented. For guidance on timely medicines administration in community care settings, please refer to Section 5.4 – Timely medicines administration in community care settings.

Regulation 59 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1] requires service providers to keep and maintain records as specified in Part 1 of Schedule 2. These records must include specific daily interventions, such as medicines support provision. The medicines administration record (MAR) chart is the recommended method for recording medicines administration. The MAR chart is not an authorisation to administer medicines or a prescription; it serves solely as a record of administration. Instructions on the medicines dispensing label provide the authorisation to administer and reflect the prescriber's directives.

The local authority, health board, and care provider share responsibility for establishing and maintaining effective systems for medicines administration. They should collaborate to ensure safe, accurate processes are in place.

This guidance also applies to micro-care providers and privately commissioned services, ensuring all care providers adhere to consistent medicines administration standards, regardless of how services are commissioned.

Processes for administering medicines should adopt a person-centred approach that involves the individual, and any unpaid carers in decisions regarding their medicines. By prioritising the specific needs of individuals over rigid schedules and activities, this collaboration can enhance adherence to prescribed treatments and empower each person, acknowledging their unique requirements. To ensure safe and effective medicines administration, adequate protected time should be designated where necessary for this specific purpose.

It is essential that all individuals receiving medicines are informed of the name, dosing regimen and, where appropriate, the purpose of the medicines being administered. Maintaining the individual's autonomy and understanding helps maintain independence in managing their medicines and health.

Support workers who have received appropriate training and have been assessed as competent and confident, as detailed in Section 12 - Training, may administer or assist with various medicines-related activities according to an individual's personal plan. This list serves as a general guide and is not exhaustive and should be tailored to the individual's specific needs and healthcare professional instructions. These activities include:

- Administering solid or liquid medicines orally.
- Administering drops or sprays to the eyes, ears, or nose.
- Applying ointments, creams, lotions, or patches (e.g. Fentanyl patches) to the skin.
- Administering non-prescription or over-the-counter medicines when directed by the individual or when confirmed as safe to do so by a health professional (see Section 5.1 - Non-prescription medicines and over-the-counter products).
- Administering medicines via an inhaler device, including through a spacer device.
- Mixing a food or liquid thickener as per a healthcare professional's instructions.
- Administering an adrenaline auto-injector for the emergency treatment of anaphylaxis. Unlike other injections, the adrenaline auto-injector is designated specifically for emergency response. Support workers may administer it only if they have received training or are acting under the guidance of emergency services (e.g. 999); ensuring timely, potentially life-saving intervention.

For activities that involve greater complexity (e.g. Level 3, enhanced Skills), appropriate delegation processes must be established to ensure safe care when support workers are taking on these responsibilities to benefit individuals and minimise delays in care provision (see Section 4.1 - Medicines support levels). These processes should recognise the need for enhanced skills training (see Section 12.0 - Training) and reflect the valuable contributions of support workers in joint working arrangements with health boards, local authorities, and independent care providers.

Support workers may undertake the following activities under appropriate delegation, only under NHS direct governance, and with enhanced skills training and competence:

- administering rectal suppositories, creams, or enemas
- administering vaginal pessaries or creams
- administering medicines with variable dosage
- administering medicines via nasogastric or Percutaneous Endoscopic Gastrostomy (PEG) tubes
- administering medicines via nebulisers
- administering injections
- administering or regulating oxygen therapy
- inserting urinary catheters
- administering bladder washouts or medicines via urinary catheters.

Support workers should not perform the following activities:

- administering medicines via syringe drivers or pumps
- administering medicines not listed in the personal plan or MAR
- administering medicines from unauthorised containers
- providing specific advice or judgments about medicines use
- administering medicines covertly, unless specified in the personal plan
- performing activities not included in the personal plan.

5.1 Non-prescription medicines and over-the-counter products

Encouraging individuals to manage their care, particularly in accessing non-prescription medicines and over the counter (OTC) products, is essential for promoting equality. OTC products available without a prescription from pharmacies or supermarkets (examples include certain analgesics and cough medicines), empower individuals to address minor, non-chronic conditions. Community pharmacy staff are readily available to provide any advice needed on the safe and effective use of OTC medicines.

Regulation 21 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1] mandates that service providers ensure individuals are supported and enabled to be as independent as possible, including assistance for self-care activities such as self-administration of medicines.

Access to OTC medicines should be facilitated through individual-led self-assessment, supported by support workers or unpaid carers under the guidance of a healthcare professional. There should be clear documentation with all relevant details recorded in the individual's personal plan.

It is essential to ensure that individuals lacking capacity do not miss opportunities for treatment of minor ailments or experience delays waiting for appointments and prescriptions.

5.1.1 Domiciliary care

†Support workers can support an individual to use non-prescribed or OTC medicines at the individual's direction or request (Level 1 support) if documented in the personal plan. Self-care involves individuals retaining responsibility for managing their medicines.

At Level 1, individuals guide support workers in their medicines regimen. Therefore, when support workers assist with an OTC medicines, the individuals are retaining responsibility. Any mismanagement arising from the individual's self-directed management will not reflect on the support worker, provided they have acted within the scope of their role and training.

Individuals are encouraged to engage in self-assessment, with healthcare professional consultation available if needed.

Key considerations for Level 2 support include:

- Any use of OTC medicines at Level 2 must occur only following guidance from a healthcare professional, which should include clear instructions authorising administration. This information must be documented in the personal plan and recorded on the MAR chart.
- Support workers are not authorised to administer OTC medicines without patient-specific labelling or direction. Therefore, OTC medicines may need to be prescribed by a relevant healthcare professional to ensure they are appropriately labelled. Once prescribed, the medicines can be added to the MAR chart, allowing care workers to administer the medicines in line with the prescriber's instruction.

5.1.2 Homely remedies in care homes

*Care homes should consider implementing a homely remedies policy and maintaining a stock of OTC medicines to address minor ailments.

This policy should advocate for responsible self-care practices, transparent documentation, and strict adherence to safety guidelines when incorporating OTC medicines within care settings. Staff training is essential to ensure competence in supporting self-care using OTC medicines. Further details on homely remedies can be found in the AWMSG Care Home Medicines Optimisation Toolkit[11], providing guidance to improve the integration of OTC medicines into care practices.

5.2 Administration of 'when required'(PRN) medicines

In both care home and domiciliary care settings, a clear procedure for administering 'when required'/ pro re nata (PRN) medicines is crucial, particularly for individuals who are non-verbal or have difficulty communicating symptoms including pain. Support workers should be trained to recognise non-verbal cues indicating discomfort or distress, and healthcare professionals should consider using tools like the DisDat[22] (Disability Distress Assessment Tool) or similar assessments to evaluate the necessity of 'when required' medicines.

† Applicable to domiciliary care
* Applicable to care homes

According to the statutory guidance[9] associated with Regulation 21 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1], it is required that staff receive appropriate training to enhance their understanding of cognitive impairment and neurodiversity. This training should include the principles of pain recognition, pain management, and effective communication to enable them to deliver plans developed by other professionals, such as Speech and Language Therapists (SALT).

