Medication and Compliance in Adult Social Care: Strengthening Safety, Records and Inspection Readiness

The Webinar will begin shortly

Welcome

Medication & Compliance in ASC: Strengthening Safety, Records and Inspection Readiness

Date: 28th September 2026

Hertfordshire

Peter Woolnough

Deputy Head of Education, Quality & Integration

(C) Hertfordshire Care Providers Association

Housekeeping

COMFORT BREAKS

BEHAVIOUR

TECHNOLOGY

TIME KEEPING

CONFIDENTIALITY

STRUCTURE

ASK QUESTIONS

KEEP LEARNING

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A stronger focus on medication management

01 WHY IT MATTERS

Medication management remains one of the most common areas identified as requiring improvement during CQC and local monitoring inspections.

National learning from incidents continues to show that medication errors, missed doses, inaccurate records and poor oversight can lead to serious harm for people drawing on care and support.

02 WHAT PROVIDERS NEED

Inspecting bodies expect providers to ensure all staff involved in medicines administration are appropriately trained, assessed as competent and receive regular refresher learning.

Increasing complexity of care means staff are supporting people with more complex medication needs, requiring greater knowledge and confidence.

Monitoring trends across the sector highlight the need for stronger medicines governance, accurate recording, safer administration practices and effective auditing.

03 HCPA SUPPORT

HCPA is committed to supporting providers to improve safety, quality of care and CQC readiness through accessible, practical medication-focused learning opportunities.

Importance of ensuring *advice and guidance is available for all types of care services*

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Learning objectives

- Understand the key medicines management risks that can affect safety, quality and compliance in homecare, care homes and wider adult social care services.
- Recognise what good medicines governance looks like from a provider and CQC readiness perspective across different service types.
- Identify practical steps to improve medicine administration records, audit trails and incident learning.
- Consider how digital medication systems can support safer, more consistent practice.
- Understand how effective partnership working with pharmacies, clinical partners and technology providers can reduce risk.

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TRiB1 Medicare
Hiral Khoda Vyas

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Medication Management

Hiral Khoda Vyas

Care Quality Commission (CQC)

The CQC asks five key questions of all care services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

