Medication Audit for Care Homes

CARE HOME -

DATE -

IMPLEMENTING NICE GUIDELINE (SC1) IN CARE HOMES

Please note some questions may not be relevant at the time of the audit e.g. you may not have any resident on warfarin or digoxin but you should indicate in the audit what your practice would be if you did have a resident taking the medication

Medication Audit for Implementing NICE Guideline (SC1) & Best Practice in Care Homes

Introduction

Care homes are subject to enormous amounts of legislation and guidance. This audit aims to provide a way to assess the care homes compliance with NICE guidelines (SC1), current national and local guidelines and best practice when administering medication. The audit can be used by the care home to self-assess and it can be used by external health professionals when completing a full medicines management assessment.

Advice for Completing the Audit

- Work through each of the questions and tick appropriate box
- If you have ticked all **white (Yes or N/A)** boxes then the audit is complete and no further action is needed.
- If you have ticked any boxes that are shaded **grey (No)** it means that action needs to be taken.
- Implement all required actions and sign right hand column to demonstrate completion of actions.
- Keep a copy of all audits completed and file as evidence
- To undertake an audit in a specific area click on the required area on the next page

Contents

Section A - Medication Policy		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
Does the homes medication policy meet the NICE guidelines - Medication in Care Homes (SC1) and cover							1.1.2
A1	Ordering, Receiving, Storage and Disposal of Medication						1.1.2
A2	Managing Controlled Drugs						
A3	Self-administration by residents						1.1.2
A4	Medication Administration including training						1.1.2
A5	Covert Administration						1.1.2
A6	Use of OTC medication and homely remedies						1.1.2
A7	Maintaining accurate and up to date records						1.1.2
A8	Reviewing of medicines						1.1.2
A9	Managing and sharing resident information						1.1.2
A10	Accurately reconciling residents' medication						1.1.2
A11	Identifying and reporting medicines incidents						1.1.2
A12	Identifying and reporting medicines adverse effects						1.1.2

Section B - Training		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
B1	Does the Home carry out a mediation administration competency assessment with all new staff whose role will be to administer medication?						1.17.6
B2	Does the Home identify and provide any medication training that staff members require to do carry out their roles?						
B3	Does the home keep a record of all training carried out by staff?						1.17.4
B4	Is there written evidence of accredited medicines training provided for all staff who administer medicines?						1.17.3
B5	Does the Home have enough trained staff to administer medication in an appropriate time scale during each medication round?						
B6	Does the home assess & record the competence of all qualified staff to administer medication at least annually?						1.17.5
B7	Does the home provide further competency assessments and support to staff following a medicines incident?						1.17.5
B8	Do all qualified staff have knowledge of and access to, the Medication Policy?						

B2. Nurse Specific Training		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
B21	Are all professional staff suitably qualified and registered with the relevant professional body?						
B23	Is there usually a Nurse on duty who has training to administer IM medication?						
B24	Is there usually a Nurse on duty who has training to administer S/C medication?						
B25	Is there usually a Nurse on duty who has training to administer medication through a PEG?						
B26	Is there usually a Nurse on duty who has training to administer Oxygen?						
B27	Do all Nurses have training for use of adrenaline in treating anaphylactic reactions? Adrenaline training: contact the eLearning helpdesk (elearning@wales.nhs.uk or 01443 848636) for an account.in order to access the online training modules						

B3. Care Workers Administering Medication in Nursing Homes		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
B28	Have all carers who administer medication received appropriate training to NVQ level 3 or above and been assessed as competent?						1.17.1
B29	Has the training been accredited and approved?						1.17.3
B30	Is a register available of all carers who have been assessed and competent to administer medication including any additional training they may have carried out as mentioned above give e.g., I.M. injections, tube feeding?						1.17.3
B31	Do carers have annual update and competency assessments?						1.17.1
B32	Is a documented assessment made of which residents would be suitable for having their medication given by a qualified carer						1.17.1
B33	Is the registered nurse aware of their responsibilities surrounding the delegation of medicines administration?						1.17.1
B34	Is the delegating nurse aware they are accountable for the carer's administration of medication in line with their professional code?						1.17.1
B35	Are the carers aware of their professional responsibilities and limitations around medication administration?						
B36	Are carers aware they are not allowed to give PRN medication without a nurse first assessing need and appropriateness?						1.17.1

