DELEGATED TASKS AND MEDICINES POLICY

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DELEGATED TASKS AND MEDICINES POLICY

PART A:

1 PURPOSE

1.1 This policy has been designed to encourage Somerset Health & Social Care staff, employed, self-employed (including Micro-providers) and/or family and friends who are currently engaged in the delivery of health and social care to reflect collaboratively on tasks proposed for delegation to non-registered staff (NRS) to ensure persons receive safe and effective care from the most appropriate person. Partner organisations may have their own delegation policies which may need to be considered in line with this policy.

This Policy covers the care arrangements for adults (aged 18 and over)

This policy has therefore been developed to help clarify the delegation process for registered practitioners and NRS and the associated issues of accountability and supervision.

This policy does not cover care delegation to unpaid carers, family or friends.

This policy provides clarity on the key issues relating to delegation of care from employed registered professionals to third party individuals who are not employed by Somerset Foundation Trust. This will provide assurance that delegation is always undertaken within the clear parameters of safe delegation as stated by the Nursing and Midwifery Council (NMC).

This policy document is endorsed by Somerset Council, Somerset Integrated Care Board (ICB) and Somerset Foundation Trust (SFT) and is recommended for use by Health and Social care practitioners and providers. It has been further supplemented by Care Quality Commission (CQC) guidance for adult social care providers.

2 LEGISLATION

2.1 Registered professionals have a duty of care and a legal liability with regards to the person. For example, there are only certain tasks that nurses can delegate, if a nurse has delegated an activity, they must ensure that is has been appropriately delegated (RCN 2017, NMC professionals & responsibilities 2018).

The person in overall charge of the nursing care of the person is usually the registered nurse however, when any commissioner is setting up or reviewing care arrangements, they need to clearly identify who is delegating and to whom. The registered professional cannot perform every intervention or activity for every individual and therefore there will be times that they will need to delegate aspects of care to trained and competent colleagues.

2.2 The principles of accountability and delegation explained in this policy can be applied to registered professionals including registered nurses and nursing associate.

The NMC Code sets out expectations of people on NMC register when they delegate to others. These requirements apply, regardless of who the activity is being delegated to.

This may be another registered professional, a non-registered colleague, or a person or carer (NMC 2018).

3 DEFINITIONS

3.1 **Non-registered Staff (NRS)**
There is currently no national policy that determines a single name for this group of workers. Numerous titles exist to reflect the many and varied roles carried out. For the purposes of this policy the term non- registered staff 'NRS' describes the third-party worker who has a role or task delegated to them. This may include unskilled carers, relatives or other individuals identified by the service user and/or their family. This can be either private employment, self-employment or through an independent contractor.

3.2 **Registered Practitioner**
This is the professional who is on a register for that particular profession, the Health and Care Professions Council (HCPC) or the Nursing and Midwifery Council (NMC) including Registered Nursing Associates.

3.3 **Delegation and Accountability**
Delegation is the process by which the delegator allocates clinical or nonclinical treatment or care to a competent person (the delegate). The delegator will remain responsible for the overall management of the service user, and accountable for the decision to delegate. The delegator will not be accountable for the decisions and actions of the delegate. (NLIAH 2010)

The registered practitioner is accountable for delegating the task and the NRS is accountable for accepting the delegated task, as well as being responsible for his/her actions in carrying it out.

4 DUTIES

4.1 Registered professionals are regulated within statute and are accountable to their regulatory body- i.e. Nursing and Midwifery Council (NMC) for nurses, midwives, and health visitors and, Health and Care Professions Council (HCPC) for physiotherapists, dieticians, and speech and language therapists, Paramedics and so on.

The NMC's The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (NMC 2015), with regards to delegation states in the section 'Practice Effectively' that the registrants must:

"Be accountable for your decision to delegate tasks and duties to other people, to achieve this you must: only delegate tasks and duties that are within the other persons scope of competence makings sure that they fully understand your instructions. Makes sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care and confirm that the outcome of any task you have delegated to someone else meets the required standard."

Although NRS are not currently regulated by statute they remain accountable for their actions in several ways, including:

- To the service user / person / client – civil law (duty of care). The NRS is accountable for their actions and omissions when they can reasonably foresee that they would be likely to injure people, or cause further discomfort or harm, e.g. If an NRS failed to report that a person had fallen out of bed.
- to the public – criminal law e.g. If an NRS were to physically assault a person, then they would be held accountable and could be prosecuted under criminal law, as well as being in breach of their contract of employment.

Employers have responsibilities, too, and as NRS develop and extend their roles the employer must ensure that its staff are trained and supervised properly until they can demonstrate competences in their new roles. NRS are required to be accountable by making sure they can answer for their actions or omissions. Employers accept 'vicarious liability' for their employees. This means that provided that the employee is working within their sphere of competence and in connection with their employment, the employer is also accountable for their actions.

5 PRINCIPLES OF DELEGATION

5.1 The delegation of skilled, specific care interventions must always take place in the best interests of the service user that the professional is caring for and the decision to delegate must always be based on an assessment of their individual needs.

Every delegation has to be safe; the primary motivation for delegation should be to meet the health and social care needs of the service user.

The registered practitioner is responsible for the service user's involvement in the assessment of care and developing a personalised care plan.

Appropriate assessment, planning, implementation and evaluation of the delegated role must be complete and documented.
The NRS delegated to undertake a task must be in an appropriate role or relationship, with the right level of experience and competence to carry it out.

Registered practitioners must not delegate tasks and responsibilities to an NRS that are beyond their level of skill and experience.

The task to be delegated must be discussed and both the delegator and the NRS should feel confident about the decision before the delegated task is carried out.

The NRS must feel able to decline to accept a delegation if they consider it to be inappropriate, unsafe or that they lack the necessary competency. Supervision and feedback must be provided appropriate to the task being delegated. This will be based on the recorded knowledge and competence of the NRS, the needs of the service user, the service setting and the tasks assigned.

The delegator must either ensure that NRS have the competencies required to carry out any tasks required or alternatively provide training to ensure the competencies required are met by the NRS. The delegator is also strongly advised to keep their own record of training using a competency assessment tool. The delegator should also review their job description with their line manager as part of their annual appraisal process.

All staff, SFT staff or members of the care support team – including agency staff, self-employed care workers or directly employed individuals have a responsibility to intervene if they consider any delegated task to be unsafe.

An NRS must be aware of the extent of their expertise at all times and seek support from available sources when appropriate. Delegated healthcare activities

Documentation, including the details of the task and delegation is completed by the appropriate person and within protocols and professional standards and codes of practice.

The delegation to the NRS must always be for the individual named service user only.

Existing national and local policies as set out by the registered practitioner must be used.

Where a third party (such as an employer) has the authority to delegate an aspect of care, the employer becomes accountable for that delegation. The registered practitioner will however continue to carry responsibility to intervene if they feel that the proposed delegation is inappropriate or unsafe. The employer will also be responsible for organising any training with the agreement of the registered practitioner in an appropriate and reasonable manner.

The decision whether or not to delegate an aspect of care and to transfer and / or to rescind delegation is the sole responsibility of the registered practitioner and is based on their professional judgment.

The registered practitioner has the right to decline to delegate if they believe that it would be unsafe to do so or if they are unable to provide or ensure adequate supervision.

The decision to delegate is either made by the registered practitioner or the employer. To ensure the details of the delegation are captured, the registered practitioner or employer can complete a risk assessment/care plan or document the details in the commissioning care arrangements.