Support workers can assist individuals in using 'when required' medicines (including controlled drugs). When support workers assume this responsibility, it is essential to ensure that specific protocols are in place. Healthcare professionals are expected to provide clarity on when support workers should and should not administer, ensuring that support workers adhere strictly to the medicine's instructions and the individual's personal plan. The medicines instruction or personal plan should include:

- when to administer.
- dose to administer.
- maximum dose in a 24-hour period.
- interval between doses.
- review date.
- cautions.
- any additional information necessary for safe and appropriate use should also be included.

†In domiciliary care settings, administering PRN/when required medicines may be achievable only if it aligns with existing care calls. Support workers may need to leave medicines for later administration, following an appropriate risk assessment if necessary.

The prescriber is responsible for providing explicit directions for the administration of PRN/when required medicines. Variable doses, such as "Take ONE or TWO tablets," should be avoided unless the individual's personal plan includes clear dosing instructions. Care workers, skilled in their roles, should seek guidance if the dosage is unclear, as they should refrain from making clinical decisions independently.

At Level 1, individuals maintain responsibility for their medicines and direct support workers on the appropriate use of 'when required' medicines. Support workers assist according to the individual's direction. Any mismanagement arising from the individual's self-directed management will not reflect on the support worker, provided they have acted within the scope of their role and training.

At Level 2, support workers are responsible for administering the PRN/when required medicines only if there are clear and explicit instructions from healthcare professionals. This can be provided via a personalised PRN/when required protocol, which gives a detailed account of how and when PRN medicines should be administered for a particular individual. It is the responsibility of the prescriber or healthcare professional to ensure that support workers have sufficient information to allow the safe administration of PRN/when required medicines.

† Applicable to domiciliary care

The administration of PRN/when required medicines must be clearly documented on the MAR. Documentation should include the time of administration, dosage given, and the reason for administration. Additionally, the outcome of the administration must be recorded (See AWTTC Care home medicines optimisation toolkit for an example) (See Section 5.4.1 Individualised Care Approach for info on refusal of 'when required' protocol).

Service providers should regularly monitor PRN/when required medicines usage to identify patterns or trends. If an individual frequently requires PRN/when required medicines, this should be escalated to a healthcare professional for a review of its ongoing appropriateness, as it may indicate inadequate management of the individual's condition. Additionally, service providers should identify any PRN/when required medicines that are no longer needed by the individual for potential review and discontinuation, as this helps simplify the MAR chart.

5.3 Medicines administration verification: single and independent second practitioner checks

5.3.1 Single responsible practitioner check (SRPC):

The SRPC involves a skilled and competent practitioner who assumes full responsibility for verifying that the administration of a medicines aligns precisely with the prescriber's instructions. This practitioner confirms the accuracy of the medicines, dosage, and timing to ensure patient safety.

5.3.2 Independent second practitioner check (ISPC):

The ISPC requires a second practitioner – appropriately trained and assessed as competent – to independently verify that the responsible practitioner administers medicines accurately according to the prescription. The second practitioner witnesses the preparation and administration without external influence, maintaining complete independence throughout. This check verifies that the selected medicines align with the prescription and safeguards against potential errors.

Both practitioners involved in the administration process must document their actions by signing after the medicines is given, with the ISPC check confirming alignment with the individual's prescription. Ensuring an adequate number of staff are assessed and designated as competent to perform second checks is essential for operational safety.

*The ISPC is generally considered good practice in settings where it is practical, such as care homes, especially for administering controlled drugs or high-risk medicines or when handling unfamiliar medicines.

†However, in domiciliary care settings, achieving an independent second check is often impractical due to the autonomous nature of the work. In these cases, it is acknowledged that double-handed calls are rare, so a second check is not required under normal circumstances.

* Applicable to care homes
† Applicable to domiciliary care

5.4 Timely medicines administration in community care settings

Ensuring timely administration of medicines is crucial in community care settings, while also recognising that individuals receiving care have varied routines that should be respected. Further information about what to do if medicines are not administered can be found in Section 15.0 – Adverse effects, incidents, and safeguarding concerns.

5.4.1 Individualised care approach

Care providers should shift from a rigid "time" and "task" approach to a more personalised strategy that accommodates individual routines. This includes:

- **Flexibility in administration:** Allowing flexibility in medicines timing based on the individual's schedule, ensuring that time-critical medicines are administered in a timely manner when necessary (AWMSG Urgent requests for repeat medication: Guidance for healthcare professionals providing NHS 111 and out-of-hours primary care services and AWMSG All Wales policy for Medicines Administration, Recording, Review, Storage and Disposal).
- **Collaboration with individuals:** Involving individuals in discussions about their care and medication administration, allowing them to express their preferences.
- **Personalised care plans:** Developing care plans that reflect the individual's needs and daily routines rather than a one-size-fits-all model.

5.4.2 Refusals

Refusals to take medicines should be documented and promptly brought to the attention of healthcare professionals or management. The frequency and significance of refusals should be evaluated based on the individual's condition and the type of medicines prescribed, as some medicines – such as anti-epileptics, Parkinson's disease medicines, or insulin – may require urgent action.

Individuals have the right to refuse medication. However, any refusals or missed doses should be clearly documented, as they may become a safeguarding concern or be classified as a medicines incident if not escalated appropriately. An escalation process must be in place to ensure timely notification of a healthcare professional to assess the situation and determine if further intervention or review is warranted. For more information on adverse effects, incidents, and safeguarding concerns, please refer to Section 15.0 – Adverse effects, incidents, and safeguarding concerns.

5.5 Covert administration

Covert administration should only be considered when absolutely necessary and justifiable, and never for individuals with decision-making capacity regarding their treatment. The decision to engage in covert administration must adhere to relevant legislation, including the Mental Capacity Act 2005[21] and the need for best interest meetings.

Covert administration must follow legal and best practice frameworks to protect both individuals and care staff. In addition to legal considerations, pharmaceutical factors must also be addressed. Therefore, advice should be sought from pharmacy professionals to ensure that medicines can be safely and effectively altered for covert administration.

A comprehensive medicines review should be conducted before implementing covert administration. This review must assess the necessity of each medicines, including adjusting timings and formulations, ensuring that the only medicines to be covertly administered are absolutely essential.

The process for covert administration involves evaluating the individual's decision-making capacity and respecting their preferences if they have capacity. If the individual lacks capacity, a multidisciplinary best interest meeting must be convened. Essential participants in this meeting should include the prescriber with input from pharmacy professionals as necessary, unpaid carers, Independent Mental Capacity Advocates (IMCAs), Independent Mental Health Advocates (IMHAs), and appointed attorneys, as appropriate.

The meeting should assess whether covert administration serves the individual's best interests and consider whether formal legal procedures, such as the Mental Health Act[5] or Deprivation of Liberty Safeguards[23], are necessary.

If covert administration is deemed in the individual's best interests, a management plan should be established. Medicines must not be covertly administered without conducting this meeting. In urgent cases, a less formal discussion may occur, but a formal best interest meeting should be arranged promptly, along with a specified review date.

Covert administration without a mental capacity assessment, a best interest meeting, and clear direction from a prescriber is considered a safeguarding issue and may be categorised as abuse under the Human Rights Act 1998.

Covert administration must be assessed in accordance with Regulation 14 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1], and the outcomes of this assessment must be incorporated into the personal plan as mandated by Regulation 15. Ongoing assessment is required under Regulation 18 (See Section 4.0 – Medicines assessment).

Regional policies should be established that extend across organisational boundaries and be developed in collaboration with relevant health and social care practitioners.