Section C - Ordering		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
C1	Does the home have at least 2 members of staff who are competent to order medication? (only 1 needs to do the actual ordering)						1.10.3
C2	When ordering medication are care home staff given sufficient protected time to check stock levels to avoid over ordering or missing items so only medications that are needed are requested?						
C3	Does the home keep a record or copies of all medication ordered?						1.10.5
C4	Are prescriptions received from the surgery and checked against the initial order before being sent to the pharmacy for dispensing?						1.10.4
C5	Is there a procedure in place to order repeat, acute and 'when required' medicines from the pharmacy and/or GP practice? (including out-of-hours) outside of the monthly order cycle						
C6	Is there a process for notifying the GP if any medications are out of stock so that an alternative can be considered and prescribed						

Section D - Receiving		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
D1	Is the receipt of all medicines, appliances and feeds booked in & signed for?						
D2	Are all medications and MAR charts received within a timescale that allows the home time to inform the pharmacy of any identified discrepancies and for them to be resolved, with a corrected MAR chart or medication supplied?						1.9.1
D3	Are remaining stocks of in-use medication (esp. PRNs) carried forward and recorded on the new MAR?						1.7.1
D4	Does the amount ordered for PRN medication reflect the quantity normally required each month i.e., if using 840ml a month of lactulose, that 500ml is not being received at the start of each cycle?						1.9.2
D5	Are all medicines individually labelled if not part of the Bulk Prescribing procedure?						
D6	Are medicines purchased by residents or their families recorded and checked with a GP or Pharmacist before being used?						

Section E - Storage		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
E1	Are medicines stored in a designated area which is appropriate & lockable?						
E2	Is the medication room kept locked when not in use?						
E3	Are keys to this area held by an appropriate person & is there a hand-over procedure? Or if there is a keypad is the code known only to designated staff?						1.12.2
E4	Is the temperature in the medication room and any storage lockers in residents' rooms maintained below 25^{o}C and the temperature recorded daily?						1.12.2
E5	Is there sufficient storage space available to store individual patient's medicines separately?						
E6	Are external and internal medicines stored separately in the medication room?						
E7	If medicines are stored within patients' rooms, is secure storage available?						
E8	Are all medications requiring temperature control between 2-8c currently stored in the fridge?						
E9	Is stock rotated and all expiry dates checked and the process recorded?						
E10	Are stock levels of medicines, appliances and feeds appropriate and not excessive?						
E11	Is there a procedure for dealing with excess stock?						

E12	Does the home have information regarding the shelf life of medications once they have been opened and in use?						

E2. Fridge Storage		**Yes**	**No**	**N/A**	**Actions Needed and Comments**	**Sign & Date** **Actions Completed**	**SC1 Ref**
E21	Is the fridge kept locked when not in use or alternatively is it in a locked room?						1.12.2
E22	If only a domestic fridge is available, is medication stored in a lockable container?						
E23	Are items requiring refrigeration put away as soon as they are received?						
E24	Does all stock currently in the fridge require temperature control?						
E25	Are max/min fridge temperatures monitored and recorded and the thermometer reset daily?						1.12.2
E26	Do records indicate that the fridge temp is consistently between 2-8^{o}C?						
E27	Is there a procedure in place for what to do if the medication room or fridge falls outside of the recommended temperature?						

E3. Storage of Medical Gases		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
E31	If the home stores Oxygen, is it stored securely?						
E32	Is there an appropriate warning notice displayed on the door of any room that has oxygen either stored or in use						
E33	Does the home ensure that there is a no smoking policy near the Oxygen?						
E34	If the home uses an Oxygen concentrator, is it stored upright and plugged into the mains (not an extension lead)?						
E35	Does the home ensure that any resident requiring Oxygen does not use any paraffin-based products?						
E36	If required, does the Home have a nebuliser for use for residents?						
E37	Are new masks and tubing available and are they cleaned and replaced regularly as per manufacturers' guidance?						

E4. Storage of Sharps		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
E41	Does the home have sharps bins for needle disposal?						
E42	Are all sharps signed and dated when opened and when sealed?						