Medicines optimisation

Quality statement

We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

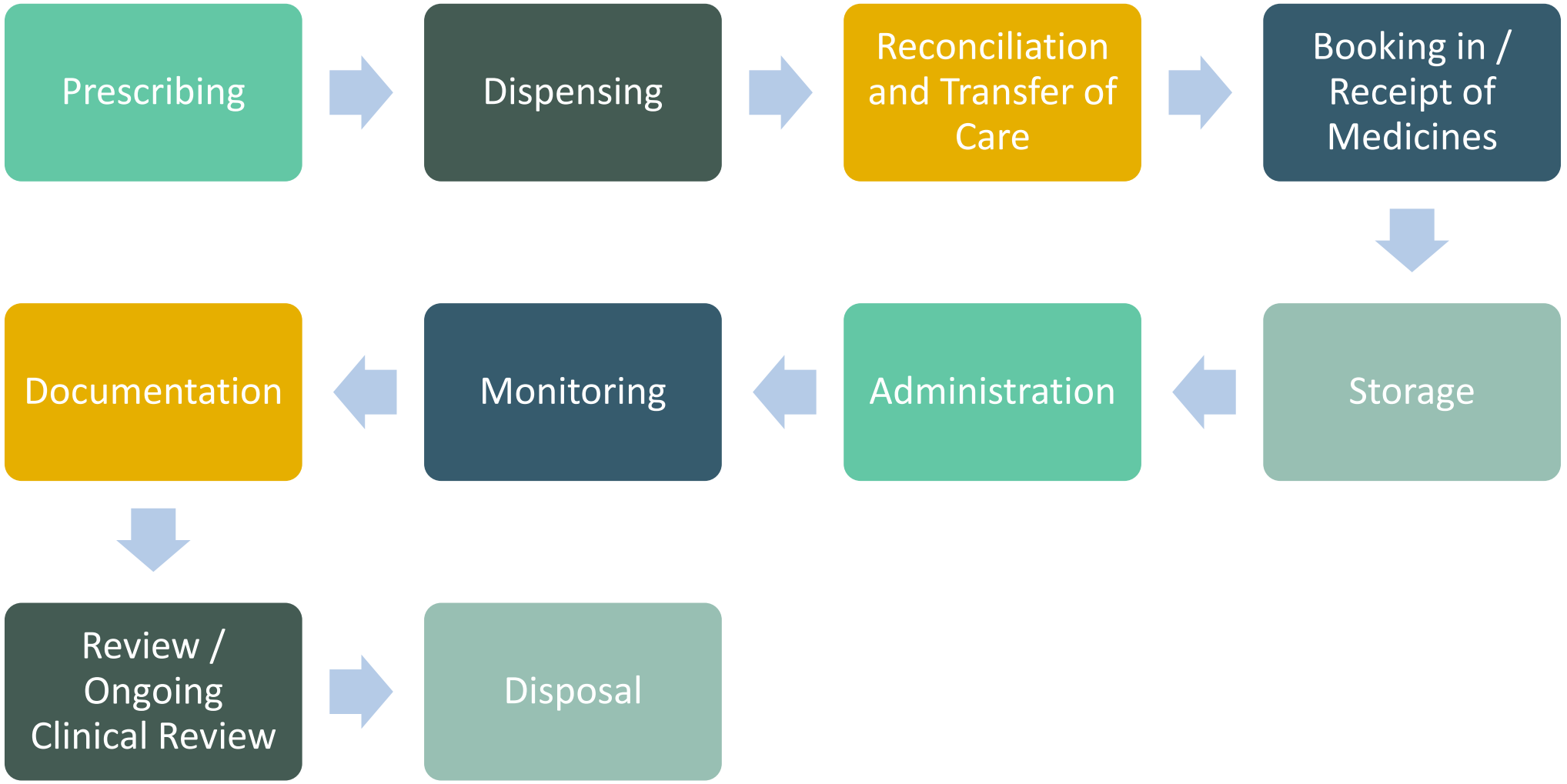
Regulated by Care Quality Commission

Why it Matters?

- **Polypharmacy** is common in social care
- Medication errors can occur at **multiple stages**
- Medicines management remains a key **CQC focus area**
- Poor practice can lead to **harm, hospital admissions, and safeguarding concerns**

Medicines safety is a whole-system responsibility

The Journey of a Medicine



Medication Errors

Medication Errors in Care Homes - EEPRU Key Findings

- 237 million medication errors occur annually in England
- 41.7% occur in care homes

Breakdown of Errors in Care Homes:

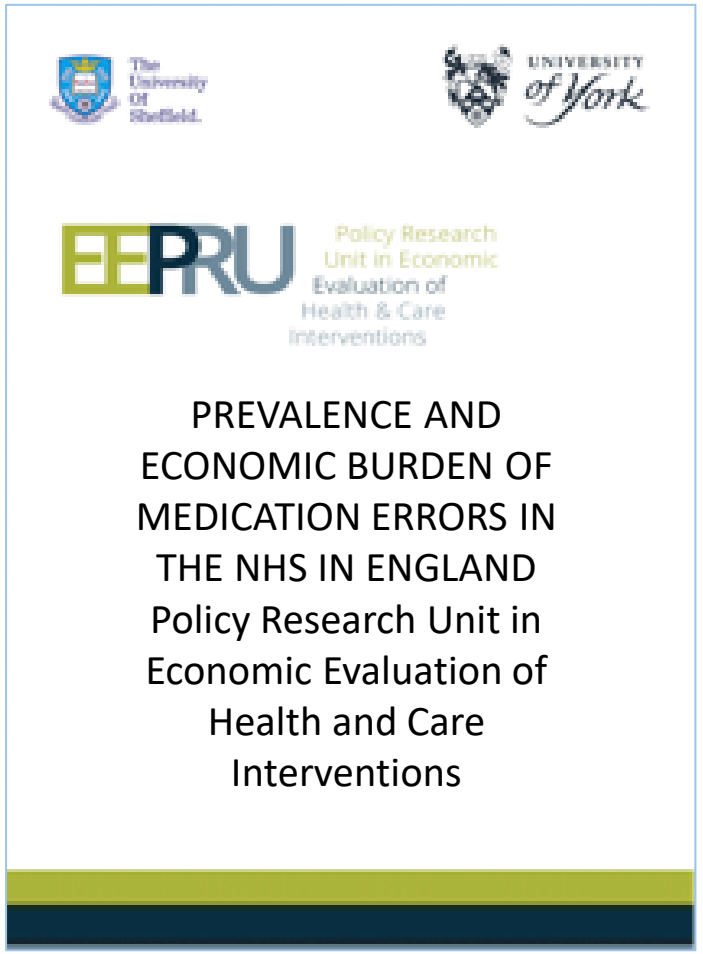
- 92.8% – Administration errors
- 3.0% – Prescribing errors
- 3.6% – Dispensing errors
- 0.6% – Monitoring errors

Impact on Residents:

- ~70% of residents experienced at least one medication error
- Average: 1.9 errors per resident

Severity:

- 72.1% minor potential harm, 25.8% moderate potential harm, 2.0% severe potential harm



- Reporting of errors and near misses
- Trend and root-cause analysis
- Competency and training
- Shared learning, coaching and analysis
- Positive learning culture