Local policies must ensure that medicated food or drink cannot be consumed by others. Clear protocols must be in place to manage situations where a person receiving medicines covertly does not consume the full amount of medicated food or drink, or if they refuse to consume it. The MAR chart must clearly indicate when medicines are to be administered covertly and provide explicit instructions on the method of administration. Alternatively, a separate personal plan should outline precisely how medicines are to be administered, in accordance with instruction from relevant healthcare professionals, such as community pharmacy teams, health board pharmacy teams, or dispensing doctors.

Administration or refusal must be accurately documented on the MAR chart. (See Section 6.1 – Medicines administration records).

Further details on covert administration can be found in the AWMSG Care Home Medicines Optimisation Toolkit and the NICE guidelines on administering medicines

covertly. Additionally, the Specialist Pharmacy Service (SPS)[24] provides valuable guidance on the legal issues surrounding the covert administration of medicines.

5.6 Individuals with swallowing difficulties

Support workers may assist individuals with capacity (level 1) who experience difficulties swallowing by modifying the form of oral medicines, such as crushing tablets, splitting, halving, or opening capsules, under the explicit instruction of a pharmacy professional and the prescriber. It is essential that the individual is fully informed of these modifications and provides consent. These practices do not constitute covert administration, as they are conducted with the individual's knowledge and agreement.

Healthcare professionals, including the prescriber and pharmacy professionals, must assess the feasibility and safety of altering medicines (e.g. crushing or splitting) to ensure treatment effectiveness. Where appropriate, other specialists, such as Speech and Language Therapists (SLTs), should also be consulted to determine the safest method of administering medicines.

All approved modifications must be clearly documented on the medicines administration record (MAR) and in the care plan to ensure clear communication and continuity of care.

6.0 Recording

Regulation 59 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1] mandates that service providers must keep and maintain records specified in Part 1 of Schedule 2. This should include documenting various aspects of individuals' medicines, including orders, receipt, administration, refusal, disposal, or return to a pharmacy.

For short break respite, medicines must be received from and returned to the individual's home at the end of the stay, ensuring documentation is maintained to accurately track these transactions.

Records regarding the care, treatment, and support of individuals utilising services must be updated at the time or as soon after the event as possible.

Records related to adults must be kept for eight years from the date of the last entry. For children (i.e. anyone under the age of 18), the records must be retained until the individual's 25th birthday or for eight years after the last entry—whichever is longest[25].

6.1 Medicines administration records (MAR)

The service provider must keep and maintain records of all medicines held for each individual, including the date and time of administration. MAR charts should be used to document both the administration and non-administration of medicines.

Collaboration between health and social care is essential to create accurate MAR charts. Handwritten MAR charts should be avoided whenever possible to reduce the risk of errors associated with rewriting or transcribing.

MAR charts should include:

- individual's name and date of birth.
- medicines name, formulation, and strength.
- frequency and timing for administration.
- route of administration.
- name of the individual's GP practice.
- any stop or review date.
- additional instructions for administration, such as whether to take with or without food (e.g., ibuprofen with food, some antibiotics on an empty stomach).

Separate MAR charts may be required for certain medicines, like warfarin, and should be clearly signposted from the original MAR chart to ensure easy access to all relevant information.

Administration should only be recorded after personally witnessing the individual taking the prescribed medicines.

PRN/'when required' medicines should always be listed on the MAR chart but should only be signed for by the individual administering the medicines after it has been given, and not when it has been offered and declined. This prevents unnecessary entries on the MAR chart and makes it easier to track actual administrations. Instances where PRN medicines were offered but declined can be recorded in the care notes instead.

In cases of individual refusal, staff should document the circumstances and reasons on the MAR chart.

If an individual spit out medicines after oral administration, any partial doses should be clearly documented on the MAR chart, estimating the amount received (e.g., "approximately half dose taken").

See Section 5.4 – Timely medicines administration in community care settings, for guidance on time-sensitive medicines and Section 5.2 – Administration of 'when required' (PRN) medicines, for advice on PRN/when required medicines; both of which are important considerations for the production of MAR charts.

6.1.1 Distinction between MAR chart and prescription label

	Prescription label	Medicines administration record (MAR) chart
Primary purpose	Provides instructions to the individual or caregiver on how to administer the medicines. Also serves as the authority for support workers to administer medicines, as it mirrors the prescriber's intention.	Part of the care record documenting the administration or non-administration of medicines by support workers. Does not grant authority; it is a record of what has been administered.
Intended audience	Individual or caregiver.	Care staff, used to record support provided.
Content focus	Dosage instructions, frequency, and administration route per the prescriber's directions.	Records each dose given, time administered, the administering staff's signature, and reasoning for any non-administration.
Legal requirement	Must follow strict legal guidelines for labelling, as per prescriber instructions. There may be a dispensing signature on the label, but no prescriber signature is required on the label itself (the prescriber signature is recorded on the original prescription).	Must be accurately maintained as a legal document for care provided and compliance audits. Signatures of the person administering the medicines will be recorded, but no prescriber signature is required.
Format	Typically printed directly on a medicines bottle or packaging.	A form or chart, paper-based or electronic.

For over-the-counter medicines, administration should follow appropriate authorisation procedures, ensuring that consent and any necessary approvals are obtained before administering (see Section 5.2 – Administration of 'when required' [PRN] medicines).

Prescribers should be encouraged to provide clear, detailed guidance for inclusion on the MAR chart to ensure safe medicines administration. This guidance may include specific instructions, such as where to apply creams, which eye requires drops, or special directions for individuals with swallowing difficulties (see Section 5.1 – Individuals with swallowing difficulties). The MAR chart provider relies on precise instructions from the prescriber and may need to seek clarification to effectively support those administering the medicines, highlighting the importance of collaboration between the prescriber and MAR provider.

Ensuring the accuracy of MAR charts is a shared responsibility among care service providers, their staff, and healthcare services, particularly those supplying the charts. Healthcare services must inform care providers of any changes and address any discrepancies in the MAR chart.

6.1.2 Guidance for medicines change

Clarity is essential when service providers receive instructions from healthcare professionals. Providing instructions in writing, rather than relying solely on verbal

communication, enhances auditability and accountability. Verbal instructions should only be used in exceptional circumstances when written alternatives pose a barrier to person-centred care, and a clear record of the exchange must be maintained.

The process of using verbal instructions should be underpinned by risk assessments and organisational policies and procedures. Where appropriate, the prescriber requesting changes should provide a prescription or amend the drug chart or medicines administration record with the new administration details as soon as possible, ideally within 24 hours. For more detailed information on this process, refer to the "Professional Guidance on the Administration of Medicines in Healthcare Settings"

Staff who are appropriately trained may make hand-written entries or produce interim MARs if it is in the best interest of the individual, following established procedures. Any amendments or additions should be dated, clearly written, and attributed to the responsible individual, including their designation. Reference to the authorising prescriber is essential.

Any hand-written entries or additions should undergo a second check by another trained staff member to confirm that the entry is correct and complete before it is finalised.

For more information on transcribing, see Specialist Pharmacy Service: Understanding Transcribing for Medicines Administration.