5.2 Deciding on Delegation

See Appendix 2a/2b Decision Matrices and Descriptors

Delegation of activity is determined in the context of the relationship that exists between the person who delegates and the person to whom some aspect of practice is delegated. A number of factors have been identified that are significant for those who delegate tasks when deciding on whether to pass a task on to an NRS, and the person who is responsible for the decision to delegate should follow the decision-making flow-chart contained in:

Appendix 2a if they are in any doubt as to the appropriate decision-making process to be followed.

A personalised assessment of the service users' needs should be carried out and documented by the registered professional and should include:

- Mental capacity
- The use of contracts
- Costs and funding / direct payments
- Risk assessment
- Health and social care needs assessment

5.3 Consent

Service users are becoming increasing sophisticated in making choices about the healthcare they receive. Raised expectations amongst the public influenced through access to the internet and also by initiatives such as the expert person programme, personal budgets, and development of clinical and service targets, etc., encourage service users to exercise greater control and choice.

Service users have the right to know who is treating them and expect that those who provide care are knowledgeable and competent.

In many circumstances consent would be inferred by co-operation with the task being performed. Consent would be required in circumstances where the delegation itself might pose a potential risk, albeit that the delegation remains should be aware of and agree to the training, assessment and task delegated.

All organisations are required to have a Consent Policy in place and all staff should familiarise themselves with and comply with the terms of the Consent Policy.

In situations where consent (to accept the task being performed by a delegated person) of patient should be sought, then capacity must of course be considered.

5.4 Mental Capacity

Under the terms of the Mental Capacity Act 2005; Where it is identified that the service user lacks mental capacity to decide that an NRS can undertake the specific task for them, then the healthcare professional delegating is responsible for ensuring that a discussion has been held with family (and / or those individuals who are deemed to have responsibility for the care of the service user) of the service user and that a decision is made in the service users best interest. A Record of Assessment of Mental Capacity and Determination of Best Interest must be completed and held in the relevant person records.
Assessment of Capacity must only be undertaken where there are doubts about an individual's capacity to make a specific decision or to consent to a specific decision. Ensure that the following principles from the Mental Capacity Act are followed:

- A person must be assumed to have capacity UNLESS it is proved otherwise.
- A person must not be treated as unable to make a decision unless ALL practicable steps to help him / her have been taken without success.
- An unwise decision does NOT in itself indicate a lack of capacity.

- If the person is without friends or family who are unable to advocate for them, referral to an IMCA (Independent Mental Capacity Advocate) should be made.

A consent form could be completed before the task is delegated and the delegator must ensure this is evident in the service user's notes. Appropriate individuals who may be deemed to have responsibility for the care of a service user can include:

- care agency or home manager.
- social worker; or General Practitioner
- Lasting Power of Attorney or Court Appointed Deputy

The question of who should carry out which task depends on a number of factors. The central elements involve:

- The individual NRS skills, competence, attitudes, and experience
- The requirements of the service user and their own choice
- The nature of the task in the specific circumstance; or
- If there is a need for a change or introduction of equipment or technology to help in meeting the need.

Risk assessment is not a substitute for professional judgement and experience and should be informed by the worker's knowledge, skill, and expertise. It is a process involving thinking about the dangers and risks that individual's face, recording these and considering where the responsibility will appropriately lie. Equally it should not be used as an excuse not to do things unless the likely benefits are outweighed by the likely danger. A risk assessment will need to be a part of and refer to the multi-disciplinary assessment so that the process can be understood.

When delegating to an NRS specified by the service user then a risk assessment risk should be completed and an agreed contingency plan. As part of the care plan consideration needs to be given to how care is provided if NRS care breaks down.

The employer of the NRS, whether this is an agency, care home or the service user should be aware of and agree to the training, assessment and task delegated.

5.5 **Supervision**

The person who delegates or commissions the activity must ensure themselves that an appropriate level of supervision is available and that the NRS has the opportunity for mentorship. On-going supervision is used to assess the NRS ability to perform delegated task and capability to take on additional roles and responsibilities. It is normally expected that a named supervisor is provided.

The following should apply:

- there should be a documented system in place for NRS to access supervision and clinical advice as required.
- regular supervision time is agreed between the registered practitioner and the NRS and both participants should keep a record of each session.
- the NRS shares responsibility for raising issues in supervision and may initiate discussion or request additional information/support.
- When the registered practitioner is absent from a setting where the NRS is working, there is an identified contact in case of query or emergency.
- Training and assessment of competence for specific skills will be specific to the person and setting.

Supervision can vary in terms of what it covers. It may incorporate elements of direction, guidance, observation, and joint working, and discussion, exchange of ideas and co-ordination of activities. It may be direct or indirect, according to the nature of the work being delegated. The decision concerning the amount and type of supervision required by an NRS is based on the registered practitioner's judgment and is determined by the recorded knowledge and competence, the needs of the service user, the service setting, and the delegated tasks. Factors to be considered by the registered practitioner therefore include:

- the level of experience and understanding of the NRS relevant to the task being delegated
- Time frame for the competency assessment reviews should be agreed at the point the task is delegated. It is anticipated that the more complex the task the more frequently the competency should be reviewed.
- degree of risk

- the complexity of the delegated tasks (i.e. whether the delegated task is a routine activity with predictable outcomes)
- the stability and predictability of the service user's health status
- the environment or setting in which the delegated task is to be performed and the support infrastructure available (e.g. whether working in a community, acute or school setting)
- availability of and access to support from an appropriate registered practitioner
- periodic review and reassessment of the service user's outcomes
- an identified process for recording and reporting

5.6 **Training**

Potential risks or safety breaches must be identified, and the risk assessment documentation completed.

Support must be given to service user and registered practitioners to make the decision re delegation.

The NRS competence & level of tolerance must be set and assessed. The level of tolerance refers to the pass or fail percentage and may include a number of supervised practices required until the NRS is signed off.

Training needs must be identified and documented in the documented in the risk assessment documentation.
The professional delegating the task is responsible for ensuring that appropriate training is provided (referral to the appropriate specialist as required e.g. Insulin Project Lead for insulin administration).

If equipment is to be used, then the manufacturing company may be able to train in use of equipment if appropriate. In every circumstance staff should receive appropriate levels of training to use medical equipment. This could be arranged by the provider, commissioner, and registered professional.

A Somerset training resource area for health and social care providers is maintained on the Local Authority Provider Engagement Network portal.
https://somersetprovidernetwork.org.uk

5.7 **Competency Monitoring**

A plan for on-going monitoring must be made and reviewed at the point of delegation. This must include:

- setting the frequency of formal competence of the NRS is assessed. Please refer to any available NICE guidance for best practice.
- on-going and regular review using the risk assessment tool (Appendix 5)
- the on-going frequency of the task

- contingency plans to cover sickness, holiday etc.
- an opt-out plan for the NRS undertaking the task.
- on-going supervision arrangements

5.8 **Documentation**

Competence and assessment documentation must be available to provide audit trail of the NRS competence and training. (**Appendix 4 – Summative Assessment Template**)

5.9 **Outcome Measures**

Achieving outcomes should be measured by service user satisfaction such as the Friends Family Test and incident or complaints as recorded on the Provider or Trust's Incident Report system.
There are a variety of pathways to report outcome measures across the system. Which could include but not exhaustive, the Quality Assurance Framework, DATIX and RADAR Reporting, and PSIRF.

5.10 **Governance Frameworks**

Clinical and corporate governance frameworks, strategies and practices should act as an enabler and not a barrier to delegation.

Healthcare Governance systems will be in place across all areas to support person safety through personalisation.

On-going monitoring and review of current clinical practice should support delegation.