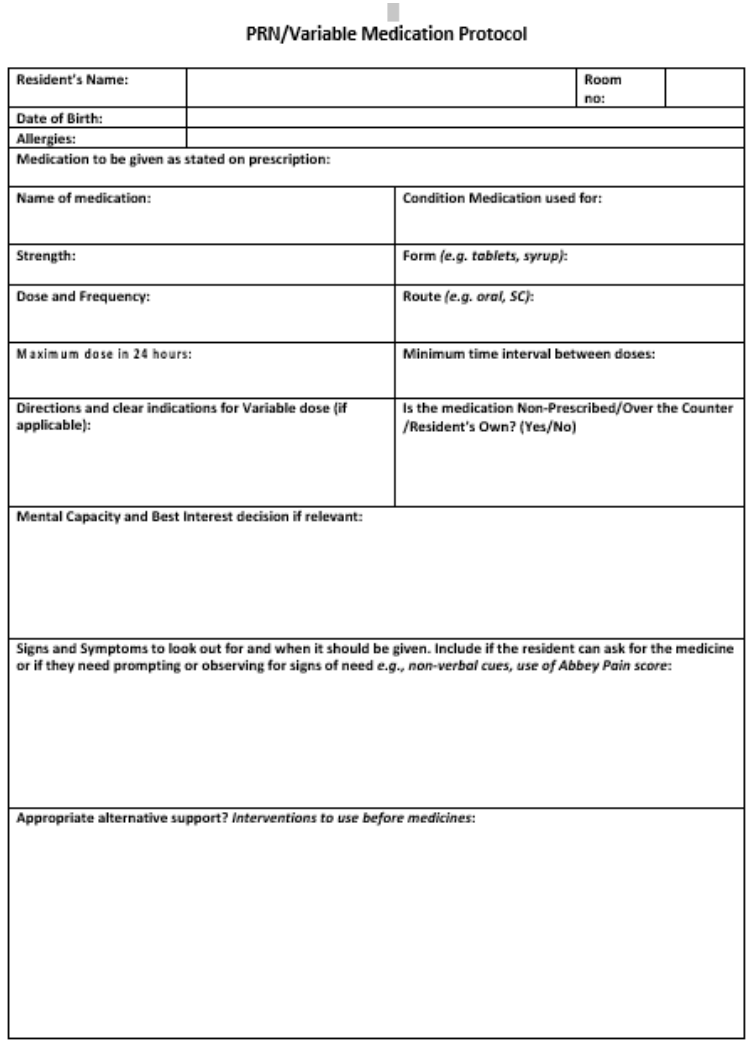
Medication Themes

- Medicines Policy and Signature Records
- Observations
- Medication Administration Records
- Ordering, Receipt and Storage of Medicines
- Medication Waste
- When Required Medicines
- Controlled Drugs
- High Risk Drugs and Care Plans
- Medication Risk Assessments
- Homely Remedies
- Oxygen
- Record Keeping
- Medicines Reconciliation
- Equality and Diversity
- Medication Review and Polypharmacy
- Medicines Errors, Adverse Effects, Safety Alerts
- Training and Development
- Stock Checks
- Nutrition and Hydration
- Medication Audits

When Required Medication

Person Centred PRN Protocol

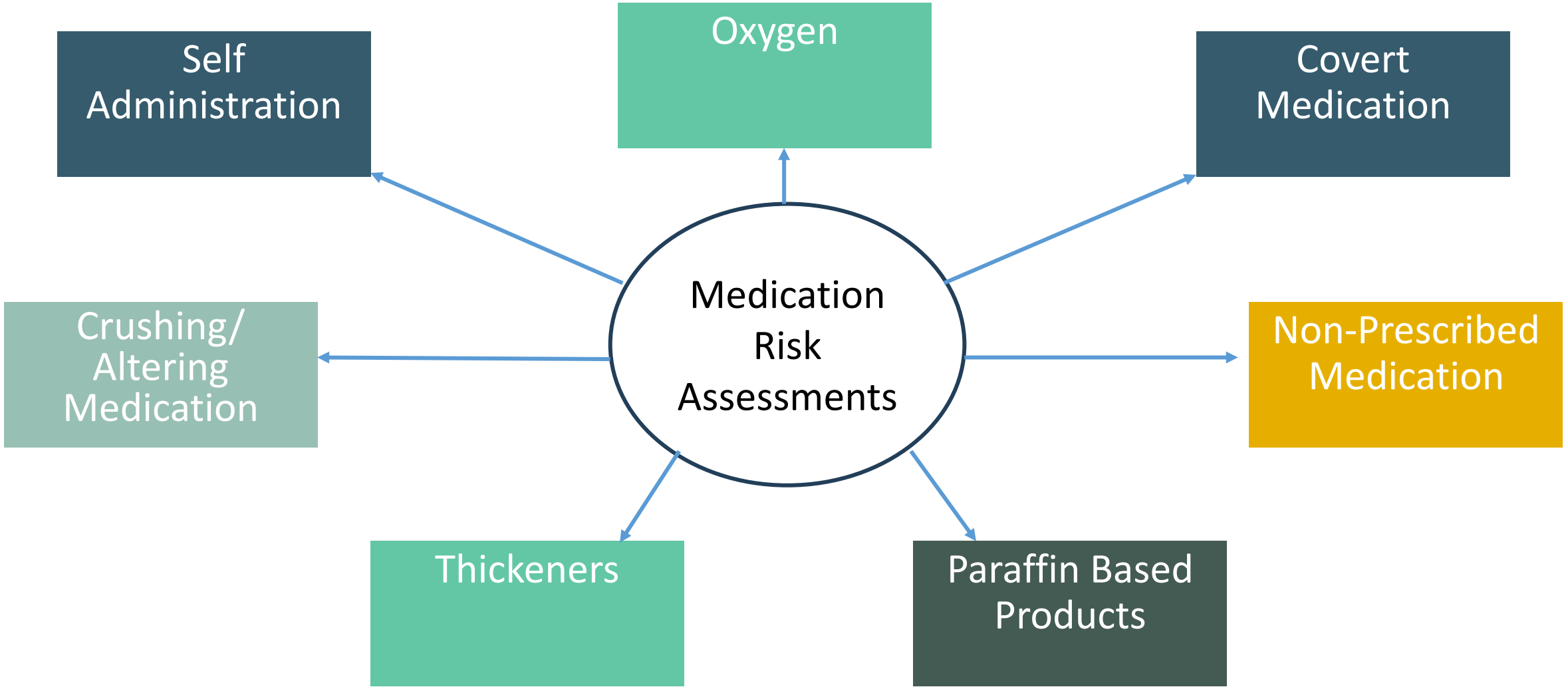
- Signs and Symptoms
- Alternative Support
- Escalation
- Cognition
- Follow up
- More than one medicine for the same condition