6.1.3 Electronic MAR charts

The Welsh Government's Digital and Data Strategy for Health and Social Care in Wales emphasises the importance of integrated, secure, and accessible digital solutions to improve care quality and safety. Transitioning to an electronic MAR (eMAR) system offers care providers an opportunity to streamline medicines administration processes. By digitising records, care workers and managers may access information more easily, potentially supporting quicker responses to individuals' needs and reducing administrative burdens. While the adoption of eMAR is encouraged, care providers should thoroughly assess how these systems can be effectively integrated into their practices to enhance the safety and quality of care for service users.

To facilitate this transition, eMAR systems must align with national record-keeping standards and comply with data governance and cybersecurity requirements.

Access to dispensing contractor support is crucial for maintaining accurate medicines records and facilitating the transcribing of information into eMAR systems. However, currently, many care providers in domiciliary settings may encounter challenges because their dispensing contractors lack the capability to input data directly into eMAR systems. As a result, these care providers may need to generate their own eMAR records. In such cases, robust governance systems must be established to ensure that staff responsible for data entry are properly trained and assessed for competence.

To enhance medicines administration, it is essential to integrate dispensing systems with eMAR systems. Suppliers of dispensing systems must collaborate with eMAR

providers to develop compatible solutions that enable seamless data entry and improve the accuracy and efficiency of medicines record.

The care provider's medicines policy should include contingency measures for system or internet outages, along with procedures for managing situations involving absent regular staff and temporary staff who may be unfamiliar with the system. In the event of a system outage, care providers should establish processes to effectively manage medicines records. Additionally, regular audits of the systems are essential to ensure ongoing compliance and safety.

The system should efficiently handle activities like managing purchased medicines, homely remedies, mid-month changes, and whenever the individual transfers between care settings. Incorporating safety alerts into the eMAR system is essential to enhance overall medicines safety and prevent errors in administration. Additionally, ensuring secure access and proper management of various paper or digital records, including those related to controlled drugs, fluid charts, insulin, patch applications, 'when required' medicines guidance, topical medicines administration, warfarin anticoagulant, covert administration, and enteral feeding administered by external healthcare professionals, is paramount.

6.2 Temporary absence from care setting

For temporary absences from the care setting (e.g. visits with family or friends), the care provider must ensure that all necessary medicines accompany the individual. The MAR (paper or eMAR) should be annotated as "on leave" for the duration of the absence. A copy, printout, or list of current medicines, including doses and administration times, must accompany the individual. Care staff should also provide clear instructions to the individual or caregiver, specifying the time of the last dose and when the next dose is due.

The care provider should not secondarily dispense the person's medicines into another container (i.e. not to repackage a medicines that has already been dispensed by a pharmacy).

Upon admission to hospitals or other healthcare facilities, the individual's medicines and a copy or printout of the MAR should accompany them. This ensures accurate medicines reconciliation, prevents delays in administering non-stock medicines (those not readily available at the healthcare facility), and avoids unnecessary duplication of dispensing.

7.0 Ordering

Service providers that decide to assume responsibility for ordering medicines on behalf of the individual, in accordance with the Social Services and Well-Being (Wales) Act 2014[2], should have appropriate procedures in place for managing repeat, acute, and 'when required' medicines, as mandated by the Regulation and Inspection of Social Care (Wales) Act 2016[10].

In shared living arrangements, this underscores the importance of ensuring that prescribed medicines are used exclusively by the intended recipient.

†Typically, the responsibility for ordering repeat prescriptions and arranging for their collection lies with the individual receiving domiciliary care or their unpaid carers. Care agencies may handle the ordering of medicines when other arrangements are not feasible, and this should be clearly specified in the individual's personal plan, with appropriate commissioning of this activity.

Additionally, consideration should be given to ordering medicines for individuals temporarily absent from the service (e.g., in hospital or short stays with family), ensuring coordination with healthcare providers and documentation.

There is a need to consider an escalation process if medicines are required urgently or at short notice.

7.1 Additional guidance for care homes

*Efficient medicines procurement in care homes is crucial to prevent missed doses, especially during out-of-hours. Challenges include limited staff availability, various prescription types, and the risk of over-ordering, which can lead to wastage.

Individuals in residential care may retain control over their own medication, and care homes should not automatically assume responsibility for ordering on their behalf.

In cases where care homes take on the responsibility of ordering medications for residents, the following practices are recommended to enhance the medicines ordering process:

- *Staffing:* At least two competent staff members should handle the medicines ordering process to ensure flexibility during holidays or absences.
- *Protected Time:* Allocate time for the medicines ordering process, particularly for monthly orders. Conduct a thorough review of usage and stock reconciliation before placing orders.
- *Ordering and inventory management:*
    - Prioritise timely ordering to avoid stock shortages and maintain accurate records, including repeat prescriptions, to guide orders and monitor medicine quantities.
    - Monitor expiry dates and manage inventory effectively. Unused items, such as ‘when required’ medicines or those with sufficient stock, should not be discarded if they are in date and still appropriate for the individual. Current stock should be carried forward, and new supplies ordered only when running low, not automatically with each cycle.

† Applicable to domiciliary care
* Applicable to care homes

    - Synchronise medicines if changes occur midway through the supply cycle to ensure alignment with the ordering cycle.
- Communication and Collaboration:
    - Care homes must navigate complexities such as alignment with multiple GP practices and managing medicines across different floors or units.
    - Establish clear communication protocols and encourage cross-team collaboration.
    - Care home providers are responsible for ordering medicines from GP practices and should actively check and verify prescriptions, which should not be delegated to dispensing contractors.

- Documentation:
    - Care home staff should maintain records of prescriptions or requisition notes when ordering medicines, ensuring accurate record-keeping and verification upon receipt. This documentation aids in following up on missing or outstanding prescriptions.
    - Care home providers should promptly inform the dispensing contractor of any changes to medicines, including discontinuations, to facilitate precise record-keeping.

8.0 Medicines collection

Efficient systems should be in place for collecting and transporting dispensed medicines from an individual's dispensing contractor to the relevant care setting.

[†]In domiciliary care, the responsibility for collecting medicines and transporting it to an individual's residence typically falls to the individual receiving care or their unpaid carers. Care agencies may assist with this process when alternative arrangements are not feasible. This responsibility should be clearly outlined in the individual's personal plan, with appropriate commissioning for these activities.

Community pharmacies are not contractually obligated to deliver medicines to an individual's residence or a care setting. Any delivery agreements with a pharmacy should be noted in the individual's personal plan.

A risk assessment must be completed for the transportation of controlled drugs. This assessment should also account for scenarios where staff are not proceeding directly from the dispensing contractor to the individual's residence. For instance, if staff have other support calls to make enroute, the assessment should evaluate potential risks and outline appropriate measures to ensure the safe handling and security of the controlled substances during transit.

[†] Applicable to domiciliary care

9.0 Receiving medicines

Care providers must establish a structured process for the receiving and inspecting of medicines upon delivery. This process should ensure that once an order is placed and dispensed, there is a clear and efficient system in place for verifying the arrival of these medicines.

†Typically, in domiciliary care, the individual receiving care or their unpaid carers assume the responsibility for receiving medicines at their place of residence. Care agencies may assist with this process when other arrangements are not feasible. For example, the care provider may manage the receipt of medicines if they are responsible for administering them (Level 2 support). This responsibility should be clearly specified in the individual's personal plan, with appropriate commissioning of this activity.

Staff responsible for receipting medicines must be adequately trained to accurately verify the arrival and condition of medications, minimising errors during the receipting process.