Line managers and professional leads should ensure they have good management and clinical leadership in order to manage and optimise the workforce capability in the most effective manner.

Clear lines of accountability should be in place as part of the wider governance responsibilities.

Each individual organisation will be required to report into their own governance structures for assurance.

To support delegation and clarify accountability it is imperative that all professional codes of conduct are interpreted consistently and understood across the organisation.

6 CLINICAL TASK LEVELS

6.1 Clinical tasks will only be undertaken by care staff as part of a package which addresses other personal care tasks.

Sometimes care providers are requested to perform tasks which will require additional training and competency assessment, some tasks may have traditionally been performed by health professionals.

There are requirements to ensure that each category of task can be performed safely. Simply because a task appears on a Category 1 or 2 list, it does not mean that the task will be performed by a member of care staff without appropriate training. Training for Category 1 or 2 tasks is likely to be provided by the registered provider but where this is not the case, arrangements for training need to be clarified between the commissioner and the provider. CQC highlight that care workers can decline to perform a task they do not feel competent to complete.

Individual commissioners need to assure themselves that the care arrangements set up can be safely at the point of placement and through regular reviews.

6.2 Level 1 – No assistance

The Person retains full control of their clinical tasks, preserving their independence, choice, and control.

6.3 Level 2 – Acceptable Tasks

These are the tasks falling within the normal range of activities undertaken by care staff as long as they have received the appropriate training and competency assessment. This training can be delivered to a group of people and the procedures issued on a generic basis. Staff must sign to say that they have received and understood their training. The trainer must also sign and date this.

Care staff must not pass on any training they have received or delegate these tasks to other staff. A review of the training needs of staff must take place whenever there is a change in circumstances or where there is concern expressed about the ability of the member of staff to perform a specific task.

Examples of acceptable Care Tasks List:

- Replacing a bag to an existing urethral or supra-public catheter.
- Emptying and measuring urine.
- Putting on penile sheaths and connecting them to urine bags
- Mouth care
- Fitting supports, trusses, artificial limbs, or braces
- Skin integrity monitoring in relation to prevention and good practice.
- Assisting with the cleaning of a supra-pubic catheter site.
- Emptying, changing/replacing urostomy, colostomy or ileostomy bags
- Applying a replacement dressing, without otherwise cleaning or treating the site
- Fitting prescription support stockings.

6.4 **Level 3 - Tasks that may be delegated by a Registered Healthcare Professional to care staff.**

The tasks in this category are nursing tasks which, in appropriate circumstances, can be delegated to care staff. They all require training specific to the individual person on a one-to-one basis by a health care professional who will assess the Care staff against a series of pre-defined competencies. The competencies will be set by the training provider and should incorporate any available NICE guidance. Competence to perform these tasks must be reassessed at a frequency agreed by the delegator this should be recorded on the staff record. The health professional may provide written procedures for the care staff to follow.

"These Level 3 tasks (which can only be delegated by a Registered Nurse) cannot be delegated to care staff commissioned by the Local Authority due to the legal limits of the Care Act (2014)."

Level 3 Tasks

Level 3 Tasks are defined as those utilising specialised techniques. This may include, but not limited to:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection for stable diabetic using a prefilled pen with a standard dose.
- Administration of medication or nutrition through a Percutaneous Endoscopic Gastrostomy (PEG)
- Vaginal administration e.g. pessaries
- Taking venous blood samples
- Administering prefilled subcutaneous injections (other than insulin) e.g. Enoxaparin

Examples of Complex care:

- Changing a two-piece stoma system.
- Assisting with obtaining midstream urine specimens, or a faecal specimen which has been medically requested. (N.B. this includes obtaining a specimen by way of an in-dwelling catheter).
- Taking a capillary blood test (finger prick test).
- Gastrostomy/jejunostomy tube feeding and flushing.
- Cleansing of gastrostomy/ jejunostomy sites, including advancing, and rotating a gastrostomy as directed.
- Cleaning and inserting false eyes.

- Aspiration of excess saliva from the front of the mouth with suction equipment.

Examples of Treatments

- Administering laxative suppositories but this procedure must be linked to a review by a health professional.
- Assist a person to self-administer routine, pre-measured doses of prescribed medicines via a nebuliser.
- Administering medication via a gastronomy/ jejunostomy tube
- Other health tasks including clinical observations may only be undertaken in line with CQC Registration for Treatment of Disease, Disorder or Injury.

Example of Emergency Care Procedures

- Administration of emergency medications

There may be occasions when managers would be willing to negotiate to establish an individual procedure, based on the experience and willingness of staff to be trained and the nature of the task.

6.5 **Level 4 Tasks – Specialist Tasks for agencies employing registered nurses ONLY.**

These Healthcare tasks may only be performed by those care providers that employ Registered Nurses and are able to offer training, assessment and supervision to the individual care staff. However, training and assessment of competence in some of these tasks may need to be sought from acute/specialist services. These clinical tasks are outside of social care responsibility and cannot be commissioned by the local authority.

Each healthcare task requires specialised training by the Registered Nurse employed by the agency or healthcare professional for each person. The Registered Nurse employed by the agency must review the care plan on a regular basis.

Nurses in any setting need to abide by their professional standards as below: https://www.nmc.org.uk/standards/

Examples of Health Led Tasks List

- Management of supra-pubic catheters, other than changing the bag and cleaning the site
- Intermittent catheterisation
- Management and treatment of pressure ulcers, other than planned interventions such as positioning the person.

- Manual evacuation or digital stimulation of the bowel
- Rectal irrigation.
- Administration of rectal enemas
- Administration of catheter maintenance solutions
- Administration of medicines through a nebuliser for acute or emergency conditions
- Flushing to unblock a feeding tube or line (not including NGT's)
- Cleaning and replacement of tracheostomy tubes
- Assisting with dialysis
- Aspiration of naso-gastric tube
- Naso-gastric tube feeding.
- Oral suction, other than oral aspiration of excess saliva from the front of the mouth with suction equipment.
- Suction through tracheostomy tube.
- The administration of medicine via a naso-gastric tube

Emergency Procedures

An emergency is defined as a life-threatening situation so there will be occasions when a person's safety may be at risk and where immediate intervention is required. Staff should not put themselves at risk.

If a staff member is seriously concerned about an individual's physical condition and they have had the appropriate first aid training and feel confident of intervening, they can do so only as a first aid measure. Staff must ensure that an ambulance is called first.

Cardiac and Respiratory Resuscitation/DNAR notices

At no time must staff make a decision themselves based on the individual's physical condition or age whether to resuscitate and they should therefore always administer first aid and call the ambulance service as stated above. Reference should be made to Treatment Escalation Plans, or other appropriate authorised documentation.

When there is no guidance and the person concerned is receiving palliative care, staff should still contact the appropriate health care professional for advice.

Self-Directed care

When people are employing personal assistants (including self-employed PA's or Micro-providers) they take on the role of employer. Whilst those personal assistants are not regulated by CQC it would be best practice to follow the guidance in this document, particularly with regards to training. Commissioner representatives should advise people at the time of assessment of the potential/need for training/competency assessment with particular tasks.

For further information on managing and developing your PA.
[Managing and developing your PA (skillsforcare.org.uk)]

7 PART B – DELEGATED TASKS FOR MEDICINES

7.1 Purpose

In March 2017, the National Institute for Health, and Care Excellence (NICE) published guidance on managing medicines for adults receiving social care in the community.

