Medication Management
POLICY

Policy Name: Medication Management	Issue Date: September 2026	Version No: 9
Status: Approved	Next Review Date: September 2027	Page **1** of **25**

Policy Control/Monitoring

Approved by: **(Position in Organisation)** **Date (dd/mm/yyyy):**	Director of Education 04/09/2026
Accountability: **(Position in Organisation)**	Clinical Nurse Manager
Revision Cycle:	Annual
Brief details of amendments made	Condensed repeating information Added definitions Added Benedict's Law Added Dysphasia information

Equality Impact Assessment

The Foundation's commitment is to create a positive culture of respect for all staff and service users and to identify, remove or minimise risks of unlawful discrimination and disadvantage in its policies, functions and activities. As part of its development this document has been assessed in line with The Foundation's equality impact assessment procedure.

Version Control Tracker

Version Number	Date
V1	15/02/2021 – Section 4 principles and 4.7 Antipsychotic drugs added
V2	18/01/2022- Lead Nurse review
V3	07/02/2023- Lead Nurse review and update. Yellow bag and oxygen information added

Version Number	Date
V4	03/07/2023- Lead Nurse review. Information about ibuprofen added
V5	02/2024- Annual update. 4.1.8- amended to reference PHF Oxygen Policy removed 4.4.4- advice about out-of-date medication added
V6	30/04/2024- reviewed and asthma policy added
V7	6/06/2024- Asthma Policy removed and external review by Northeast Commissioning Support Medication Optimisation team
V8	25/06/2025- external review by Northeast Commissioning Support Medication Optimisation team
V8(a)	January 2026
V9	September 2026

1. Introduction

The safe, effective, and efficient management of medicines is central to the delivery of high-quality care within The Percy Hedley Foundation. This policy outlines the Foundation's commitment to safeguarding and promoting the welfare of every child, young person, and adult who accesses its services.

Individuals in our care may have long-term or complex medical needs requiring ongoing support, medications, and tailored care to help them manage their conditions. Others may require timely interventions in emergency situations. Recognising that health needs can evolve unpredictably; this policy supports regular review and adaptation of care plans.

The Foundation aims to foster confidence among parents, families, and carers by ensuring that all aspects of medication management are handled with professionalism, competence, and compassion. Providing a safe environment and effective medical support is a key priority.

A person-centred, integrated approach underpins all care delivery. Where individuals lack the capacity to make decisions about their care, health and social care professionals will act in their best interests, in accordance with the principles of the Mental Capacity Act 2005. See Consent to Treatment Policy.

This policy provides comprehensive guidance on the safe handling, storage, administration, and disposal of medicines across all Foundation settings which evidences our compliance with statutory requirements and good practice standards in medicines management. It also ensures staff are equipped to meet a wide range of health needs while maintaining the highest standards of safety and accountability.

2. Purpose

The purpose of this Medication Policy is to define the overarching framework for the safe and effective management of medicines within The Percy Hedley Foundation. It sets out the principles of best practice and aligns with applicable legislation and regulatory standards to ensure lawful, consistent, and high-quality medicines management.

This policy supports the Foundation's duty of care to safeguard and promote the welfare of every child, young person, and adult using its services. By embedding clear standards, the policy helps minimise the risk of medication errors and ensures staff uphold a safe, person-centred approach in all aspects of care.

The policy is informed by the following key legislation and regulatory guidance:

- The Medicines Act 1968 https://www.legislation.gov.uk/ukpga/1968/67
- The Misuse of Drugs Act 1971 https://www.legislation.gov.uk/ukpga/1971/38
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – particularly Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) https://www.legislation.gov.uk/uksi/2014/2936/contents/made
- The Mental Capacity Act 2005 https://www.legislation.gov.uk/ukpga/2005/9/contents
- CQC Guidance on Medicines Management
- https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-administration-records-mar-charts

This framework ensures that the Foundation's medication practices meet the standards required by law and regulators, while supporting staff in delivering safe, respectful, and person-centred care.

3. Scope

This Medication Policy applies to all employees, bank and agency staff, and parents or carers who are involved in the administration of medicines within any of The Percy Hedley Foundation's services.

The policy provides the overarching framework for medicines management but does not cover the prescribing or dispensing of medicines, which fall outside the responsibilities of Foundation staff.

Staff are only permitted to carry out aspects of medicine management for which they have received appropriate training and have demonstrated the required level of competency. No employee or carer should undertake tasks related to medication administration unless they have been trained and assessed as competent to do so.

In addition to this policy, each individual service within the Foundation must refer to and follow its own local procedures document, which sets out the specific operational processes relevant to that setting.