Upon receiving the medicines, the staff should cross-verify the dispensed items against their order records, if available. Additionally, they should compare the old MAR chart against the new one, ensuring accuracy in the individual's details, medicines, dosage, administration route, and timing. This check ensures that all requested medicines have been accurately supplied. Any discrepancies should be promptly addressed by referring back to the dispensing contractor, without causing any delays in an individual's treatment. This verification process forms a vital part of ensuring individuals receive the appropriate care.

*In care home settings, many residents may have the capacity to manage their own medication. Therefore, individuals may wish to retain responsibility for receiving their medicines. When care homes do take on the responsibility for receiving medicines, implementing a second check whenever possible can enhance accuracy and safety.

9.1 Controlled drugs register

*The care home provider must document any transfer or handling of a Schedule 2 controlled substance within a designated controlled drugs register. Local practice may include documentation of additional schedules as best practice. There must be a clear audit trail of any medicines received, administered, or disposed of – including a running total. The balance should always reflect the remaining stock and be checked regularly to identify any discrepancies. If all quantities of a controlled drug have been fully used or appropriately disposed of, the balance should be zero.

A "register" refers to either a bound book (excluding loose-leaf registers or card indexes) or a computerised system that complies with best practice and legal requirements[26]. Each formulation and strength should be logged separately, displaying the name, form, and strength of the medicines, with a dedicated section for each individual and preparation.

Electronic controlled drug (CD) registers are permitted as an alternative to a bound-book CD register only if safeguards are in place, including ensuring that the

* Applicable in care homes

author of each entry is identifiable, access is restricted to authorised personnel, and a full audit trail is maintained with all data entered and retrievable for review.

Best practice often recommends at least a weekly stock check, with more frequent checks (e.g., daily) in high-use settings or where specific risk factors, such as high turnover of medicines or previous discrepancies, indicate a need for increased monitoring.

9.1.1 Self administration of controlled drugs

*Individuals capable of self-administering their medicines can also self-administer their controlled drugs.

A record of an individual's own Schedule 2 controlled drugs should be maintained, in addition to the records maintained on the medicine's administration record. When the individual is wholly independent, responsible for requesting a prescription, and personally collecting the controlled drugs from the community pharmacy/GP dispensary, there is no requirement to keep a record in the controlled drug register.

However, if the individual relies on care home staff to arrange the supply and collection of controlled drugs, clear records should be maintained in the controlled drugs register. This includes documenting receipt from the supplying pharmacy, supply to the individual, and any subsequent disposal of unwanted controlled drugs.

It is crucial to clearly designate personnel responsible for each aspect of controlled drug management within the care home records.

Supporting self-administration with controlled drugs requires striking a practical balance between fostering the individual's independence and maintaining secure governance within the care home.

†While it is wise to take reasonable precautions, there is no requirement to keep a controlled drug register in a person's own home.

Controlled drug accountable officers (CDAOs)

The Controlled Drugs (Supervision of Management and Use, Wales) Regulations 2008 include information relating to Accountable Officers. Healthcare bodies which include Local Health Boards, NHS Trusts and Welsh Independent Hospitals must appoint Accountable Officers who make the arrangements that relate to the regulations, this includes safe disposal and auditing.

Accountable Officers also have responsibilities for others whose work involves controlled drugs within their healthcare body. These responsibilities include keeping records of the investigation of concerns and taking action where appropriate.

* Applicable in care homes
† Applicable in domiciliary care

10.0 Medicines storage

Strict adherence to the manufacturer's storage guidelines is essential to maintain medicines efficacy and safety. Medicines should remain in the original packaging, or the container supplied by the dispensing contractor. It is crucial that medicines are only used by the individuals for whom they were prescribed, as mandated by the Human Medicines Regulations 2012[27]. Maintaining a cool and dry storage environment (below +25ºC), unless refrigeration (between +2°C and +8°C) is required, is essential to preserve medicines integrity. Regular monitoring and recording of product expiry dates, including post-opening expiry (e.g. creams and eye drops), is necessary to uphold medicines effectiveness and safety.

10.1 Domiciliary care settings

†In domiciliary care settings, it is important to recognise that the medicines belongs to the individual, giving them the autonomy to decide on its storage.

However, promoting good practice includes advising individuals to store medicines away from direct light or heat sources. Where concerns arise, such as cognitive impairment or other safety considerations, care providers may find it prudent to conduct a risk assessment to evaluate whether additional security measures are necessary.

While healthcare professionals are responsible for educating individuals about the storage of medicines they prescribe or dispense, the practical implementation of that knowledge is typically assumed by care providers. Care providers are well-positioned to promote good practices, such as advising individuals to store medicines away from direct light or heat sources and out of reach and sight of children and animals. If concerns arise, such as cognitive impairment or other safety issues, it may be prudent for care providers to conduct a risk assessment to determine the need for additional security measures or to communicate any safety concerns to healthcare professionals for appropriate intervention.

Unless a risk assessment specifically advises otherwise, there is not a legal mandate to handle dispensed controlled drugs differently or segregate them from other medicines. While it is wise to take reasonable precautions, there is no obligation to have a designated controlled drug storage unit within an individual's home. In some cases, a risk assessment might warrant the placement of a locked box if there is a perceived risk of inappropriate use.

10.2 Care home specific guidance

*In care homes, medicines may be stored either in individuals' own rooms or in a central location. Each individual’s storage needs should be assessed on a case-by-case basis, similar to the approach for those living independently. This assessment should determine the most suitable storage solution, considering the person’s preferences, risk factors, and chosen medicines system, including any additional requirements for medicines that require cold storage or may be prone to misuse. Care providers are responsible for implementing these storage arrangements based on the assessment.

* Applicable in care homes

According to the statutory guidance associated with Regulations 43 and 44 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1], individuals should have access to safe and secure storage for personal belongings, including medicines. To support self-administration, care home providers should ensure that secure storage is available within the individual's room, keeping medicines safe and inaccessible to others.

All organisations providing NHS-funded care must ensure compliance with the expectations outlined in PSN055 regarding the safe storage of medicines.

Refer to the AWMSG Care Home Medicines Optimisation Toolkit[11] for additional guidance on storage, including the Medicines Expiry Date Checklist, Storage Requirements of Common Medicines, and Temperature Monitoring Record.

10.2.1 Recording temperature

*In care homes, it is essential to record the room and fridge temperatures daily where medicines are stored. This includes documenting minimum, maximum, and current temperatures using a minimum/maximum thermometer, which should be reset after each reading in line with the manufacturer's guidance.

Care providers should establish a clear procedure for temperature monitoring which should outline the actions to take if temperatures fall outside the recommended range, including identifying who to contact for further advice. Additionally, when monitoring refrigeration, staff should ensure the thermometer probe cable does not interfere with the door seal, as this could impact the ability to maintain the correct temperature range.

10.2.2 Secure medicines storage systems and governance

*The designated authority, such as a registered manager or care home manager or supervisor, should establish a secure medicines storage system in consultation with senior staff. Poor management of medicines storage can lead to errors, wastage, and delays. It is their duty to ensure safe and secure storage of medicines and implement robust governance arrangements. This includes aspects such as adequate lighting, controlled drugs cupboards, storage of flammable liquid medicines. Regular risk assessments should confirm if these areas are appropriate.