7.2 Scope

The NICE guideline covers medicines support for adults (aged 18 and over) who are receiving social care in the community and makes a number of recommendations. It aims to ensure that people who receive social care are supported to take and look after their medicines effectively and safely at home. It offers advice on assessing if people need help with managing their medicines, who should provide medicines support, and how health and social care staff should work together.

The guidance is intended for:

- Health and social care staff providing care for people by regulated and unregulated providers in the community.
- Health professionals providing care, training and assessment of competence for people receiving social care in the community and their support staff.
- Commissioners and providers of services for people receiving care in the community, and
- People receiving social care in the community, their families and carers.

The aim of the local joint guidance is:

- To promote independence through encouraging people to manage their own medicines as far as they are able.
- To help people remain in their own homes and prevent avoidable admissions to care homes or hospital by supporting people with their medication and clinical care appropriately.
- To ensure that Colleagues use the safest possible practices when supporting people with their medication.

Health and Social Care staff are employed primarily to provide social care but on occasion may be required to provide care and support to someone with healthcare needs. An important component of their role can include carrying out tasks that are of a clinical nature which they can only carry out if they

have had adequate training and competency sign off as detailed within this policy.

7.3 Principles

Where equipment or medicines are supplied by the service provider, ensuring that there are enough of these to ensure the safety of persons and to meet their needs.

The registered Health and social care provider's medicines policy should provide guidance to staff on the safe management and administration of medicines.

Agencies should ensure that they are able to respond to any reasonable request to provide records that will demonstrate evidence of compliance and Person safety.

7.4 Definitions

The following descriptions define what assisting with medicines means and what administering medicines means:

- When a care worker assists someone with their medicine, the Person must indicate to the care worker what actions they (the care worker) are to take on each occasion, i.e. 'can you open this bottle please' (but person pours out required amount) or 'can you pop this pill out of this packet please'.
- If the person is not able to do this, or if the care worker gives any medicines without being requested (by the person) to do so, this activity must be interpreted as administering medicine. This includes if the person expresses any doubt or hesitation regarding the dosage.

General rules for adults

Adults supported in their own homes by a health and social care staff will normally be responsible for their own medicines, both prescribed and non-prescribed. Some Persons are able to fully administer their own medicines, others will require varying levels of support. In some cases, the level of support required for medication will be substantial.

Care workers may administer medication (including controlled drugs) to another person with their consent, provided this is done in accordance with the prescriber's directions or manufacturers guidance (The Medicines Act 1968) and the care provider has an appropriate Medications Policy in place. However, when medication is given by invasive techniques, care workers will need additional specialist training and competency assessment. This must be person specific.

https://www.nice.org.uk/guidance/ng67

In every service where care workers administer medicines, they must have a Medication Administration Record (MAR). This must detail:

- Details of the medicines (this includes drug name, dose, strength and quantity)
- When they must be given and frequency
- Route of administration
- Any special information, such as giving the medicine with food.
- For PRN medication, details must include why the medication is being taken, what the minimum timescales should be between administrations and what the maximum cumulative dose is within a 24hr period.

Please note: MAR charts are not provided by GP practices.

Care workers must not offer advice to people about prescribed medicines, over-the-counter medication or complementary treatments.

The registered provider is responsible for the following:

- Agreeing the level of support required and ensuring that the appropriate record-keeping and training needs are met. When providing an assessment of competency, the individual undertaking this role, must be competent and able to undertake this function.
- The person's care plan will require regular review as their needs change.
- Where the person's capacity to make decisions about their care is in doubt the agency must ensure compliance with the Mental Capacity Act.

The agency should also take into account the person's preferences and cultural/ religious beliefs and is responsible for recording agreement or otherwise within the appropriate Care Plan.

Where multiple Agencies are contracted to provide services, an agreement regarding which Agency holds the responsibility for support with medication will be required. Clear communication channels between agencies must be agreed to ensure appropriate care is provided and so information can routinely be shared between the agencies and with any other appropriate professional.

A care worker should not mix medicine with food or drink if the intention is to deceive someone who does not want to take the medicine. This is called 'covert administration'. The only exception is where the prescriber has provided written confirmation that an assessment under the MCA has been undertaken, and it has been deemed in the person's best interests for essential medications to be administered covertly.

When a person has difficulty swallowing, the prescriber should be asked to review the person's medication and consider an alternative prescription. It is

potentially unsafe to crush medication, and as a result advice must be sought on all occasions when this may be requested.

7.5 Level 1: General Support (also called Assisting with Medicine)

General support is given when the person takes responsibility for their own medication and particularly when they contract the support through Direct Payments or any other form of Individual Budget. In these circumstances the care worker will always be working under the direction of the person receiving the care. This does not, however, alter the level of medicines support needed. The support given may include some or all of the following:

- Requesting repeat prescriptions from the GP.
- Collecting medicines from the community pharmacy/dispensing GP surgery.
- Disposing of unwanted medicines safely by return to the supplying pharmacy/dispensing GP practice (when requested by the person).
- An occasional reminder from the care worker to an adult to take their medicines.
- A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medicines and should trigger a review of the person's care plan.
- Manipulation of a container, for example opening a bottle of liquid medication or popping tablets out of a blister pack at the request and direction of the person and when the care worker has not been required to select the medication.
- Any indication of confusion or lack of clarity by the person over the medicines or dosage to be taken indicates that the person requires a higher level of support. The care worker should contact their line manager to request a review.
- When the care worker puts out medication for the person to take themselves at a later (prescribed) time to enable their independence.

General support needs should be identified at the care assessment stage and recorded in the person's care plan. Ongoing records will also be required in the continuation notes when care needs are reviewed. Where equipment to assist opening bottles or containers is assessed as necessary these should be requested in line with community equipment provision.

If, after assessment by a Community Pharmacist under the Disability Equality Duty imposed on them as part of the Equality Act 2010, it is decided that a compliance aid is the most appropriate way of administering medicines, then this should be considered.

Any compliance aid or monitored dosage system (MDS) must be dispensed and labelled by the community pharmacist. The Person may qualify for a free service from a community pharmacist if they meet the criteria under the Equality Act 2010.

7.6 **Level 2: Administering Medication in accordance with the MAR chart.**

The care assessment made identifies that the person is unable to take responsibility for their medicines. This may be due to impaired cognitive function but can also result from a physical disability.

The need for medication to be administered by care staff should be identified at the care assessment stage and recorded in the person's care plan. Ongoing reviews of this need will also be required.

The person must agree to have the care worker administer medication and consent should be documented in the person's care plan. Reference must be made to earlier considerations regarding mental capacity and best interest decisions.

Administration of medication may include some or all of the following:

- When the care worker selects and prepares medicines for immediate administration, including selection from a MDS or compliance aid (without direction from the person)
- When the care worker selects and measures a dose of liquid medication for the person to take
- When the care worker applies a medicated cream/ointment; insert drops to ear, nose or eye; and supervise the administration of inhaled medication.

The registered care provider should have a system in place to ensure that only competent and confident staff are assigned to people who require help with their medicines. The Providers procedures should enable care workers to refuse to administer medication if they have not received suitable training and do not feel competent to do so. Records of training and competency assessment should be kept and regularly updated in line with National Guidance and CQC Regulation.

Health and social care workers should only administer medication from the original container, dispensed and labelled by a pharmacist or following manufacturer's guidance. This may include MDS and compliance aids. A care worker must not under any circumstances administer medicines prepared in an MDS by anybody other than a pharmacy.

A person discharged from hospital may have medication that differs from those retained in the home prior to admission. The Provider should obtain confirmation of current medication from the person's GP if there are any discrepancies. This should be done as soon as possible to avoid delayed or missed doses of medicines.