Section F - Controlled Drugs		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
F1	Are all CDs stored in a locked cabinet which meets the requirements of the Misuse of Drugs (Safe Custody) regulations1973?						1.12.1
F2	Are keys to the CD cabinet held by a designated person?						
F3	Is the CD cabinet kept locked when not in use?						
F4	Is there a hand over procedure for the CD keys?						
F5	For homes using MDS, are blisters containing CDs stored in the CD cabinet?						
F6	Is there a bound CD register with numbered pages?						
F7	Does the CD register contain a separate sheet for each CD for each resident?						
F8	Does the register contain complete records of the receipt, administration and disposal of CDs?						
F9	Does the register contain running balances of CDs which are checked regularly?						1.14.16
F10	Is all CD medication entered into the register immediately on receipt and the balances updated?						
F11	Are all alterations to CD entries noted in footnotes and not crossed out?						

F12	Are the stock levels of all CDs correct?						1.14.16
F13	If the balance is incorrect in the CD register is this investigated by the Care Home Manager or clinical lead?						
F14	If after investigation the discrepancy cannot be rectified is this reported to the Responsible Individual?						
F15	Are all unwanted CDs recorded and disposed of (either returned to pharmacy or with a DOOM kit)?						1.12.5
F16	Is the administration of CDs witnessed by a second member of staff?						1.14.9
F17	In nursing homes, are all CDs administered by registered nurses or medical practitioners only?						
F18	When administering are medications that are liable to misuse (DLM's) recorded and running totals kept						

Section G - Disposal		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
G1	Are medicines awaiting disposal stored securely and separated from medicines in-use?						1.12.6
G2	Are appropriate records (date, patient name, medicine and quantity) maintained of all medicines that are disposed of in a separate record book?						1.12.6
G3	Are waste medicines returned to a pharmacy (non-nursing only) or via a waste management company?						
G4	Are records of receipt provided by the pharmacy or waste company and retained in the home?						
G5	Following the death of a resident, are medicines kept for 7 days before disposal or in the case where there is a coroner's inquest, until after the inquest?						1.12.2

Section H - Medicines Administration		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
H1	Are staff given sufficient protected time to carry out an administration round?						
H2	Are medication rounds normally completed within two hours? (if not discuss possible solutions)						
H3	Is the medication trolley always supervised when in use and locked when left unattended?						1.12.2
H4	Are records made as soon as possible after medication is taken and before moving on to the next resident?						
H5	Are medications only prepared at the time of administration i.e., not potted up for use later?						
H9	Are medicines only given to the resident they were prescribed for? (excluding Bulk Prescribed items)						1.10.1
H10	When medication has the option of a variable dose have the number of tablets, mls etc. actually administered recorded on the MAR charts?						1.14.7
H11	Is additional information available to support administration of PRN or variable dose medication? • What the medication is for • How much to give • Minimum time between doses • Maximum daily dose • Indication for repeating the medication if the medication has not had the desired effect?						1.14.2

H12	Is the home able to offer PRN medication between rounds?						
H13	Is there a procedure to administer regular medication outside normal rounds i.e., Parkinsons medication?						
H14	Are all medicines administered directly from labelled containers supplied directly by the pharmacy?						
H15	Are medication details on labels & MARs checked before each administration?						
H16	Are all labels legible and not smudged or faded?						
H17	Do all creams, ointments, eye preparations and insulin once opened have the date opened recorded on the bottle or tube?						
H18	Is a residents allergy status checked before a medication is administered?						

Section I - MAR Charts		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
I1	Is there a photo of each resident that is it up to date and observable during medication rounds?						
I2	Are MAR charts fully completed at each administration?						
I3	Are the following correctly specified on MAR chart? (check) • Name/s of resident? • Date of Birth? • Current GP /surgery? • Allergy status						1.14.8
I4	If the resident has no allergies is No Known Drug Allergies (NKDA of KDA) written in the Allergy box and not left blank						1.14.8
I5	Does the MAR charts contain all medicines, including PRN medication and topicals?						
I6	Are all special instructions for administration contained on the MAR charts i.e., with or after food?						1.14.8
I7	Are all dosage instructions (esp. PRN medication) clear and unambiguous?						1.14.7
I8	Can you determine what and when a medication has been given to the resident from the MAR chart?						
I9	Are all boxes signed on the MAR chart for regular medication or appropriate code used for non-administration?						1.14.1