4. Definitions

To ensure clarity and consistency in the application of this policy, the following definitions apply:

- **Medication/Medicines:** Substances used to prevent or treat disease, relieve symptoms, or manage medical conditions. This includes prescription medications, over-the-counter (OTC) medicines, controlled drugs, nutritional supplements, and topical preparations.
- **Administration of Medication:** The process of giving a medicine to an individual, either by staff or carers, in accordance with the prescribed instructions.
- **Prescribing:** The legal process of authorising the supply of a medicine, undertaken by a qualified prescriber (e.g., GP, nurse prescriber). Prescribing is outside the scope of this policy.
- **Dispensing:** The preparation and supply of a medicine by a registered pharmacist or pharmacy technician. Dispensing is **outside the scope of this policy**.
- **Competency:** The demonstrated ability of a staff member to carry out tasks related to medicine management safely and correctly, following completion of appropriate training and assessment.
- **Controlled Drugs (CDs):** Medicines that are subject to specific legal controls under the Misuse of Drugs Act 1971 due to their potential for misuse and dependence.
- **PRN Medication:** “Pro re nata” (as needed) medication, which is not taken routinely but administered when required to manage specific symptoms (e.g., pain relief, anxiety).
- **MAR Chart (Medication Administration Record):** A document used to record the administration of medicines to individuals, ensuring accountability and continuity of care.
- **Person-Centred Care:** An approach that respects and values the individuality of the person receiving care, and supports their choices, dignity, and preferences in managing their health.
- **Mental Capacity:** The ability of an individual to make decisions about their care and treatment. If a person lacks capacity, decisions must be made in their best interests in line with the Mental Capacity Act 2005.
- **Safe Handling of Medication:** The process of managing medicines in a way that ensures they are received, stored, prepared, administered, recorded, and disposed of in accordance with legal, regulatory, and organisational requirements. This includes preventing errors, maintaining hygiene and security, ensuring the correct medication is given to the right person at the right time and dose, and reducing the risk of harm to individuals and staff.
- **Transcribing:** A trained individual who can copy a prescription from a doctor or pharmacist onto a MAR chart to be used within the foundation.

5. Principles

The principles outlined in this policy are intended to promote a culture that supports the safe, effective, and accountable management and administration of medicines across all services within The Percy Hedley Foundation.

These principles apply to all activities involving medicines and form the foundation for consistent and high-quality practice. They ensure that medicines are managed in a way that prioritises the safety, dignity, and well-being of individuals, while also protecting staff and the organisation.

5.1 Prescription Medication

Medications administered within the Percy Hedley Foundation must be prescribed by a healthcare professional. In certain circumstances over the counter medications can be given (see 5.2), but these must undergo different checks.

Prescribed medications must arrive and be stored in their original packaging or pharmacy container, with attached pharmacy label which includes the prescribers' instructions and two forms of identification verification i.e name and date of birth or address.

Medication must only be administered to students/service users for who it has been prescribed.

Medication should not be prepared ahead of time; this is supported by best practice guidance and minimises errors.

If a change has been made by the prescriber written confirmation must be obtained of this change. It is not always possible to get a new label for the medication on site, in which case the written confirmation of the change should be stored in both the individuals file and with the medication. This change should also be marked on the MAR.

In certain circumstances when an immediate change is required verbal instructions can be used. These must be clearly documented by the individual receiving the instructions and written confirmation should follow from the prescriber.

The state of medications should not be altered without prior authorisation. This includes crushing tablets or opening capsules.

Oxygen is a prescribed medication and should be stored and administered with the same considerations as any other prescribed medication.

5.2 Over the Counter Prescription Medications

As a foundation we recognise that some students/service users may also use herbal remedies and supplements to support their health. When appropriate students and service users will be supported to access these.

A limited range of non-prescribed (over-the-counter) medicines may be administered within The Percy Hedley Foundation at the discretion of the Nursing Team, Head of Service, or Registered Manager, these will be administered following regulatory advice from the CQC and other relevant professional bodies.

Based on assessed individual need and on the advice of a healthcare professional, the Foundation may consider the administration of non-prescribed medicines. Evidence of such advice should be retained to support staff in safely using these medicines or preparations.

Each request for the use of non-prescribed medication must be evaluated for everyone, considering the person's health status and current prescribed medications.

The administration of non-prescribed medicines must be managed with the same level of control, documentation, and accountability as prescribed medications.

Consent and clinical advice to administer non-prescribed medicines must be obtained via written or emailed confirmation from a relevant party, this may include: A prescribing GP or consultant, a registered healthcare professional, the individual themselves or next of kin, where appropriate. Consent must be documented on the appropriate systems used in each service.