7.7 **Level 3: Administering medication by specialised techniques.**

In exceptional circumstances, and following training and competency assessment by a registered healthcare professional, a Health and social care worker may be asked to administer medication by a specialist technique including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by pre-filled pen
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Nebulised therapy
- Oxygen therapy (training is provided by the supplier, and includes oxygen delivery and care of the cylinder
- Buccal Midazolam

"These Level 3 tasks (which can only be delegated by a Registered Nurse) cannot be delegated to care staff commissioned by the Local Authority due to the legal limits of the Care Act (2014)."

All training and competency documentation must have a review date and state who is responsible for each task. This training and competency assessment will always be person specific however, where standardised training has been provided for a specialist technique it may be possible for care workers to use the training and competency assessment to deliver care to another person. In order to do this, further delegation, training, and competency assessment needs to be considered by the registered health care professional. All competency documentation must be signed by the registered professional and the care staff member.

The following outlines acceptable/non-acceptable delegated administration routes. For administration routes outside of the listed categories an individualised risk assessment should be undertaken that includes best interest assessment and multiagency agreement.

Acceptable delegated routes of administration following training and competency assessment.

- Intra – ocular (eye), nasal, aural (ear)
- Oral
- Sublingual
- Buccal
- Subcutaneous injection
- Transdermal (patches)
- Topical
- Per rectum

Routes that may require delegation to care staff following individualised assessment, specific training and competency assessment.

- Intramuscular injection
- Per vagina
- Percutaneous Endoscopic Gastrostomy

Level 4: Nurse led tasks. Routes for services who employ registered nurses ONLY.

- Intravenous
- Nasogastric

Please note, that level 4 tasks can be only delegated by a Registered Nurse to another Registered nurse and cannot be delegated to care staff. The delegation could be internal to the provider or via other healthcare commissioning pathways. Delegators need to be aware of the risks of delegating and the need for contingency planning.

Delegation

If the task is to be delegated to the health and social care worker, the named registered healthcare professional or the equipment provider must train the care worker and be satisfied they are competent and confident to carry out the task. The individual remains accountable for carrying out the appropriate task as they have been trained to do. Accountability for monitoring and compliance with best practice remains with the care provider.

One care worker is not authorised to delegate to other care workers.

The registered Providers medicines policy must ensure that care workers can refuse to assist with the administration of medication by specialist techniques if they do not feel competent or confident to do so.

Training for Health and Social care workers

When a Person's needs mean the care worker needs to administer medicines, training in safe handling of medicines is essential. The Provider is expected to provide a training package that will meet the needs of care workers and Persons to enable safe care to be delivered. The essential elements of this training should include:

- How to prepare the correct dose of medication for ingestion or application.
- How to administer medication that is not given by invasive techniques, including, tablets, capsules and liquid medicines given by mouth; ear, eye and nasal drops; inhalers; and external applications and patches.
- The responsibility of the care worker to ensure that medicines are only administered to the Person for whom they are prescribed or intended, given in the correct dose, at the correct time by the correct method/ route.

- Checking that the medication ‘has not expired.
- Checking that the person has not already been given the medication by anyone else, including a relative or care worker.
- Recognising and reporting possible side effects.
- Reporting refusals and medication errors.
- How a care worker should administer, and record medicines prescribed ‘as required’, for example, pain killers, laxatives.
- What care workers should do when people request non-prescribed medicines.
- Understanding the service provider’s policy for record keeping.
- Ensuring good infection control practices are adhered to, to include, for example, washing of hands prior to administering any medicine and having an available supply of Personal Protective Equipment (PPE).
- Issues relating to medicines storage and disposal.

The Agency must establish a formal mechanism to assess whether a care worker is sufficiently competent in medication administration before being assigned the task.

Regional Office of Skills for Care can assist care providers in identifying suitably accredited training organisations. Support should also be available from the local Social Services Authority and/or Health Organisations and National Organisations such as UKHCA.

8 POLICY AND PROCEDURES

8.1 The health and social care provider must have a clear, comprehensive written medicines policy to support care workers to administer medicines safely.

This must cover the following topics:

- The appropriate level of medication administration and the skills needed to perform such duties.
- The limitations of assistance with prescribed and non-prescribed medication
- Which healthcare tasks the care worker may not undertake without specialist training / delegation
- Detailed procedures for safe handling of medication, including requesting repeat prescriptions; collecting prescriptions and dispensed medication.
- Procedure for administration, including action should the person refuse the medication; administration and disposal (return); procedure for removal of unwanted medication; procedure to deal with a medication error.

- The training and competency requirements for each level of medication administration
- How this will be monitored, including completion of audits etc.

The registered Provider should determine and document the following in the Person's care plan:

- The nature and extent of help that the Person's needs
- A current list of prescribed medicines for the Person, including the dose and frequency of administration and the method of assistance.
- Details of arrangements for medication storage in the Person's home and access by the Person, relatives, or friends
- A statement of the person's consent to care worker support with medication, if required.

8.2 Monitoring, Auditing, Reviewing & Evaluation

This policy will be reviewed in 36 months from ratification and every three years thereafter. It will be reviewed by the Delegated Tasks and Medicines Policy Group which is made up from representatives from NHS Somerset, Somerset ICB, the Local Authority and the Registered Care Providers Association.

8.3 Equality Impact Assessment

NHS Somerset ICB aims to design and implement services, policies and measures that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

As part of its development, this policy and its impact on equality have been assessed. The assessment is to minimise and if possible, remove any disproportionate impact on employees on the grounds of race sex, disability, age, sexual orientation, or religious belief. No detriment was identified.

8.4 Associated Documentation

This document references the following supporting documents which should be referred to in conjunction with the document being developed.

- Record of Assessment of Mental Capacity and Determination of Best Interest.
- Consent Policy.
- Health and Safety Policy – Risk Assessment Guidance.

9 REFERENCES

DHA short guide for care and support workers and personal assistants February 2026
DHA short guide for people drawing on care and support February 2026
DHA short guide for providers and organisations February 2026
DHA short guide for regulated healthcare professionals February 2026
Skills for Care and Health (2013) Code of conduct for healthcare support workers and adult social care workers in England: DOH

Cox C. Legal responsibility and accountability; Nursing Management 17: 3: 18-20 June 2010

Nursing and Midwifery Council (NMC 2015). The Code: Professional standards of practice and behaviour for nurses and midwives. London: NMC; Updated 10 October 2018

Royal College of Nursing. (2017) Accountability and delegation. A guide for the nursing team. London 2017.

Skills for Care (2010) Personalisation and Partnership – A Successful Working Relationship: What Factors Disabled People Feel are Important in their Relationships with their Personal Assistants, Carers and Support Workers:

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Information about the Mental Capacity Act

NMC Standards of Proficiency for Registered Nurses

Delegation and Accountability - NMC Code

Equality Act 2010

Medicines Act 1968

Delegated Healthcare Decision Tree (skillsforcare.org.uk)

10 APPENDICES:

1. Consent and capacity guide and forms
2A. Decision Matrix 1 – Assessment of Task flow chart
2B. Descriptor table for assessment of task

3A. Decision Matrix 2 – Assessment of the Individual being Delegated To flow chart

3B. Descriptor table for the assessment of individual

4. Training and Competency Record for Non-Registered Staff (NRS) delegated for tasks external to SFT (Annual Form)

5. Risk assessment

6. Equality Impact assessment

APPENDIX 1. CONSENT AND CAPACITY GUIDE AND FORMS

Whilst there is usually no legal requirement to ask a person to sign a consent form, there are principles that should be followed to record the person's consent or refusal. To evidence that the process of gaining consent or acknowledging a refusal is captured a clear record needs to be made. Approaching consent using the following principles is likely to ensure good practice is achieved and Health and Social Care regulations have been met.