PRN/Variable Medication Protocol

Resident's Name:		**Room no:**	
Date of Birth:			
Allergies:			
Medication to be given as stated on prescription:			
Name of medication:		**Condition Medication used for:**	
Strength:		**Form** ***(e.g. tablets, syrup)*****:**	
Dose and Frequency:		**Route** ***(e.g. oral, SC)*****:**	
Maximum dose in 24 hours:		**Minimum time interval between doses:**	
Directions and clear indications for Variable dose (if applicable):		**Is the medication Non-Prescribed/Over the Counter /Resident's Own? (Yes/No)**	
Mental Capacity and Best Interest decision if relevant:			
Signs and Symptoms to look out for and when it should be given. Include if the resident can ask for the medicine or if they need prompting or observing for signs of need ***e.g., non-verbal cues, use of Abbey Pain score*****:**			
Appropriate alternative support? ***Interventions to use before medicines*****:**			

Medication Risk Assessments



High Risk Drugs and Care Plans

- Therapeutic drug monitoring drugs
- Diabetes management
- Anticoagulation
- Epilepsy management
- Antipsychotic medicines
- End-of-Life medicines

- Time specific medicines
- Inhalers
- Cytotoxic drugs
- Teratogenic medication
- Adrenaline Auto-injectors
- Paraffin-based emollients

Person centred

Management Plan

Monitoring

Rescue Medication

Escalation

STOMP & STAMP: Medicines Optimisation

Why it matters

- People with a learning disability and autistic people are more likely to be prescribed psychotropic medicines.
- Some medicines remain in use without regular review or a clear ongoing clinical indication.
- Reducing inappropriate prescribing can improve quality of life without compromising safety.

What good practice looks like

- Regular multidisciplinary medication reviews.
- Person-centred care plans with non-pharmacological strategies.
- Monitoring for effectiveness, side effects and physical health.
- Use of behavioural support tools (e.g. ABC charts) to inform decision-making.
- Partnership working with GPs, psychiatrists, pharmacists, families and carers.

STOMP is not about stopping medicines - it's about ensuring every medicine has a clear purpose, is regularly reviewed, and supports the person's quality of life.

CQC's New Framework – Medicines

KLOE: Are medicines and treatments safe and delivered in a timely way, in line with people's needs and preferences?

Scope of this key line of enquiry and topic areas include:

- Roles and responsibilities and delegation
- Self-medication
- Safe administration and record keeping
- Consent/decisions/covert administration (including Mental Capacity Act 2005 and Mental Health Act 1983)
- Controlled drugs
- Storage and disposal
- Innovative medicines and MedTech safety
- Antimicrobial stewardship
- Stopping over medication of people with a learning disability (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)
- Intravenous medicines/fluids/medical gasses

CQC's New Framework – Medicines

What will distinguish Outstanding?

- **Proactive**, not reactive, medicines management.
- Innovation and continuous quality improvement.
- Partnership working with residents, families and healthcare professionals.
- Demonstrable evidence that medicines improve outcomes and quality of life.

The focus is shifting from medicines compliance to medicines optimisation, demonstrating how safe, person-centred practice improves outcomes for people.

CQC's Medicines Themes

- PRN Medicines
- Person-Centred Medicines Care Plans
- Governance & Meaningful Medicines Audits
- Covert Medicines / Mental Capacity Act (MCA)
- High-Risk & Time-Critical Medicines
- Stock Control & Reconciliation
- Medicines Storage & Temperature Monitoring
- MAR/EMAR Accuracy
- Medication Training & Competency
- Topicals, Patches & Thickeners
- Self-Administration of Medicines
- Learning from Medication Incidents

CQC Report

Medicines optimisation

Score: 2

The provider did not always make sure that medicines management was safe and met people's needs. Improvements were required as there was no body map for the administration of insulin so as to identify the site of injection. Where a variable does of medication was prescribed, for example, 1 or 2 tablets, the actual amount of medication administered was not consistently recorded. Where people were prescribed a transdermal patch to deliver a specific medicine through the skin, a record depicting the site of application was not completed by staff. The record of fridge temperatures demonstrated medication requiring cold storage were not stored at the correct temperature. The latter was fed back to the manager, whereby new thermometers to monitor the fridge temperature were purchased and available on the second day of our assessment.