Non-prescribed medicines must only be administered to the individual for whom they were supplied.

Detailed records must be maintained for the purchase, administration, and disposal of all non-prescribed medicines. These records should be clearly documented in: The individual's Medication Administration Record (MAR) chart, the relevant medication file, the individual's care plan.

The Percy Hedley Foundation does not support the use of CBD (Cannabidiol) products unless they are specifically prescribed by a qualified medical professional.

5.3 Storage of medication

Medicines must be stored at the correct temperature and must not be exposed to light in order maintain their effectiveness. Incorrect storage may render medications ineffective or unsafe, resulting in poor care outcomes or unnecessary waste.

To ensure secure handling of medication, keys to medication storage areas must be kept in a designated key safe. All staff share responsibility for the appropriate management and security of these keys.

Drug cupboard keys must be stored together, separate from all other keys, and clearly identifiable, such as by using a coloured tag or label.

All medicines must be stored in a designated, dry, and secure locked room or cabinet, with the room temperature monitored regularly and not exceeding 25°C. The storage setup must include:

- Lockable cupboards for general medicines
- Separate lockable storage for Controlled Drugs, in accordance with the *Misuse of Drugs (Safe Custody) Regulations 1973* (applicable to care homes only): Misuse of Drugs (Safe Custody) Regulations 1973
- Refrigerated storage for temperature-sensitive medicines

Upon admission or receipt, all medications must be checked in and accurately documented.

All boxed medications must be opened and checked to ensure the supplied quantity matches the label and prescription information. Any discrepancies must be identified and addressed immediately.

The medication storage area must be clean, well-maintained, and compliant with infection prevention and control standards.

A handwashing facility must be located nearby, including a sink with liquid hand soap and disposable paper towels or a hand dryer, to support hygiene during medication handling.

External-use medicines (e.g. creams, lotions) must be stored separately, labelled, using a dedicated box or shelf to avoid cross-contamination and ensure safe handling.

5.4 Record Keeping

All documents relating to medications must be:

- Kept securely in locked storage or password protected systems.
- Maintained in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, CQC guidance, and Data Protection Act 2018
- Retained for a minimum of 2 years after which they must be securely destroyed.

MAR charts and CD books must be filled out at the time of administering the medication. If the medication cannot be administered the correct key code must be used to document this and nurses/managers informed when appropriate.

5.5 Best Practice Standards for Medication Documentation

The following standards must be consistently applied to all written or electronic records:

- Entries must be legible, unambiguous, and written in permanent ink if on paper
- The medication name, dose, and route must be clearly recorded
- Milligram (mg) or other appropriate units must be used; avoid vague terms like "1 tablet" unless tablet strength is clearly stated
- The route of administration (e.g. oral, inhaled, topical) must be written in full
- The 24-hour clock must be used for all times of administration
- If a mistake is made, it must be clearly crossed through with a single line, dated and signed, with no attempt to obscure or erase
- Correction fluid must never be used

Accurate and well-maintained records serve the following functions:

- Provide a clear chronology of medication administration and clinical decisions
- Demonstrate the individual's response to treatment
- Support safe handover and continuity of care
- Provide evidence in the event of clinical reviews, complaints, investigations, or safeguarding concerns
- Meet the standards required by CQC, professional regulators, and legal processes

5.6 Safe and Timely Administration of Medicines

Timely administration of medication is critical to ensure effectiveness and safety. Staff must follow the exact instructions on the prescription, including timing and dosage. These details must be clearly documented in the individual's Health Care Plan and on their Medication Administration Record (MAR).

Managers must ensure that all staff authorised to administer medication complete a Medication Administration Staff Signature/Initials Sheet, which is held on each site and updated as required.

Managers must maintain accurate records of all staff who have completed approved medication administration training. This includes retaining copies of: Training certificates (where applicable), Completed Medicines Management Competency Assessments

Medicines must never be used beyond their expiry date, as they may become unsafe or lose effectiveness. Staff must always check expiry dates before administering medication. Expiry dates are printed on the packaging and may appear as:

"Expiry date: July 2024" means do not use after 31 July 2024 "Use by: July 2024" means do not use after 30 June 2024

Some medicines carry shortened expiry dates once opened. This will be specified on the medication label or in the Patient Information Leaflet (PIL). For example: Use withing 28 days of opening. If this is stated bottles must have an open date written on them by staff. If opened at home, family/carers should be contacted for this information.