- When a person is asked for their consent, information about the proposed care and treatment must be provided in a way that they can understand. This should include information about the risks, complications and any alternatives. A person with the necessary knowledge and understanding of the care and treatment should provide this information so that they can answer any questions about it to help the person consent to it.
- Discussions about consent must be held in a way that meets people's communication needs. This may include the use of different formats or languages and may involve others such as a speech language therapist or independent advocate. Consent may be implied and include non-verbal communication such as sign language or by someone rolling up their sleeve to have their blood pressure taken or offering their hand when asked if they would like help to move.
- Consent must be treated as a process that continues throughout the duration of care and treatment, recognising that it may be withheld and/or withdrawn at any time.
- When a person using a service or a person acting lawfully on their behalf refuses to give consent or withdraws it, all people providing care and treatment must respect this.
- Consent procedures must make sure that people are not pressured into giving consent and, where possible, plans must be made well in advance to allow time to respond to people's questions and provide adequate information.
- Where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

- If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

If someone is unable to understand information about their proposed care and treatment and you have reason to doubt that they have the mental capacity to decide about the specific treatment/support, a mental capacity assessment will need to be completed by someone with the relevant training and competence.

In Somerset, the Mental Capacity Competency Framework can be used to determine the right level of training required to implement the Mental Capacity Act for people undertaking different roles.

Somerset Mental Capacity Act Compete

It is important to remember that it is not for the person to demonstrate to you that they have mental capacity, in fact it should be assumed that they do. A person who has the mental capacity to make their own decision can decide what is in their own best interests, whether you believe their decision to be unwise.

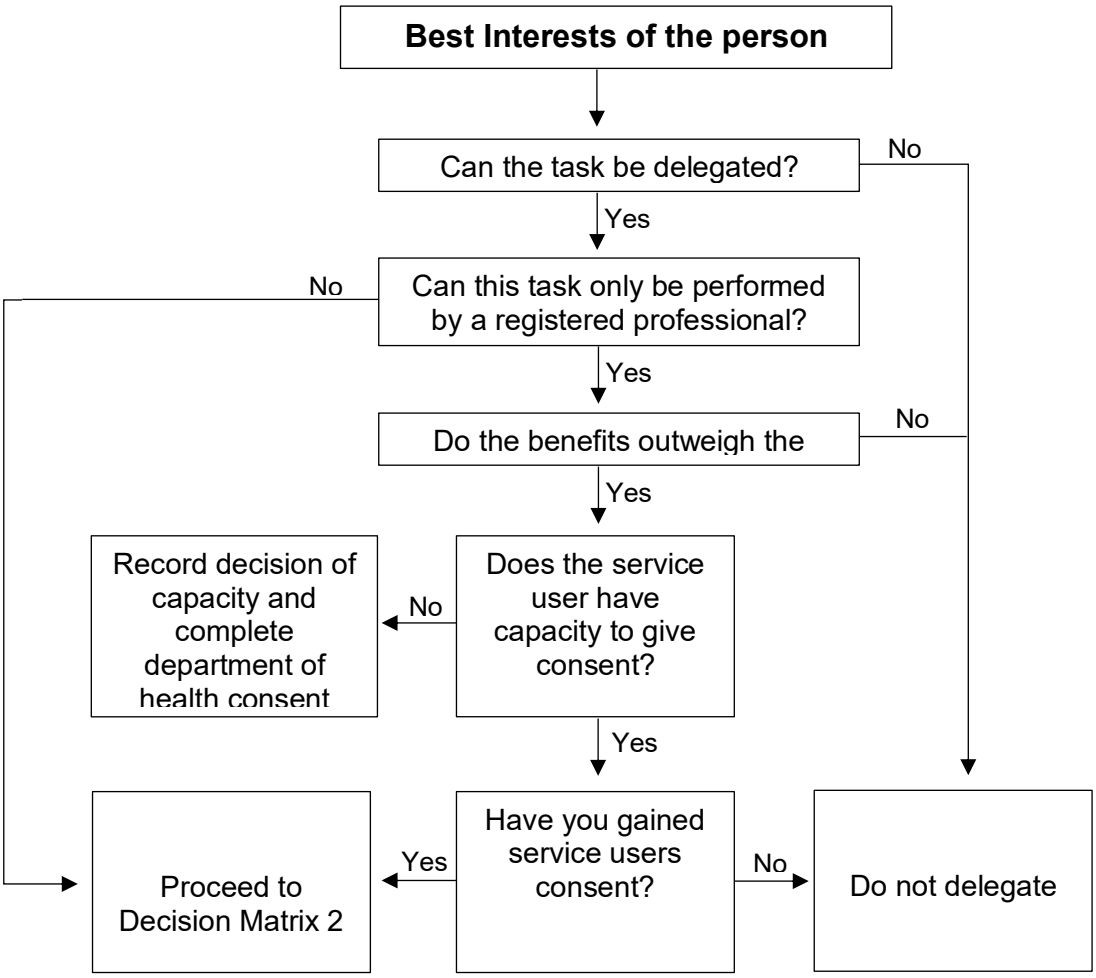
It is only once a lack of mental capacity has been established through assessment that a best interest process should be followed.

Mental Capacity Assessment - Blank C

Best Interest Decision - Blank Copy.docx

If the person lacks mental capacity and is objecting to their care and treatment **or** there is not a consensus about what care and treatment is in the persons best interests, professional/legal advice should be sought through the organisation commissioning the care arrangements.