Staff confirmed they had received appropriate medicines training and had their competency assessed at regular intervals to ensure their practice remained safe when supporting people with their medicines. However, we found there was no evidence of competency assessments for night staff. This had been raised by the Local Authority during their assessment of the service in February 2025 but remained outstanding.

CQC Report

Medicines optimisation

Score: 2

The provider did not always make sure that medicines and treatments were safe and met people's needs, capacities and preferences. Staff did not always involve people in planning.

Not all PRN (as required) medicines had robust protocols in place to advise staff when and how to administer PRN medicines. This was related to pain relieving and anxiety relieving medication. No pain chart or agitation charts were in place to monitor for effectiveness. This meant people were at risk of not receiving medicines when they needed them, as documents did not detail signs for staff to look out for to indicate these were needed. There were also no directions for staff to use distraction techniques before administering anti-anxiety medicines. The recording of the running total for PRN medicines was inconsistent and for some there were large discrepancies for which staff could not account for.

The medicine administration records were not completed following good practice guidance, there were multiple crossing outs, gaps with no reason documented and as there was no running total, it could not be checked as whether it was a missed signature or not given. Staff were not using codes or using the code to explain gaps. Therefore, we were not fully assured that people received their prescribed medicines.

CQC Report

There was a clinical cupboard, which was cluttered and disorganised, there was tablets left in the cupboard which we were told had been found in someone's room and which were not prescribed for that person. These tablets had not been recorded on any document. An incident report had not been completed or reflected in the person's care records. Risk assessments were not in place for managing the use of unprescribed drugs and alcohol with anti-viral, anti-depressants and anti-seizure medicines. This placed people at risk of harm. During the assessment process, the provider sought immediate support from the Medicines Optimisation for Care Homes (MOCH) who have provided training for all staff and competency assessments, which has mitigated immediate risk to people, however this will take time to embed.

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Hertfordshire County Council

Bryony Morris
Head of Provider Monitoring and Assurance Team

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Quality expectations and good governance of medicines

Bryony Morris

Head of Provider Monitoring and Assurance Team

Provider Monitoring and Assurance Team

Our approach to quality monitoring ensures:

- contracted providers deliver high quality care and support services in Hertfordshire
- services give people choice and control
- people are confident the care and support they receive will be of high quality and that they will be safe and treated with dignity and respect
- the approach to monitoring and assurance is consistent across all service types
- the provider market is clear of our expectations toward quality and safety
- HCC fulfils Care Act duties to *facilitate a diverse, sustainable high-quality market for their whole local population*
- PAMMS audit/assessment is aligned to the standards in the East of England Contract

PAMMs Structure

- Five regional outcomes
- 16 standards in PAMMs to assess the outcomes

Involvement and Information		Personalised care and support		Safeguarding and Safety		Suitability of Staffing		Quality of Management	
1	Respecting & Involving Service Users	3	Care & Welfare of Service Users	6	Safeguarding People who use the Service from Abuse	11	Requirements Relating to Staff	14	Assessing & Monitoring the Quality of Service provision
2	Consent	4	Meeting Nutritional Needs	7	Cleanliness & Infection Control	12	Suitability of Staffing	15	Complaints
		5	Co-operating with other Providers	8	Management of Medicines	13	Supporting Staff	16	Records
				9	Safety & Suitability of Premises				
				10	Safety, Availability & Suitability of Equipment				

How is this assessed

- People who use the service
- Environment and approach
- Records, Process and Learning

Standard 8: Medications ‘A’

A16. Care & support plans document that people have been involved in all decisions regarding their medications (where they have capacity to do so). If medication is administered covertly this is evidenced by an assessment of capacity and best interest decision making and signed agreements from the GP and pharmacy provider.

- Care plan confirms individuals involvement Risk assessments in place if self-medicating.
- Where relevant LPA for Health and Welfare is documented on the care plan.
- Where individuals are unable to make decision regarding their own health and / or medication the MCA is followed, best Interest documented and where required Dols process followed.
- Record of how person would like to take their medication and where
- Care plans include information regarding medication reviews and annual health checks.

Standard 8: Medications ‘B’

Discussion with people accessing the service confirms staff handle medicines safely, securely and appropriately. **Discussion with people accessing the service confirms staff handle medicines safely, securely and appropriately.**	**People confirm that they are involved in decisions regarding their medication.**
Observation: - Medication room doors must be kept locked at all times and open trolleys must not be left unattended. - Staff explain medication to individuals when administering / prompting and are observed to follow the organisations own medication policy & guidance - Staff do not disturb the member of staff administering medication. - The 6 Rs of medication are: Right Patient, Right Drug, Right Dose, Right Route, and Right Time, Right Documentation.	- People confirm they have been involved in decision making process and can request access to the GP when needed. - LPA for Health and Welfare is involved in decision making process if one is in place. - Supported Living: People are actively supported to manage their medication - Observation: involving individuals when giving medication

Standard 8: Medications ‘C’

Staff where responsible are able to explain the appropriate handling of medications, that they have undertaken the required training and competency skills in line with the mandatory training requirements and are aware and follow any local requirements under the contract.