Where a pharmacist's instruction includes additional expiry limitations (e.g. "discard 7 days after opening"), staff must adhere to these directions. Any remaining medicine after this period must be returned to the pharmacy/home for safe disposal. Responsibility for this lies with the individual, parent/carer, or designated staff member.

Expired or unused medication must be sent home or to a pharmacy for appropriate disposal.

5.7 Self-Administration of Medication

Individuals in both adult and children's services may request to self-administer their medication, or this may be requested on their behalf by a parent or carer. In line with person-centred care and promoting independence, the Percy Hedley Foundation supports self-administration where it is safe and appropriate to do so.

Before any self-administration is authorised, a personalised risk assessment must be completed and stored within the individual's file. This assessment will evaluate: The individual's mental capacity, in accordance with the Mental Capacity Act 2005, and the individual's practical ability to manage and take their medication safely. We recognise that this may not be applicable to all the medications the individual requires. This should be documented on their individual risk assessments. Risk assessments must be reviewed regularly or with any change in circumstance.

Where the individual is a child or lacks capacity to make an informed decision, the risk assessment must be undertaken in consultation with the parent, carer, or appropriate healthcare professional, and decisions made in the individual's best interests.

Self-administration must only proceed once authorisation has been obtained from an appropriate healthcare professional.

Best practice and applicable legislation, including the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) and CQC guidance must be always followed to ensure the safe, respectful, and lawful implementation of self-administration in Foundation services.

5.8 Controlled Drugs

Controlled Drugs (CDs) are substances regulated under the Misuse of Drugs Act 1971 due to their potential for misuse, harm, and illegal distribution. It is a criminal offence to possess, supply, or administer controlled drugs without lawful authority.

Across the Percy Hedley Foundation we adhere to the strict legal and procedural requirements as stated for residential care homes. These must be followed for the ordering, receipt, storage, administration, and disposal of Controlled Drugs. This includes:

- The presence of two trained staff members to witness all activity related to CDs.
- Both staff must sign the Medication Administration Record (MAR) and the Controlled Drugs Register (where used, e.g. in care homes)
- All Controlled Drugs must be logged in a Controlled Drugs Register, which is a legally required, bound document with pre-numbered pages.
- Each CD for the individual must be recorded on a separate page.

The following events must be clearly recorded in both the MAR and the CD Register:

- Receipt of the drug
- Date and time of administration
- Any disposal or destruction
- Ongoing stock levels completed after each administration. (Any discrepancies must be reported immediately in line with safeguarding and medication incident procedures.)

Any incidents involving CDs should also be reported to the CD Accountable Officer: www.cdreporting.co.uk

Controlled Drugs must be stored in a locked, approved CD cabinet, compliant with the Misuse of Drugs (Safe Custody) Regulations 1973, and located within the designated secure medication storage area. Access must be restricted to authorised staff only.

5.9 Antipsychotic Drugs

Antipsychotic drugs are a class of psychotropic medicines commonly prescribed to manage behavioural and psychological symptoms such as aggression, agitation, delusions, or hallucinations. These symptoms may be present in individuals with dementia, mental health conditions, learning disabilities, or autism.

The Percy Hedley Foundation recognises that, while antipsychotic medicines can help maintain safety and stability in certain cases, they should not be the first or only approach. The Foundation supports strategies to reduce unnecessary use and promote safe, appropriate prescribing.

In alignment with national guidance, including STOMP (*Stopping Over-Medication of People with a Learning Disability, Autism, or Both*), the Foundation prioritises non-drug interventions such as recognising and treating pain, improving communication, enhancing environmental factors, and increasing social interaction without the immediate use of medication.

The Foundation requires that any individual prescribed antipsychotic medication has a robust STOMP Care and Action Plan, which must include: name of the medication, dosage, frequency, and clinical purpose

Where non-drug strategies are insufficient or symptoms are severe, the Foundation will seek advice and direction from qualified prescribing professionals, including GPs, pharmacists, NHS medical staff, or behavioural specialists, to determine the safest course of action.

Antipsychotic medication will only be used when clinically justified, with the informed involvement of the prescribing officer, and where a clear benefit outweighs the potential risk. Use will always be based on individualised assessment, in accordance with legal, ethical, and best practice standards.

5.10 Covert Medication

Covert medication refers to the concealed administration of prescribed medicines, typically hidden in food or drink, without the individual's knowledge, where they have refused medication and lack the capacity to make an informed decision about their treatment.

Covert administration must only be considered in exceptional circumstances, where:

- The individual has been assessed as lacking mental capacity to make decisions about their medication
- The medication is deemed essential to maintain the individual's health or safety.
- Non-covert alternatives (such as changing the medication form or approach) have been tried or ruled out.