APPENDICES 2A: DECISION MAKING MATRIX 1

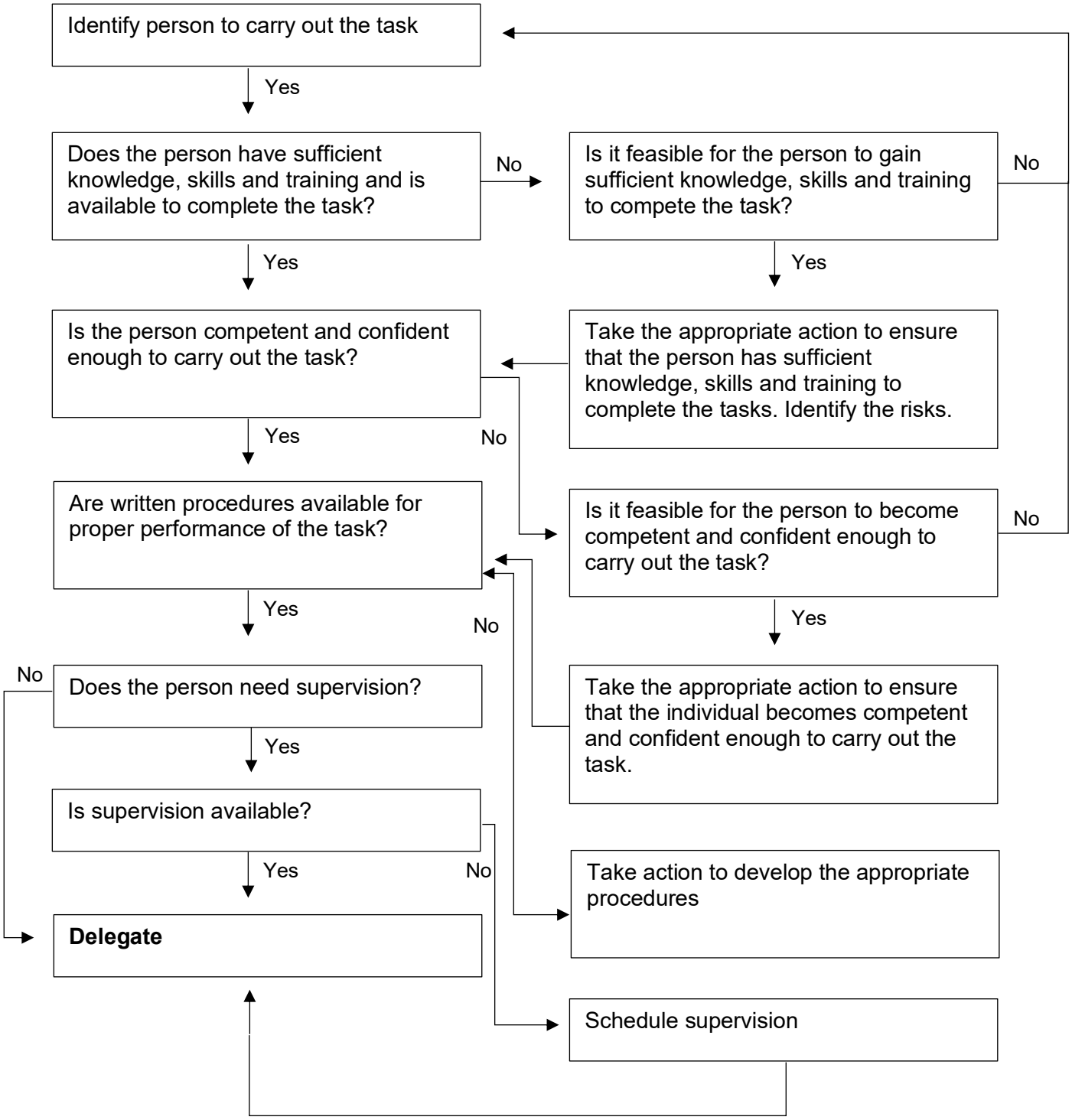


APPENDICES 2B: DESCRIPTOR TABLE FOR ASSESSMENT OF TASK

This stage will assist delegators in deciding if the task can or cannot be delegated Descriptor table for Assessment of Task.

Question	Descriptor
Can the task be delegated?	When considering whether the task can be delegated take into account the level of the task, what skills the NRS would need to perform the task and if this is a task that needs to be delegated?
Can this task only be performed by a registered practitioner?	Before this task is delegated it needs to be considered whether this task must be performed by someone authorised in the profession.
Do the benefits outweigh the risks to the service user?	Having conducted a benefit and risk assessment, have the benefits of delegating the task outweigh the risks of delegating the task?
What risks have been identified?	Should a risk assessment be completed?
Do you need to gain service user consent?	In certain circumstances you may need to gain service user consent to carry out the task.
Have you gained service user consent?	Have you consulted with the service user and made them aware that the task that is being undertaken on them will be conducted by an identified NRS

APPENDICES 3A: ASSESSMENT OF THE INDIVIDUAL BEING DELEGATED TO FLOW CHART



APPENDICES 3B DESCRIPTOR TABLE FOR ASSESSMENT OF INDIVIDUAL

This stage will enable you to identify the correct individual to delegate the task.

Identify Individual	Having decided that the task is delegable it is important to identify whether there is someone available to conduct the task.
Does the person have sufficient knowledge, skills and training to undertake the task?	When determining whether the individual has sufficient knowledge, skills and training to undertake the task please bear in mind the following: • Has the individual been trained to carry out this task before? • When was this training last given? • Has the task changed since training was given? • Has the NRS's training been updated since their last training session?
Is there person competent and confident to carry out the said task?	When considering whether the person is competent and confident to carry out the task, please note the following: Has the person expressed concerns about the task? Do you believe the person to be competent to carry out the task? Is the person confident in themselves to carry out the task? What risks have been identified? Should the Risk Assessment Tool be used?
Are written procedures available for proper performance of the task?	Before the person is given the delegated task please check to see if there is written procedure or policy documents available to assist the person when carrying out the task.
Is supervision required?	The delegator will need to decide whether this task requires supervision.

APPENDIX 4 Training and Competency Record for Non-Registered Staff (NRS) (Annual Form)

Name of Non-Registered Staff: Designation: Date Start:

TASK	**NRS Competent** *Signed by registered staff*	**NRS Sign** *Consented to undertake task*	**Risk Assessment Complete** *Signed by registered staff*	**Monthly Review** *Signed by registered staff*		**4 Monthly Review** *Signed by registered staff*	**Remarks**
				Jan	July		
				Feb	Aug		
				March	Sept		
				April	Oct		
				May	Nov		
				June	Dec		
				Jan	July		
				Feb	Aug		
				March	Sept		
				April	Oct		
				May	Nov		
				June	Sept		
				Jan	July		
				Feb	Aug		
				March	Sept		
				April	Oct		
				May	Nov		
				June	Dec		

APPENDIX 5 – RISK MANAGEMENT

Risk Assessments should be reviewed at least annually, or after incidents, near misses and when significant changes in personnel or work practices occur. To assist staff when completing their risk assessment, guidance is available

What is a Hazard? 'A Hazard is a potential source of harm or adverse health effect on a person or persons.
What is a risk? 'Risk is the likelihood that a person may be harmed or suffers adverse health effects if exposed to a hazard'.

Name of Assessor:		**Name of Manager:**	
Designation:		**Designation:**	
Service:		**Signed:**	
Location:		**Date:**	
Assessment date:		**Date for review:**	

Does this risk need to be entered onto the Trust Incident and Risk Reporting System? YES / NO (please delete as appropriate)
NB - Should there be a situation where immediate action is required and the required action has been taken, then this **does not** need to be recorded on the Risk Register.

Task Being Assessed:

What are the hazards	Who might be harmed	How might they be harmed	Inherent Risk Rating			What are you already doing? i.e. existing risk control measures	Residual Risk Rating			Do you need to do anything else to manage the risk?	Action by whom and when?	Completed
			C	L	R		C	L	R			
e.g. *Slips and trips*	*e.g.* *Staff and visitors*	*e.g.* *They may be injured if they trip over objects or slip on spillages*	**5**	**4**	**20**	*Staff, supervisor to monitor*	**3**	**2**	**6**		*01/10/2018 Associate Director of Governance*	**01/10/18**

C = Consequence L = Likelihood R = Risk Rating

Appendix 6

Somerset Equality Impact Assessment

Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer or www.somerset.gov.uk/impactassessment

Organisation prepared for (mark as appropriate)	Somerset Council		NHS Somerset	X	NHS Somerset NHS Foundation Trust	

Version	**0.1**	**Date Completed**	**20.05.2025**

Description of what is being impact assessed

Delegated Tasks and Medicines Policy

Evidence

What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here

Joint Strategic Needs Assessment (JSNA) - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations

Joint Forward Plan (NHS Somerset ICB)

Guidance pertaining to delegation of tasks and rationale (RCN, Skills for Care etc)

Safeguarding adult review learning

Coroner reports

Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?

The policy has been distributed to colleagues throughout NHS Somerset ICB, Somerset Council and Somerset Foundation Trust and comments that have pertained to EQIA have been taken into account.

Analysis of impact on protected groups

The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.