- Staff confirm that mandatory training is in place and that they have understood the training.
- Staff confirm competencies assessments are completed by an appropriately trained person.
- Staff confirm that they are confident in managing medication.
- Staff can explain the difference between prompt, assist, administer.
- Staff are confident to explain medication processes and understand different terms, e.g. covert meds, PRN protocols, ordering etc.
- Staff competencies are completed in line with best practice

Standard 8: Medications ‘E’

Medicines are stored and administered safely including any homely remedies and covert medication.

- Storage appropriate and secure – clear in care plan (homecare)
- Temperatures should be recorded for room, fridge – frequency and escalation
- Trolley is secure in the clinical room which is locked, Trolleys and cabinets are locked. If Trolleys are stored in the corridors outside the clinical room the trolleys must be secured to the wall.
- Medication given by routes other than oral are stored separately form oral medication.
- Homely and Covert med policies if applicable.
- Covert medication – copy of covert risk assessment signed off by GP and Pharmacist.
- Boxed and bottled medication has date of opening recorded on it.
- CD medication stored appropriately.

Standard 8: Medications ‘F’

Appropriate records are maintained around the prescribing, administration, monitoring and review of medications.

- Audits take place weekly to ensure medication count is correct for all medication. Daily CD count /reconciliation takes place.
- Evidence of Pharmacy audit and in house audit, with missing entries highlighted & error identified and followed through in supervision, copies of prescription returns, sharps box date assembled and location recorded on it), not excess stock, changes being identified.
- MARS sheets, are completed correctly, dated photograph in place that is no older than 12 months or when change occurs in appearance. No gaps. Does it contain what meds, side effects, allergies? Hand written entries must be double signed. Check for correct use of codes.
- MCA consent
- Medication policy (refer to homely & covert medication)
- Records. Evidence of internal audits conducted on regular basis and actions (Action Plan) being followed up to improve shortfalls identified. Include (as appropriate):
- Epilepsy protocols to be signed off by GP or pharmacy.
- Dates, dosage, quantity code, controlled drug & PRN policy & procedure
- PRN Protocols fit for purpose
- Specific on timings of administration clear visibility of this to ensure all staff are aware (e.g. for Parkinsons medication).
- Clear process for who re-orders, when, how

How to achieve Good?

Paperwork:	Processes	Environment	Staff	People
Good audits – regular, robust audits that are effective and actions followed up	Clear procedure from ordering to dispensing and clear escalation if things go wrong,	Organised rooms, right temperature and paperwork	Up to date training, Competency checks every six months	Resident input into medication decisions – likes, dislikes, personalised and triangulated to care plans and other docs, e.g. epilepsy protocols, PRN protocols
Robust recording of allergies, triangulation on care plan and on mar chart, clear PRN	Good management of anti-psychotics and alignment to DOLs and good understanding of what works	In SL – storing in rooms	Medication champion	Good administration practice, engagement with residents
Meds errors and learning	Robust MCA around medications, especially for sedatives and anti-psychotics and linking to DOLs.		Good PRN protocols and recognising non-verbal signs of pain	People know the protocol for epilepsy, who has Buccal, where is it, specific training and competency provided
sign in / out – for day care	Linking with local pharmacy for professional advice.		Awareness of STOMP and self-medication – positive risk approach to self-medication	

