

# Medicines Management Issues in Domiciliary Care

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Produced by the Medicines Management Team

## Sharing learning from medication incidents and frequent questions

These bulletins can be found <http://www.cambscommunityservices.nhs.uk/Publications/Cambridgeshire/tabid/1564/language/en-US/Default.aspx> and on the Trust Intranet under [Incident Bulletins and Medicines Snippets](#)

### Medicines left out for the service user to take later (prepared)! – a reminder

It is very important that any decision to 'prepare' medicines for a service user to take themselves later is made by a senior member of staff, fully risk assessed, and described in the care plan.

**Care staff must not take this upon themselves!**

**See Paragraph 6.2 of the Domiciliary Medicines Policy and Sept. Bulletin**

### Warfarin – TAKE CARE!

- Dose varies according to blood test results (INR)
- Check you have the latest instructions
- The dose is always expressed in milligrams (mg) – not in number of tablets
- May need a combination of strengths to achieve the dose, e.g. a 4mg dose may be given as (four x 1mg tablets) OR as (one x 3mg and one x 1mg tablet)
- Always record the dose given on the MAR chart
- Is given once daily, usually at tea-time
- Be aware of when the next blood test is due. If it is delayed please raise the question with the GP, in case it has been overlooked.

**Click on this link for further information: [Frequently Asked Questions](#)**

### Do you really need a Monitored Dosage System? (E.g. Nomad, 'dosette box')

Incidents involving Monitored Dosage Systems (MDS) are widespread across the Trust.

In Luton alone there were 25 incidents reported in the last 4 months with Nomad systems. Examples include:

- Incorrect contents due to a change in medication or dose
- Medicines omitted from MDS
- Supply of the same medicine in the MDS and in an individually labelled container resulting in double doses
- Confusion between old and new boxes
- Doses being taken from the MDS by the patient but also given by the carer from a MAR chart
- MDS and MAR charts that don't match
- Medicines that had deteriorated in the MDS device spoiling the other medication.

**Patients with MAR charts should not have an MDS as well. Carers are trained to administer medicines from the individual labelled containers.**

**MDS should only be used when the risks and benefits have been assessed and it is essential for the patient to have one to enable them to self-administer their medicines safely.**

### Oxygen

Assistance with oxygen is level 3.

This means that staff need to have specialist training before they should be permitted to give this assistance, to ensure they are aware of potential problems.

**BOC provide homecare oxygen to patients in the East of England, and staff training can be arranged by contacting them on 0800 136603 or by email to [healthcare.home-uk@boc.com](mailto:healthcare.home-uk@boc.com). BOC do not provide their own training certificates, but the trainer would be willing to sign a form for the attendee to confirm attendance.**

**Cambridgeshire County Council's training adviser is arranging bespoke sessions for care providers, details to be circulated soon. Please contact [Kerry.connelly@cambridgeshire.gov.uk](mailto:Kerry.connelly@cambridgeshire.gov.uk) for further information.**