Protected group	Summary of impact	Negative outcome	Neutral outcome	Positive outcome
Age	• This policy should not impact either negatively or positively on people due to their age.	☐	☒	☒

Disability	• The proposed policy is anticipated to safeguard people who are in requirement of health and social care interventions.	☐	☐	☒
Gender reassignment	• This policy should not impact either negatively or positively on people due to gender reassignment.	☐	☒	☐
Marriage and civil partnership	• This policy should not impact either negatively or positively on people due to marriage and or civil partnership.	☐	☒	☐
Pregnancy and maternity	• This policy should not impact either negatively or positively on people due to pregnancy/maternity.	☐	☒	☐
Race and ethnicity	• This policy should not impact either negatively or positively on people due to their race or ethnicity.	☐	☒	☐
Religion or belief	• This policy should not impact either negatively or positively on people due to their religion or beliefs.	☐	☒	☐

Sex	• This policy should not impact either negatively or positively on people due to their sex.	☐	☒	☐
Sexual orientation	• This policy should not impact either negatively or positively on people due to their sexual orientation.	☐	☒	☐
Armed Forces (including serving personnel, families and veterans)	• This policy should not impact either negatively or positively on people due to due have been in/currently in the armed forces.	☐	☒	☐
Other, e.g. carers, low income, rurality/isolation, etc.	• This policy should not have any other impacts not discussed.	☐	☒	☐

Negative outcomes action plan
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it be monitored?	Action complete
	Select date			☐
	Select date			☐
	Select date			☐

	Select date			☐

If negative impacts remain, please provide an explanation below.	
Completed by:	**Lynette Emsley**
Date	**20/05/2025**
Signed off by:	
Date	
Equality Lead/Manager sign off date:	
To be reviewed by: (officer name)	
Review date:	

APPENDIX 7 Clinical Tasks Levels

Level 0 **No assistance**	**Level 1** **Assistance**	**Level 2** **Administration**	**Level 3** **Specialist assistance**	**Level 4** **Nurse led**
The service user retains full control of their medication and clinical tasks, preserving their independence, choice and control**.**	Health and Social care Staff provide general support, always under the direction of the person receiving care. The assistance provided may include some or all of the following: • Occasional reminders or verbal prompts with timing or order of taking prescribed medications. This should be no more than once a week. A persistent need for reminders may indicate that a person lacks	The task is within the range of activity undertaken by Health and social care who have received the appropriate advanced training and have been signed off as competent by their registered manager. Medicines should only be administered from the original container, dispensed and labelled by a pharmacist or dispensing doctor. Where these conditions are not satisfied, the	Level 3 training is service-user specific and not transferable. In exceptional circumstances and following assessment, Health and social care staff may only assist with the administration of medication by specialist techniques once they have successfully completed training by a Registered Nurse and signed to indicate they feel confident to do so. These healthcare tasks **may** be performed by Health and social care staff in agreement with the provider. The individual member of staff will need to have been trained by the provider or health professional and be willing to carry out this higher level of task and feel confident in doing so. This will have been negotiated between health, the provider and the service user. Where these conditions are not satisfied, the responsibility for the task remains with the health service. Level 3 tasks may include some or all of the following: <u>Signed off by the provider:</u>	These healthcare tasks may only be performed by care providers that employ Registered Nurses and are able to offer on-site training, assessment and supervision to the Registered nurse/ Provider. Each healthcare task requires specialised training, and the Registered Nurse must be signed off as competent by the Registered Nurse or health professional for each person “Person specific competencies”. The Registered Nurse must review the care plan on a regular basis.

Level 0 No assistance	Level 1 Assistance	Level 2 Administration	Level 3 Specialist assistance	Level 4 Nurse led
	the ability to take responsibility for their own medicines and should prompt a review of the person's care plan. • Collecting medicines from the pharmacy in exceptional circumstances. • Help with opening prescribed medication containers. • Requesting repeat prescriptions from the GP. • Returning unwanted medicines to the pharmacy (see 1.11.6)	responsibility for the task remains with the health service. The service user will be assessed as Level 2 if they require help with selecting and/or preparing prescribed medicines: • Selection and preparation of medicines for immediate administration from the packaging supplied by the pharmacy in accordance with the current MAR chart. • Administration of liquid medicines. • Administration of topical creams and ointments	• Administering person's own oxygen, which will be stored safely, following risk assessment procedures. • Assisting cleaning around gastrostomy tube sites. • Changing/replacing colostomy bags. • Changing/replacing urostomy bags • Cleaning of a supra-pubic urinary catheter site. <u>Signed off by a registered professional:</u> • Administering anaphylactic pens, as an emergency procedure only • Assisting the service user with the taking of a capillary blood glucose test before they self-administer insulin. • Administering pre-set doses of insulin (dependent on glucose reading and advice taken from clinical professional when required as set out in the care and support plan). • Administering rectal diazepam, only as an emergency procedure and subject to on-going review • Administering routine, pre-measured doses of medicines via an inhaler with a spacer if needed or nebuliser as a regular procedure for chronic conditions only.	• Administration of medicines through a nebuliser for acute or emergency conditions • Administration of medicines through a naso-gastric tube • Giving any medicines by injection • Intermittent catheterisation • Management of supra-pubic catheters, other than emptying the urine • Manual evacuation of the bowel • Naso-gastric tube feeding. • Obtaining a specimen by way

Level 0 No assistance	Level 1 Assistance	Level 2 Administration	Level 3 Specialist assistance	Level 4 Nurse led
		where skin is unbroken. • Administration of ear drops, eye drops and eye ointments. • Inhaled medication via volumetric device. Acceptable clinical tasks include: • Inserting hearing aids • Fitting supports (trusses), artificial limbs, braves or non-prescription support stockings. • Basic mouth care. • Timely reporting of any problems about pressure care in relation to prevention and	• Administering suppositories • Administration of liquid buccal Midazolam for status epilepticus • Administration of medicine through a gastrostomy tube (PEG) • Administration of regular rectal enemas. (Administration of phosphate enemas is only permitted following a risk assessment and only used in Learning Disabilities service in consultation with the health service). • Assisting with gastrostomy tube feeding, by attaching feed to PEG where not associated with medication and where the condition is stable. To include flushing/cleaning of the 'PEG Tube' • Assisting with obtaining midstream urine specimens, or a faecal specimen, which has been medically requested (not day care settings). • Assisting with Transcutaneous Nerve Stimulation (T.E.N.s) machines, only where their use has been approved by the GP or other appropriate health care professional. • Changing dressings (as part of an agreed care plan) • Changing two-piece system of stoma	of an in-dwelling urinary catheter • Urine dip testing • Maintaining urinary catheter patency as part of an agreed care plan • Diagnostic recording: rating blood pressure, temperature or pulse

Level 0 No assistance	Level 1 Assistance	Level 2 Administration	Level 3 Specialist assistance	Level 4 Nurse led
		good practice to prevent skin breakdown. • Replacing a bag to an existing catheter. • Emptying and measuring urine, if required. • Administration of 'as required' PRN medicines (see 1.21). • Applying a replacement dressing without otherwise cleaning or treating the site (as a first aid measure). • Toenail cutting unless requires specialist chiropody.	• Flushing to unblock PEG. • Fitting prescription support stockings • Fitting prescription anti-embolic (TED) stockings • Inserting prosthetic eye (false eye) • Oral aspiration of excess saliva from the front of the mouth only • Administering Pessaries per vagina • Putting on penile sheaths and connecting sheath to urine bag • Removal and application of medicinal patches (First patch must be fitted by nurse) For example, Fentanyl patches (analgesia) and Nicotine patches (smoking cessation).	
	Level 1 and 2 training is transferable between care packages		Level 3 training is Person / Service User specific – please refer to 7.7	