Camascope

Jamie Murphy

(C) Hertfordshire Care Providers Association

Camascope

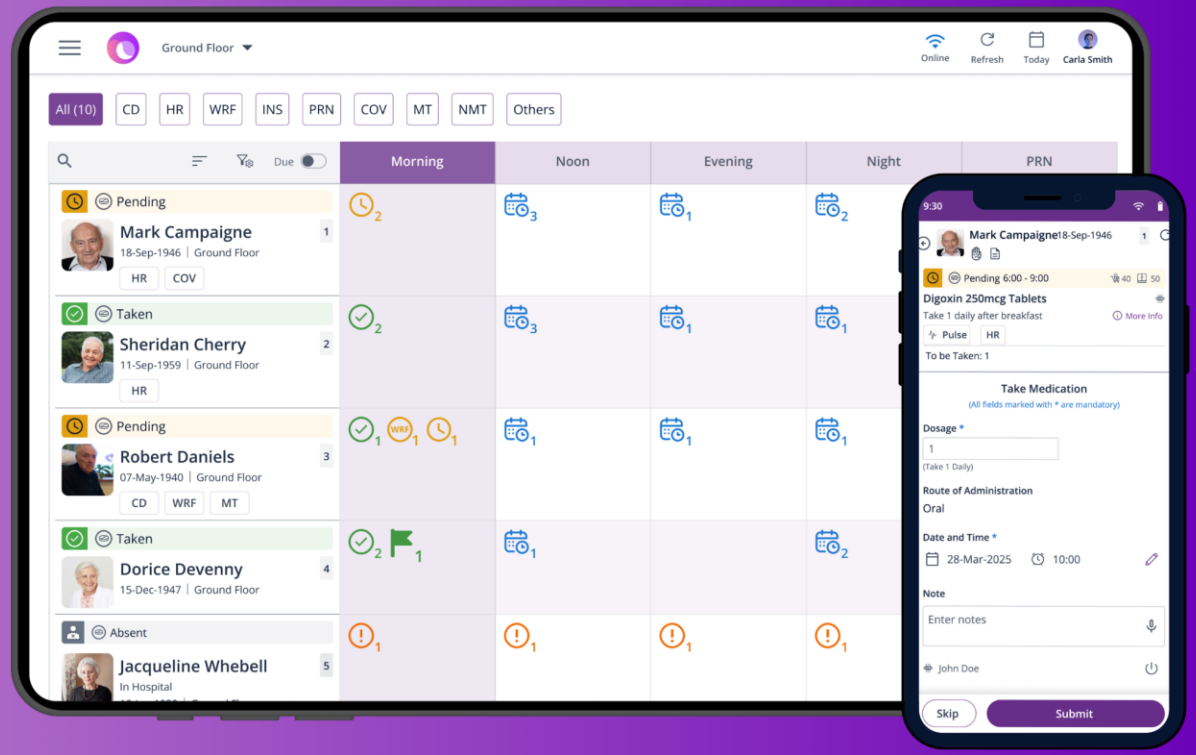
scan me to find out more

Live Demo hcpa

Using digital systems to strengthen medication safety

with **Jamie Murphy**

National Account Lead



Case Study & Panel Discussion

Provider scenario, what would you do?

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Case Study – Two Signatures, One Error

- Resident prescribed **Lamotrigine 25mg TDS**
- Medication delivered and **checked by 2 staff** (nurse + senior)
- Administered for **3 days**
- Day 4: Resident found **unconscious → 999 called**
- **Error** identified: **50mg tablets** supplied and administered

Case Study – Two Signatures, One Error

What Went Wrong?

- Checking process was **task-based, not clinical**
- Dose verification failure (**strength vs prescription**)
- False reassurance: “2 signatures = safe”
- No robust **booking-in / reconciliation process**
- **6 R’s** not consistently applied (right drug / right dose)

Case Study – Two Signatures, One Error

What Was Done?

- Full **competency review** (day + night staff)
- Targeted **re-training**
- Strengthened **booking-in/checking processes**
- Incident reported, **lessons learnt, reflection, RCA etc. completed**
- **Safeguarding + CQC notification** completed
- **ICB involvement** for system learning
- Staff wellbeing support

Practical Tool: Governance

- Medicines reconciliation
- Follow medicines policy and clear processes
- Regular auditing (identify themes, not just issues)
- Staff training and ongoing competencies
- Prompt incident reporting → investigation → learning
- Medication huddles and shared learning
- Open, transparent culture
- Effective use of EMAR systems to support safe administration, monitoring, and oversight

Practical Tool: Governance

Safe systems = Technology + People + Process

Please direct any questions to the Q&A function or chat feed

Questions and key takeaways

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Questions raised

- What are best practices for medication audits and staff competency assessments?
- How should medication reviews be carried out in community care?
- How many staff should book in or check a new medication delivery from the pharmacy?
- Should self-administered creams and nutritional drinks appear on the MAR, and should support staff sign for them?
- What is best practice for reporting medication errors and demonstrating compliance?
- What are the current medication-administration procedures?
- What medication-compliance failures are commonly found in audits, and what evidence demonstrates safe governance?
- What are the safe-practice requirements when medication is taken home, decanted or witnessed, and when repeated refusal may require a medication review?
- What is best practice for MAR charts and controlled drugs?
- How should responsibilities be documented when medication administration is shared with family or the person, and how should missed eMAR signatures be corrected?
- What should staff do when a medication dose is dropped or spoiled and an urgent replacement cannot be obtained?
- Who should assess the medication competency of a trainer or medication lead, and is an assessment still required for someone with a nursing background?
- What should PRN protocols, care plans and MAR records contain, including administration, monitoring, effectiveness and blister-pack issues?
- How should home remedies be managed and discussed with people receiving support?
- When was the latest HCC medication policy published?
- What does safe medication management require in practice?
- How can digital MAR/eMAR systems maintain compliance, reliable signing and effective audit trails?
- What policies apply to medication via NJ tube, PEG feeding and topical routes, and when could crushing tablets for PEG administration be considered covert medication?
- How should detoxification and drug interactions be managed for people with dual diagnosis or other medical conditions?
- How should liquid-medication stock be tracked and reconciled?

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Education

- **Safe medication principles**
- **Medication – Extended Knowledge**
- **Medication Governance**
- **Medication CHAMPION**

If you have a larger workforce and would like to explore dedicated training sessions exclusively for your organisation, we would be pleased to discuss your requirements.