Any decision to administer medication covertly must follow the principles of the Mental Capacity Act 2005, including:

- A documented capacity assessment, showing the individual lacks capacity for the specific decision
- A clearly documented best interests' decision, involving input from health professionals, the individual's family/carers (where appropriate), and their representative (e.g. advocate or attorney, if appointed)
- Written consent and guidance must be obtained from the prescribing professional or responsible clinician, confirming that covert administration is necessary and in the person's best interests
- The exact method of administration (e.g. whether the medication can be crushed or dissolved) has been verified by a pharmacist to ensure it remains safe and effective

That the decision aligns with local policies, CQC expectations, and NICE Quality Standard QS85 (Statement 6)

Where covert medication is used as part of managing behaviours of concern or distress, this must be in line with the individual's Positive Behaviour Support Plan and reviewed regularly with clinical input.

Covert medication must be regularly reviewed (e.g. 6 monthly or as clinically required) and discontinued as soon as it is no longer necessary. Reviews must involve the prescribing clinician, relevant health professionals, and, where possible, the individual and/or their advocate or carer.

Covert administration must never be used for staff convenience or as a substitute for proper engagement, support, or therapeutic interventions. It must be fully compliant with CQC regulations, safeguarding requirements, and ethical clinical practice.

5.11 Adverse Drug Reactions (ADRs)

If an individual becomes unwell or shows signs of an adverse reaction after taking any medication, staff must: Immediately seek clinical advice from the prescribing GP or NHS 111 (out of hours service)

In cases of severe or life-threatening reactions (e.g. anaphylaxis, difficulty breathing, seizures), call 999 immediately

As soon as the individual is safe and appropriate action has been taken, an incident report must be completed in line with the Foundation's accident/incident reporting procedures. The report should include: A detailed account of the event

- Medication involved
- Action taken
- Clinical advice received
- Any follow-up required

All suspected or confirmed adverse drug reactions must be reported to the prescribing healthcare professional (e.g. GP, consultant, pharmacist), who will advise on whether to stop or amend the medication. This communication must be recorded in the individual's care records.

Where appropriate, the reaction should also be reported through the Yellow Card Scheme, managed by the Medicines and Healthcare products Regulatory Agency (MHRA). This helps monitor the safety of medicines and vaccines in the UK.

CQC regulations and national best practice require that medication-related incidents are treated as safeguarding concerns where harm has occurred or there is a risk of harm. These must be escalated through the appropriate safeguarding and quality assurance channels within the Foundation.

5.12 Dysphagia and Medication

All medication given orally to a person with dysphagia should be given in compliance with the mealtime management plan (MMP). Do not use syringes to administer medicines to people with swallowing difficulties as this can increase the risk of aspiration.

Administration advice for liquid medications

- Liquid medications drawn up in a syringe and given from a spoon.
- Medication can be drawn up in a syringe to ensure accuracy but transferred onto the spoon.
- Follow MMP advice for administration guidance.
- Do not add thickener to liquid medication as the correct consistency cannot be achieved, and there may be an interaction between the thickener and medication.

Options for administration to people with swallowing difficulties

- Whole medicine administered with normal fluids (if SaLT advise this consistency is safe).
- Medicine (whole or crushed tablet/whole or opened capsule) administered with semi-solid or pureed food (depending on consistency required for the person). This is the preferred option for most people as it is the most palatable option. **Crushing tablets/opening capsules must be a pharmacy decision and this must be provided in writing.**
- Medicine (whole or crushed tablet/whole or opened capsule) administered with thickened fluid (to the appropriate level as advised by SaLT). Generally this is less palatable. There is also some limited evidence that thickened fluids can reduce the bioavailability of some medicines. **Crushing tablets/opening capsules must be a pharmacy decision and this must be provided in writing.**

Drug-thickener interactions (most common with starch-based thickeners)

- There is a known interaction between macrogol laxatives and starch-based thickeners which reverses the thickening effect and has caused choking and death. Nestle Resource Thicken-Up Clear is the most prescribed thickener which is xanthan gum-based and does not carry this risk.

Drug-food interactions

- Some medication should be given on an empty stomach to ensure the drug is well absorbed.
- Please see box and information leaflet for specific medication advice.

5.13 Medication Following a Death

In the event of a death, all involvement with the individual's medication must cease immediately. No medication should be administered or disposed of until official guidance is followed.

All of the deceased person's medications, associated documentation, and administration records (e.g. MAR charts) must be secured and left undisturbed for a minimum of 7 days, unless advised otherwise by a coroner or legal authority. Medications must be kept on site in a secure, locked cabinet.