Except for individuals' bedside medicines cabinets, medicines should be stored in metal cupboards or automated dispensing systems compliant with British Standard (BS) 2881[28]. All storage units, including cupboards, trolleys, automated dispensing systems, medicines storage rooms, and refrigerators, must be lockable and secured when not in active use. Locks, in compliance with BS 3621[29], must be installed on metal cupboards, excluding individuals' bedside medicines cabinets, and within automated dispensing systems.

10.2.3 Controlled drugs

*In adult care homes, compliance with the Misuse of Drugs Act 1971[26] and its associated regulations is mandatory regarding controlled drugs. This includes the proper storage of controlled drugs. The minimum standard for controlled drug storage, depending on the drug's schedule, is outlined in Schedule 2 of The Misuse of Drugs (Safe Custody) Regulations 1973[30]. While children's homes (which provide

* Applicable in care homes

care for individuals up to 18 years old) are not bound by these regulations, it is advisable to adopt similar practices for best care standards.

The controlled drugs cupboard must meet the security requirements defined in BS 2881[28], specifically at security level 1. It should be securely affixed to a wall or floor using bolts inaccessible from the outside, equipped with a sturdy lock, and constructed from durable metal with robust hinges. The selection of the cupboard's location is crucial, ensuring the surrounding walls are of sufficient thickness and made from suitable material like bricks for secure installation. There is no need to enclose the controlled cupboard within another cabinet, nor any need for a warning light.

10.2.3.1 Self administration of controlled drugs

*Individuals capable of self-administering their medicines can also self-administer their controlled drugs. They are not required to utilise a controlled drugs cabinet and can securely store them in a personal lockable non-portable cupboard or drawer within the individual's room if appropriate.

Safe custody regulations (The Misuse of Drugs (Safe Custody) Regulations 1973[30]) apply when the care home is entrusted with the management of an individual's controlled drugs or when it assumes responsibility for ordering controlled drugs on behalf of the individual.

10.3 Fridge storage

Medicines requiring refrigeration, falling within the “cold chain”, must be stored within the range of +2°C and +8°C.

10.3.1 For domiciliary care

†In domiciliary care, a separate medicines fridge is not necessary. However, individuals should be advised that the fridge used for medicines storage should be in proper working order. While daily temperature check is not mandated, regular maintenance is advised.

If a person does not have a suitably functioning fridge, it is advisable for care providers to contact a healthcare professional for guidance. Where a fridge is shared with others (e.g., in supported living, shared tenancy, or family settings), medicines should be clearly labelled and stored in a secure, dedicated container to prevent accidental use.

10.3.2 For care homes

*Dedicated medicines fridges in care homes should meet specific standards for maintaining medicines at the correct temperature. Service providers should ensure the fridge's security and limit access to authorised staff only. It should not be used to store food or biological samples, and the plug should be clearly labelled with a cautionary notice indicating that the fridge must not be switched off. Additionally, large quantities of medicines should not be stored to avoid inadequate air circulation and potential freezing. Regular checks of the contents' expiry dates and routine cleaning and defrosting of the fridge are essential.

† Applicable in domiciliary care
* Applicable in care homes

A protocol should be in place for situations where the temperature falls outside the normal range. It is also considered best practice to include details in the care home's medicines policy about whom to contact locally, such as the supplying pharmacy, in the event of a storage issue.

10.3.2.1 Refrigerating controlled drugs

*Controlled drugs with safe custody requirements that necessitate refrigeration must be stored in a locked medicines fridge. While there are no medicines fridges compliant with Misuse of Drugs (Safe Custody) Regulations[30], controlled drugs meeting safe custody requirements and requiring refrigeration should be stored in a standard medicine's fridge. For added security, controlled drugs should be kept within a lockable box within the fridge, with restricted access.

10.4 Storage of medical gases

Oxygen is a medical gas and should be handled with the same care as any medicines. It poses a fire hazard, so precautions are essential near electronic devices (e.g., laptops), heat sources (e.g., heaters), and smoking areas, including electronic cigarettes. Additionally, batteries from e-bikes, e-scooters, and mobility scooters can also ignite fires, so caution is required in their vicinity. Flammable substances (e.g., aerosols) and petroleum-based products should not be used near oxygen.

Oxygen cylinders must be securely stored to prevent tipping. This can be achieved by securely attaching them to a wall with a chain, using appropriate trolleys, or storing them in cages.

Staff members who handle oxygen must undergo training regarding the safe handling and storage of medical gases. This training should include instruction on how to turn on the regulator in an emergency and proper procedures for managing oxygen cylinders.

*In care homes, statutory hazard notices should be displayed in areas where oxygen is stored. Additionally, regularly check the expiry dates on oxygen cylinders.

10.5 Maintaining emergency medicines supply in care homes

*Care homes with nursing may hold emergency stock supplies of medicines, including but not limited to oxygen, controlled drugs, and medicines for anaphylaxis.

"Stock" medicines refer to those not individually dispensed to named individuals but retained by the care home to ensure timely administration upon authorisation by a prescriber or following an agreed procedure for certain medicines, such as oxygen and adrenaline, specifically for life-saving purposes.

Care homes must have the appropriate equipment and storage facilities in place. A clear, written policy for the use of emergency medicines should be established, along with regular staff training on these procedures. Staff members must demonstrate competency in handling and administering emergency medicines, with ongoing assessments to ensure their proficiency.

* Applicable in care homes

Regular reviews of stock levels and expiry dates, along with updates to protocols based on evolving needs, are essential.
Care homes without nursing are legally restricted from maintaining stocks of prescription-only medicines. They may only possess prescription-only medicines that have been specifically prescribed and dispensed for individual residents.

10.5.1 Holding "stock" controlled drugs

*While controlled drugs are typically prescribed for each resident, maintaining a limited stock can enhance palliative and end-of-life care by facilitating prompt symptom management and ensuring continuous access during out-of-hours periods. This allows for administration upon authorisation by a prescriber, effectively addressing storage constraints and minimising waste.

Care homes without nursing are not legally authorised to hold stocks of controlled drugs; they can only store those prescribed and dispensed specifically for individual residents. In contrast, care homes with nursing are permitted to maintain stocks of controlled drugs. However, to hold Schedule 2 controlled drugs, they must possess a Home Office controlled drugs license if less than 50% of their funding comes from public funds or charitable donations. For Schedules 3, 4, and 5, care homes with nursing can hold stocks without the need for a Home Office license.

For more information about obtaining a Home Office license, please visit GOV.UK – Controlled Drugs Domestic Licences.

11.0 Disposal of medicines

It is a legal requirement that all waste be disposed of correctly. Medicines are categorised as clinical waste for waste management and segregation purposes. The disposal of medicines is regulated by The Controlled Waste (England and Wales) Regulations 2012[31].

Service providers must adhere to a structured procedure for the safe disposal of medicines, including clinical waste removal. This process should include timely disposal of expired or no longer needed medicines, including controlled drugs. Notifying the dispensing contractor to prevent unnecessary medicines replenishment is crucial.

Medicines actively prescribed, within their designated expiry date, and not subject to a specified limited shelf-life upon opening, do not require immediate disposal. Instead, these medicines should be incorporated into the next month's ordering process to prevent over-ordering. Please refer to Section 7.0 – Ordering.