Education need request

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Available to everyone, 24/7

Includes local and national resources, tools, guidance, policies, and contacts in a wide variety of areas

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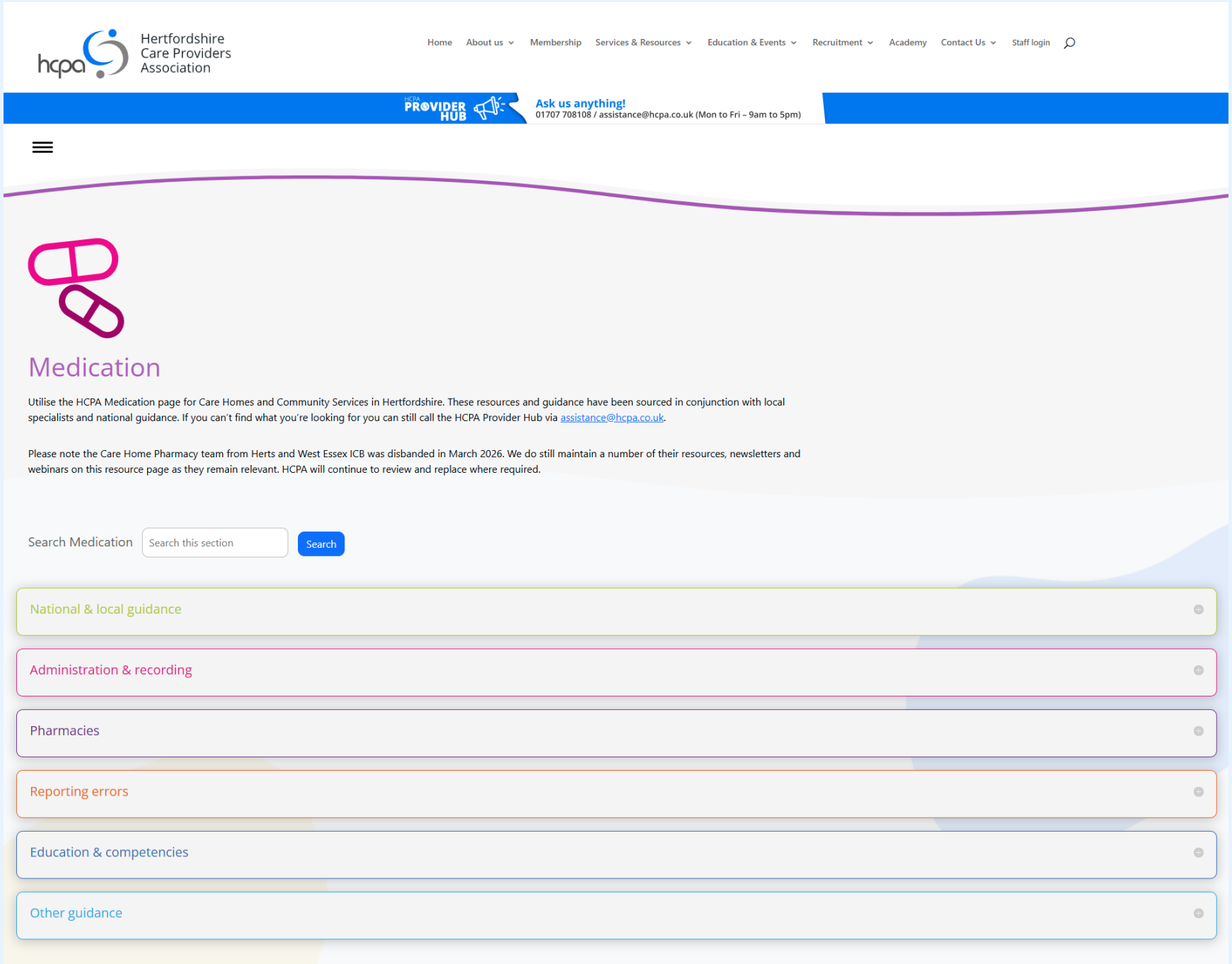
Resource Library | Medication



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Resource Library | Medication

Practical resources to support safe medication practice

Governance & policies

Accountability, procedures and good practice

Medication management

Ordering, supply, storage, transport and disposal

Administration & recording

MAR/eMAR, PRN, OTC and covert administration

Competency & learning

Observation and competency assessment resources

Incidents & improvement

Reporting, escalation and learning from medication errors

Plus: previous webinars, newsletters and relevant resources from the former Care Home Pharmacy Team.

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Changes to Pharmacy Support

HWE Care Home Pharmacy Team no longer in place

- Pharmacy Team disbanded in March 2026
- Relevant existing resources remain available through HCPA
- Resources will be reviewed and updated where required
- Providers remain responsible for safe medication systems and appropriate clinical escalation

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What we have planned

Strengthening medication support for providers

Education

Develop and broaden the medication offer

Partnerships

Bring additional expertise into provider support

Resources

Review and refresh medication guidance and tools

Quality

Strengthen competency, governance and learning

Provider needs

Respond to feedback, incidents and emerging priorities

Priority focus:

Supported Living

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Support Service Directory

All the contacts you need, in one place

Up to date contact details for all the Hertfordshire support services you need

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- Covid: PPE, vaccinations and infection control
- Liaison with Hertfordshire County Council
- Funding, contracting and commissioning
- Staff wellbeing and recognition
- HR, Staffing and recruitment
- Training and education
- Business continuity
- Data protection
- Monitoring
- Equipment
- Insurance

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HCPA: 'Sharing best practice in care through partnership'

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