They must not be removed from the premises by staff or given to family members.

A record must be made detailing the date and time of death, medications held, and secure storage location

Access to these items must be restricted and monitored.

In cases of sudden, unexpected, or unexplained death, the Coroner may request access to medications and accompanying records as part of an inquest. Therefore, all items must remain intact and available for review.

Documentation must include:

- A clear inventory of all medication held at the time of death
- Details of where the medicines and records are stored
- Any instructions received from emergency services, a GP, or other professionals involved

After the 7-day period and once formal investigations or inquests are complete, medications must be returned to a pharmacy for safe disposal, in accordance with the Foundation's medicines disposal policy and CQC guidance.

5.14 Disposal of Medication

Safe and appropriate disposal of medicines is essential to prevent harm, misuse, or environmental contamination. All medication that is no longer required, such as expired items, discontinued treatments, or surplus stock, must be disposed of in accordance with legal, regulatory, and professional standards.

The following actions must be followed for the safe disposal or return of medication:

- The date of disposal or return must be clearly recorded on the relevant Medication Signing
- Details recorded must include name of medication
- Quantity returned or disposed of
- Reason for disposal (for example, expired, discontinued, refused, deceased)
- Name and signature of the staff member handling the disposal
- Name of the receiving party (for example, pharmacist or parent or carer)

Medication must be returned to the pharmacy for safe disposal (preferred option), or the parent or carer

Medicines must never be disposed of in general waste or flushed down sinks or toilets, in accordance with environmental safety regulations and CQC expectations.

Controlled Drugs (CDs) must be disposed of in line with the Misuse of Drugs Regulations 2001 and guidance from the Royal Pharmaceutical Society. Disposal must be:

- Witnessed by two authorised staff members
- Recorded in the Controlled Drugs Register
- Returned to a pharmacy licensed to receive CDs, where applicable

Services must maintain an up-to-date medicines disposal log, which is subject to audit. Disposal procedures must form part of the local medication policy and be covered in staff training and supervision.

5.15 Emergency Care

All individuals who require emergency care planning must have this clearly outlined in their GP or Consultant reports. These must be reviewed and agreed in collaboration with the individual, their parent or carer, and should include details such as:

- Known medical conditions
- Triggers or warning signs for emergency episodes (e.g. seizures, asthma attacks)
- Emergency protocols or medications
- Preferred hospital for non-emergency admissions

In the event of a medical emergency where 999 is called, the hospital destination will be determined by the attending emergency medical personnel, based on clinical need, location, and availability.

A consent form for emergency care and routine health checks must be completed annually, signed by the individual (where appropriate) or their legal representative, and stored in the individual's main file. This form must accompany any NHS-approved emergency care plans, including:

- Seizure Management Plans
- Asthma Action Plans
- Allergy or anaphylaxis protocols

For individuals who access Foundation services from home or non-residential settings, admission to the service cannot be permitted if:

- The emergency medication is missing
- The yellow bag is not present
- The medication is expired, damaged, or does not match the current prescription

If these events occur families should be contacted to bring in this medication.

The date of the most recent emergency medication administration must be recorded in the individual's health records, Hospital Passport and referenced in the Care Plan.

Original documents must be readily accessible on site and accompany the individual when appropriate.

Responsibility for ensuring emergency medication is present, accurate, and in-date is shared as follows:

- Parents or carers must ensure the individual leaves home with the correct medication
- Escorts or transport staff must ensure the medication is present during transit
- The Percy Hedley Foundation is responsible for confirming medication is present, in date, stored correctly, and leaves the premises with the individual.

This process aligns with CQC Fundamental Standards (Regulation 12: Safe Care and Treatment), which requires that all medication is managed safely and available when needed. It also supports obligations under the Health and Safety at Work Act 1974 and Children and Families Act 2014, ensuring individuals with medical needs receive the appropriate care and support in all settings.

Across education sites spare EpiPens can now be stored on site and used for school trips, under Benedicts Law. These can be administered to any child who is believed to be in anaphylaxis. The child does not require a diagnosis of an allergy for this to be administered. The spare EpiPens should not be locked away, be in a secure central location but kept out of reach of children.

5.16 Medication Errors

Medication errors are defined as any preventable event that may cause or lead to inappropriate medication use or patient harm. All medication incidents must be taken seriously, reported promptly, and handled in accordance with The Percy Hedley Foundation's safeguarding, clinical governance, and disciplinary procedures.