11.1 Domiciliary care

†Clinical waste is treated akin to household waste in these settings. Any medicines that are no longer required should be returned to a dispensing contractor who are obliged to accept back unwanted medicines from individuals for appropriate disposal.

* Applicable in care homes
† Applicable in domiciliary care

In domiciliary care settings, the responsibility for transporting medicines, including controlled drugs, for disposal typically falls on the individual receiving care in their own home or unpaid carer. Service providers may assist with this process when alternative arrangements are not feasible. This responsibility should be clearly outlined in the individual's personal plan, with appropriate commissioning for these activities.

It is essential to obtain consent from the individual or their representative prior to the removal of any medicines, as these are considered personal property. It is good practice to maintain a record of medicines being returned to a dispensing contractor to ensure an audit trail of medicines leaving an individual's premises.

Service providers that normally and regularly assist individuals in transporting pharmaceutical waste back to the dispensing contractor must register as waste carriers. "Normally and regularly" indicates that this activity is part of their usual business operations, even if it occurs infrequently. An example of not falling under this requirement is when waste transport is carried out in an emergency situation or when there is a safety risk that necessitates immediate action.

If service providers need to register, they will fall under the lower tier, which is free and indefinite. Additionally, all employees of the organisation will be covered by their employer's registration. See Natural Resources Wales – Register or renew as a waste carrier, broker or dealer.

11.2 Nursing care homes and non-nursing care homes

*Waste disposal must be conducted in accordance with established protocols, ensuring that only authorised entities manage waste.

Non-nursing care homes	Clinical waste is treated as household waste. Medicines that are no longer needed should be returned to the dispensing contractor for disposal.
Nursing care homes	The waste should be consigned to a suitably authorised waste management facility (this may be the dispensing contractor that supplies the medicines; however, nursing care homes need to check if the dispensing contractor has appropriate arrangements in place and agrees to disposing of the medicines). Under any private arrangement, the dispensing contractor must arrange for a waste management facility independently, ensuring it is a separate arrangement from the one contracted by the health board.

In the event of an individual's death, their medicines should be securely stored, separate from other medicines, and kept under lock and key within the care home for a minimum of seven days, awaiting potential coroner's investigations. Disposal can occur once the death certificate is signed.

* Applicable in care homes

11.3 Records for disposing of medicines

When disposing of medicines, accurate and prompt record-keeping is essential, including details like the date of disposal, medicines name, strength, form, quantity, reason for disposal, and the staff member's name.

The MAR chart is a valuable tool for tracking any remaining medicines at the end the month cycle. If the medicines are still prescribed and within their expiration date, they should be kept for future use and do not require disposal. Medicines designated for disposal should be securely stored (in a tamper-proof container within a locked cupboard for care homes), until they can be collected or transferred to the pharmacy. Providers should inform the pharmacy of discontinued or unnecessary medicines to prevent inclusion in the next supply cycle, minimising waste.

11.4 Disposing of controlled drugs in care homes

11.4.1 Non-nursing care homes

*Controlled drugs should be promptly returned to the relevant community pharmacy/GP dispensary for proper disposal, with accurate documentation of the types and quantities.

An entry in the controlled drugs register should be made, and the balance adjusted accordingly.

11.4.1.1 Nursing care homes

*Arrangements must be made for the collection of waste medicines through coordination with a licensed waste disposal company, in compliance with Waste Management Regulations. Individuals' personally labelled controlled drugs (Schedules 2, 3, and 4 [Part I]) must undergo denaturation before being handed over to the waste disposal company. This process is categorised as waste processing by Natural Resources Wales. Care homes with nursing must apply for a T28 waste exemption from Natural Resources Wales[32], which is provided at no cost.

Controlled drugs must undergo denaturation using specially designed kits before being handed over to the disposal company. These denaturation kits must be securely stored for a minimum of 24 hours during the denaturing process. If the controlled drugs have additional safe custody requirements, they must be stored in the controlled drugs cupboard during this time, or in accordance with the specific instructions provided with the kit. Best practice includes one staff member recording the controlled drug destruction in the controlled drugs register, while a second staff member witnesses the physical destruction of the drug, verifies the accuracy of the record, and signs to confirm.

Additionally, any Schedule 2 Controlled Drug stock (i.e. not individually labelled for a specific person) must be destroyed in the presence of an appropriate authorised witness. Community pharmacy teams or health board pharmacy teams are well-positioned to provide guidance.

Following disposal, an entry in the controlled drugs register should be made, and the balance adjusted accordingly.

* Applicable in care homes

11.5 Storage of sharps

Service providers should ensure staff understand correct sharps usage and conduct risk assessments for both individuals receiving care and care staff, implementing necessary precautions to prevent injuries.

11.5.1 Domiciliary care

†External healthcare professionals using sharps should dispose of them safely through their designated sharps disposal process. Support workers using sharps for delegated activities should follow a secure sharps disposal protocol, which may involve engaging a waste contractor. The responsibility for arranging and funding a waste contractor, as well as conducting risk assessments for the delegated activity, lies solely with the healthcare professional or the organisation employing them.

11.5.2 Care homes

11.5.2.1 Non-nursing care homes

*External healthcare professionals using sharps should dispose of them safely through their designated sharps disposal process. Support workers using sharps for delegated activities, should follow a secure sharps disposal protocol, which may involve engaging a waste contractor. The responsibility for arranging and funding a waste contractor, as well as conducting risk assessments for the delegated activity, lies solely with the healthcare professional or the organisation employing them.

11.5.2.2 Nursing care homes

*Sharps used by nurses in a nursing home should be disposed of in a dedicated sharps waste bin via the clinical waste contractor.

11.5.3 Self-administration

Individuals self-administering medicines, such as insulin injections or blood glucose readings, should properly dispose of sharps in a dedicated sharps waste bin, which can be prescribed or provided by the local authority. Arrangements should be made for timely collection of these items.

12.0 Training

All Wales guidance to support the delivery of medicines training for health and social care support workers is currently in development.

The All Wales Therapeutics and Toxicology Centre (AWTTC), Health Education and Improvement Wales (HEIW) and Social Care Wales are working collaboratively to develop the guidance. Please contact awttc@wales.nhs.uk for further information.

Training for staff in all care settings should align with the regulations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016[10].

Please refer to the All Wales Medicines Management Support Training Framework[15], for further guidance.

† Applicable in domiciliary care
* Applicable in care homes

13.0 Supporting medicines reviews

Individuals receiving care and support often have complex health conditions that require regular monitoring for safety and effectiveness. Medicines reviews can enhance medical condition management, improve individual involvement in decision-making, reduce unnecessary prescribing, minimise unused medicines, promote cost savings, and reduce adverse effects.

The AWMSG Welsh National Standards for Medication Review[14] guide healthcare professionals by outlining key activities to ensure that reviews are conducted effectively and align with best practice expectations.

Implementing a structured approach to medicines reviews within care planning and assessment will help improve their effectiveness. Healthcare professionals are responsible for conducting medicines reviews and establishing mechanisms to ensure these reviews are completed. Collaboration between healthcare professionals and care providers ensures the appropriateness of medicines regimens and facilitates necessary adjustments to better align with care call times and the unique needs of both providers and individuals.

Medicines reviews should be tailored to each individual's unique needs, prioritising safety. As part of a multidisciplinary review, individuals should receive a medicines review upon entering a care setting to optimise their medicines regimen. Residents should receive a minimum of one annual medicines review, with additional support provided for significant medicines changes.