If a medication error occurs the following should be followed:

Missed medication

- If a dose is missed, either because the individual forgot or staff omitted administration, this must be reported to senior staff, and clinical advice must be sought immediately (e.g. contacting the prescribing GP or NHS 111).
- Parents/carers must be informed by phone. If the medication has been completely missed, a written explanation must be provided in addition to verbal contact.
- An incident report or safeguarding referral must be completed in accordance with Foundation procedures.
- A full internal investigation will be carried out by the Registered Manager or Senior Leadership Team, supported by the Student Welfare and Family Liaison Officer (or equivalent) and Human Resources.

- If safeguarding concerns arise, the Designated Safeguarding Lead (DSL) will escalate the matter to the relevant local authority safeguarding team.

Lost or missing medication

- Lost or Missing Medication All medication must be signed in and out of storage (fridge, cupboard, building) using the designated logs.
- If medication is discovered to be missing, misplaced, or lost, staff must carry out an immediate and thorough search.
- If the medication cannot be located, the incident must be reported to the Service Manager, and an incident report must be filed.
- If there is any indication of theft or foul play, the matter must be reported to the police, and the CQC and safeguarding authorities informed as appropriate.
- Controlled drugs must follow statutory incident reporting and destruction protocols in line with the Misuse of Drugs Regulations 2001.

Medication given incorrectly (wrong person, route, time, dose)

- Immediately assess the individual for harm or adverse effects.
- Seek clinical advice without delay from the individual's GP, NHS 111, or emergency
- Notify the Service Management Team.
- Inform parents/carers promptly by phone.
- A senior member of staff will be appointed as investigator.

When a medication error occurs the following internal process will happen.

- The staff member(s) involved will be temporarily suspended from medication duties pending investigation.

- The investigator, with HR support, will compile a comprehensive incident report, including written statements from involved staff
- Timeline of events
- Contributing factors
- Root cause analysis
- A conclusion and recommendations will be submitted to the Service Manager.
- Where appropriate, the disciplinary procedure may be initiated.
- Safeguarding teams and regulators (e.g. CQC) will be notified as required.
- The entire staff team may receive a refresher or lesson-learned briefing to prevent recurrence.
- Staff involved may be required to complete retraining and reassessment before resuming medication duties. 5.13.5 Legal and Regulatory Framework This section complies with: The Medicines Act 1968
- The Misuse of Drugs Regulations 2001

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 12: Safe care and treatment
- CQC Guidance: Managing medicines in care homes and community settings
- NMC Standards for Medicines Management (where nursing staff are involved)
- The Duty of Candour (Regulation 20) – Full transparency with families and professionals following significant incidents

6. Monitoring and Compliance

The Percy Hedley Foundation is committed to ensuring that all staff involved in medication handling, administration, and support receive training appropriate to their role, responsibilities, and regulatory requirements.

The Foundation's Organisational Development Team supports the planning, delivery, and monitoring of training in line with CQC Fundamental Standards, Skills for Care Core and Mandatory Training Framework, and other sector-specific guidance.

Line managers are responsible for identifying individual training needs during supervision, annual appraisal, or as part of induction. Mandatory and statutory training must be scheduled and reviewed regularly to ensure compliance and up-to-date practice.

6.1 Medication Training

All new staff will receive foundation-level training in medication awareness and handling during their induction period. Ongoing training will be provided to support the development of confidence, competence, and professional accountability in line with the staff member's role. It is recommended that new staff do not administer or sign for medication during their probationary period to allow them to become comfortable in the environment and with the students.

Where a new staff member presents with prior training in medication handling, a local competence assessment must still be carried out before they are authorised to administer or manage medication. Certification alone is not sufficient.

Staff must complete either: An internally approved Safe Administration of Medication training programme, or a nationally recognised Level 2 qualification in the Safe Handling of Medicines.

Core medication training must include the following elements:

- Legal and regulatory requirements for supply, storage, and disposal of medicines
- Safe administration techniques, including infection control and hygiene standards

- Record keeping, documentation standards, and use of Medication Administration Records (MAR)
- Understanding of accountability, duty of care, and confidentiality
- Safe handling of non-prescribed, over-the-counter, and PRN medications

Where staff are required to administer specialist or complex medications, they must also complete additional training delivered by an appropriately qualified clinician (e.g. NHS professional or nurse on site). This includes (but is not limited to):

- Administration of emergency seizure medication (e.g. Midazolam)
- Medication via PEG (Percutaneous Endoscopic Gastrostomy)
- Use of controlled drugs (CDs)
- Management of diabetes, insulin injections, or other condition-specific treatments

Staff must successfully complete a competency assessment after they have completed the required medication training course. This confirms their readiness to safely manage and administer medicines in practice.