The frequency of multidisciplinary medicines reviews should not exceed one year and should be recorded in the personal plan.

Certain individuals, such as those commencing new medicines or taking high-risk ones, may require prioritised reviews. More frequent reviews might be necessary for individuals in end-of-life care, those recently diagnosed with long-term conditions, those requiring frequent monitoring, or those newly transferred to care settings after a care transition, including hospital discharge. The next review date should be established during the medicines review process.

While social care professionals are not responsible for conducting medicines reviews or monitoring key health parameters, they play a supportive role by documenting review dates. If they identify individuals who could benefit from a review or who are overdue for health monitoring (e.g. blood tests, blood pressure checks, or weight records), they should proactively guide these individuals to the appropriate healthcare services for assistance.

14.0 Medicines reconciliation

Seamless medicines management is vital for ensuring safe, high-quality care during transitions between care settings. Communication gaps can leave individuals and care providers with limited information about their prescribed medicines, particularly those that are time critical.

Medicines reconciliation is essential in community care settings to reduce errors and enhance safety. Health and social care providers responsible for care delivery must allocate resources for effective reconciliation, appointing a designated individual, such as a care home manager, to coordinate this process within the personal care plan.

Healthcare professionals are responsible for providing accurate and timely medicines information, including updates from recent consultations or hospital discharges. They should also implement reconciliation protocols to ensure that medicines records, such as MAR charts, are both accurate and up to date. This approach minimises the risk of medicines errors and ensures continuity of care.

To address reconciliation challenges, effective collaboration and communication must be established among all members of the Multidisciplinary Team, including healthcare professionals, social care providers, hospitals, and unpaid carers. Agreed-upon protocols should be developed at the local level to facilitate this cooperation.

Medicines reconciliation should involve synchronising the medicines administration record with the most current medicines information. This includes the GP practice's medicines list, recent discharge summaries, and supplementary information from other acute service providers or specialist services. Additionally, integrating services such as the Community Pharmacy Discharge Medicine Review Service can improve the accuracy and completeness of medicines information during care transitions.

15.0 Adverse effects, incidents, and safeguarding concerns

In accordance with Regulation 80 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017[1], service providers must have suitable arrangements in place to assess, monitor, and analyse medicines incidents to ensure the quality and safety of the service.

Additionally, Regulation 60 specifies that medicines incidents no longer necessitate reporting to Care Inspectorate Wales unless severe harm has occurred[1].

All health and social care staff should encourage individuals and/or their unpaid carers to raise any concerns about their medicines. Where concerns are clinical in nature, the individual or unpaid carers should be supported to raise these with the individual's GP, pharmacist, or other appropriate healthcare professional.

Concerns regarding medicines management may include, but are not limited to, the following:

- Individuals regularly declining or not adhering to prescribed medicines.
- Experiencing adverse effects from medicines.
- Stockpiling or misusing medicines.
- Changes in mental or physical health impacting medicines use.

Where an individual chooses to regularly decline their medicines, the individual's GP or other appropriate healthcare professional should be informed. In the event of an

individual declining medicines, agreed actions to be taken should be documented in the individual's personal plan.

Providers and commissioners should collaborate with stakeholders across health and social care to formulate a locally agreed action plan for the identification, reporting, review, and learning from medicines incidents, with a focus on quality improvement. This should align with existing safeguarding processes and principles established by safeguarding boards, which include the learning and review of all incidents, including those related to medicines.

Medicines incidents may include:

- Failure to administer medicines as prescribed unless an individual has expressed their refusal.
- Administration of incorrect medicines or dose.
- Administration via the wrong route or at the wrong time.
- Delayed administration of time-sensitive medicines.
- Inaccurate or incomplete record-keeping of medicines administration or omission.
- Failure to have prescribed medicines readily available. Discrepancies in the handling, administration, or documentation of controlled drugs.

In the event of a medicines incident, care providers may need to contact a healthcare professional (e.g., GP, pharmacist, or NHS 111) to assess any potential risk to the individual and determine appropriate actions. This ensures that any potential harm is identified and addressed promptly.

Providers should have a transparent process for reporting safeguarding incidents associated with medicines, adhering to the Wales Safeguarding Procedures[33].

A medicines-related safeguarding incident may involve:

- Deliberate withholding of medicines without valid reason.
- Incorrect use of medicines for purposes other than benefiting the individual.
- Deliberate attempt to harm an individual through medicines.
- Repeated errors in adhering to the medicines instructions specified in the personal care plan.

Service providers should have mechanisms for reporting incidents originating from other parts of the system, such as errors from GPs or pharmacies, or issues arising during hospital discharge. This includes internal procedures for staff to report these matters to their employers, as well as statutory sector procedures that enable providers to report incidents outside of their organisations.

Promoting joint working and instilling a culture of continuous learning and improvement across various sectors is essential for elevating the standard of care delivery.

Near misses are crucial indicators of potential incidents. They should be formally examined and reported. All incidents, including near misses, should be documented as safety incidents, and reported, as necessary.

According to section 6.3 of the Code of Professional Practice for Social Care[34], and section 4 of the NHS Code of Conduct for Health Support Workers in Wales,

practitioners are expected to take responsibility for the quality of care they provide. This includes being transparent and forthright with individuals in the event of any incidents and providing a comprehensive and timely account to their employer or the appropriate authority, and adhering to the principles of the NHS Duty of Candour. Practitioners must communicate openly and honestly and promptly report any concerns or errors.

Similarly, unregistered support workers, like personal assistants and micro-care providers, who currently do not fall under regulatory mechanisms, should uphold the same duty of candour as all registered social care professionals regulated under Social Care Wales. This entails being open and honest, as well as demonstrating a willingness to reflect upon and learn from any mistakes.

15.1 Reporting adverse effects

To enhance understanding of potential adverse effects associated with commonly used medicines, care support staff should refer to authoritative sources like the British National Formulary (BNF)[35], Summary of Product Characteristics (SPC), and Patient Information Leaflet (PIL),[36] which is the instruction provided within the medicines box.

Suspected adverse effects should be promptly reported to the prescriber and documented in the personal plan. Individuals receiving care and care practitioners are encouraged to report these effects to the Medicines and Healthcare Products Regulatory Agency through the Yellow Card Scheme[37], with further action being guided by a healthcare professional.

16.0 Safety alerts and information

Providers should collaborate with healthcare professionals, including pharmacy teams and GPs, to ensure the safe and effective use of medicines. Valuable advice and assistance can be obtained from the local community pharmacy or the pharmacy that dispensed the medicines, with the pharmacy's contact information provided on the medicines label. Service providers should also have access to pertinent medicines resources, such as current patient information leaflets. Furthermore, complimentary digital access to the updated BNF[35] and BNF for Children[38] is readily available.

Providers are obligated to adhere to pertinent safety alerts and patient safety notices issued by the Welsh Government to ensure patient well-being.

17.0 Audit

Care providers should establish robust systems for ongoing oversight and periodic audits of medicines management to ensure patient safety and regulatory compliance. Refer to the AWMSG Care Home Medicines Optimisation Toolkit[11], which includes tools like the Care Home Audit Checklist and the In-house Monthly Medicines Review Tool, aiding in maintaining effective medicines practices and optimising care.

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