Competency assessments must be conducted using recognised NHS or Skills for Care competency tools. Each staff member must be observed on at least three separate occasions by a trained assessor before being signed off as competent.

Only upon successful completion of the assessment process may a staff member independently administer or manage medications, with the exception of emergency medications.

All staff, including those not directly administering medication, must complete awareness training covering: Types and categories of medication

- Administration processes and safety
- Signs of adverse drug reactions
- Reporting responsibilities under the Duty of Candour

Competency will be reviewed annually through formal reassessment by a trained assessor, and on an ad hoc basis through peer observation or clinical supervision.

Where a medication error has occurred, the staff member involved will have their competency reassessed by a Service Manager or PHF Nurse following the conclusion of the investigation.

If a staff member demonstrates a lack of confidence or capability to administer medicines safely, their competency must be re-evaluated promptly and additional support or retraining offered.

Staff cannot decline a competency review by a Service Manager or PHF Nurse. These assessments form part of the Foundation’s quality assurance framework and professional standards.

In some services operating under an NHS contract or local agreement, competency assessments may be carried out by an NHS pharmacist or healthcare professional in line with local schedules and service specifications.

6.2 Emergency Medication Training

Emergency medication training will differ between sites due to different CQC and OFSTED regulations. Please see the procedures for site specific emergency medication training.

Staff must receive condition-specific training in the recognition of the medical emergency and the safe administration of the relevant emergency medication. Training must include practical instruction, an assessment of competence where appropriate, and regular updates in line with Foundation policy and the manufacturer's guidance.

Only staff who have completed the required condition-specific training can administer emergency medication and support the students/service users who may require this. The Foundation will ensure that appropriate training, and ongoing support are available to staff who may be required to undertake this role.

6.3 Compliance

The Percy Hedley Foundation is committed to ensuring that all aspects of medicines management are carried out in accordance with legal, regulatory, and professional standards. Ongoing monitoring and compliance are essential to safeguarding individuals and delivering high-quality, safe care.

Compliance with this medication policy will be monitored through a combination of:

- Internal audits of medication records, storage, and administration practices
- Spot checks and peer reviews by trained staff or managers
- Supervision and competency observations
- Medication audits conducted by Registered Managers or the PHF Nursing Team
- Regular review of incident, error, and near-miss reports

Audit findings will be used to:

- Identify trends and risks
- Improve practice through training, feedback, or policy review
- Address non-compliance through individual supervision, retraining, or formal procedures where necessary
- Inform action plans for service improvement

Medication policies and procedures will be reviewed annually or sooner in response to:

- Changes in legislation, NICE guidance, or CQC requirements
- Identified risks, incidents, or concerns
- Changes to clinical or operational practice

Service Managers and Nurses are responsible for ensuring:

- All staff are familiar with and follow this policy
- Audits and spot checks are completed to schedule
- Any deviation from policy is reported, investigated, and addressed

Compliance with this policy will also be reviewed through:

- CQC inspections and Key Questions
- Local Authority checks
- Ofsted regulations
- Contract monitoring visits by commissioning authorities
- Reviews by external professionals (e.g. pharmacists, NHS partners)

Failure to comply with the medication policy may result in:

- Additional supervision or retraining
- Restriction from medication handling duties
- Disciplinary action in accordance with the Foundation's HR procedures

7. Associated Policies and References

This Medication Policy must be read in conjunction with the following related policies, procedures, and guidance documents used across The Percy Hedley Foundation. Together, they support safe, lawful, and effective care:

Internal Foundation Policies

- Safeguarding Children and Safeguarding Adults Policy
- Infection Prevention and Control Policy
- Incident Reporting Policy
- Positive Behaviour Support and Restrictive Practice Policy
- Health and Safety Policy

- Mental Capacity and Consent Policy
- Record Keeping and Confidentiality Policy
- Equality, Diversity and Inclusion Policy
- Training and Development Policy Relevant External Guidance and Legislation
- The Medicines Act 1968
- Misuse of Drugs Act 1971 & Misuse of Drugs Regulations 2001
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Mental Capacity Act 2005
- Children and Families Act 2014
- NICE Guidance (e.g. QS85: Covert Medicines Administration)
- CQC Guidance on Managing Medicines in Care Homes and Community Settings
- Royal Pharmaceutical Society: The Handling of Medicines in Social Care
- NMC Standards for Medicines Management (for nursing staff)
- Department of Health and Social Care Guidance on Over-the-Counter Medicines
- NHS STOMP/STAMP Frameworks (psychotropic medicines use)
- Benedicts Law
- https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-administration-records-mar-charts
- Guideline for the Management of Medication in Patients with Swallowing Difficulties