I10	When the non-administration “Other” is used, is a note made on the back of the MAR chart to clearly define why the medication was not administered?						
I11	Does all medication have the correct dose i.e., 0.5 for half a tablet not 1 or * in the appropriate section of the MAR chart?						
I12	Is the administration of all insulin, drops & creams recorded on the MAR chart or signposted to a separate chart or the care plan (including those in resident’s rooms) where it's use is recorded?						
I13	Do all handwritten MAR entries contain full and accurate medicine information to ensure safe and effective administer?						1.14.9
I14	Is the handwriting on paper MAR charts legible and in ink?						
I15	Are all medication changes recorded appropriately? Previous medication clearly stopped (avoid altering existing paper MAR entries) New MAR entry for all new or amended medication on paper MAR charts						1.14.9
I16	All handwritten changes on paper MAR charts dated and signed by two members of staff to ensure accuracy of transcription On eMAR charts are changes and alterations witnessed to ensure accuracy of transcription						

Section J - Record Keeping		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
J1	Does the care home, where practical, involve the resident or their family in discussions and decisions concerning their medication?						1.2.1
J2	Upon arrival at the care home, do residents receive a medication review by a clinically qualified professional or multidisciplinary team to ensure accuracy, and appropriateness and includes confirmation, if appropriate of medication history from their previous GP?						**1.3.3**
J3	Are all medication changes detailed on the MAR and in the resident's care plan?						
J4	Are verbal instructions for changes to medication taken by a trained member of staff and confirmed in writing as soon as possible?						1.9.6
J5	Does the home have an up-to-date list of all staff's signatures with full staff initials i.e. RS not R as this could be confused with the code for refusing medication						
J6	Is there a policy covering residents on social leave?						1.14.1
J7	Does the home have appropriately trained staff who manage the personal and sensitive information of residents?						1.3.1
J8	Does the home have procedure for ensuring all staff are aware when a medication has been stopped, started or changed? how is the information shared) e.g., diary, communication book, handover						1.9.3

J9	Is information of any interim medication supplied from another pharmacy shared with your regular pharmacy supplier so that they can advise on any actions that may be required to ensure the residents safety?						1.4.1
J10	Is your supplying pharmacy informed of any medication changes that require alteration of the MAR charts i.e., stopped or started medication, allergies not recorded on MAR etc.?						1.4.1
J11	Is there a procedure in place for obtaining acute medication (and MAR chart) so that the delay in starting administration is kept to the minimum						
J12	Is a copy of the discharge medication summary sent to the pharmacy when a resident is discharged from hospital?						1.3.8
J13	Do you supply information about a resident's mediation when a resident attends appointments or when admitted to hospital?						1.3.5
J14	Do you have a document listing a resident contact information, medical and medication history available when the resident transfers between care settings?						1.7.1
J15	Does the home have a record of when every resident's annual medication review is due?						1.8.1
J16	Does the home ensure that all residents prescribed antipsychotics are review by a GP or CPN every three months?						1.8.2

Section K - Medicines Reconciliation		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
K1	Upon admission to the home, is the following information gathered within 24 hours: • Resident's details: Name, DOB, NHS No. and weight • Details of GP and other healthcare providers • Known drug allergies • Medication details (inc. name, strength, form, dose, route, timing, and indication) Details of last dose of PRN/weekly medication						
K2	Is all medication received for the new cycle reconciled with their prescription and the new MAR chart?						1.7.1
K3	Are new and old MAR paper charts compared to ensure all current medication is listed on the MAR and discontinued medications have been removed? With eMAR charts is there a procedure to ensure discontinued medication is not carried across to the new cycle and new medication is carried forward						1.7.1
K4	Are MAR charts updated as soon as possible with any changes to medication?						1.4.1
K5	Is there a procedure for checking a residents medication on discharge from hospital for medication changes?						

Section L - Specialist Medication Information / Monitoring		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
L1	Is short course medication, i.e., antibiotics, have an end date or duration indicated on the MAR?						
L2	Is the residents pulse taken and recorded before relevant medication is administered e.g., digoxin?						
L3	Do staff who administer medication understand the different techniques for different types of inhaler and spacers?						
L4	Are staff able to assess the suitability of each inhaler device and encouraged to report if residents' technique is no longer appropriate for that device?						
L5	Do all residents who are at risk of a seizure have epilepsy rescue medication i.e., diazepam rectal tubes, or midazolam buccal, available?						
L6	Do all residents who are at risk of a hypoglycaemic attack have glucose gel or glucagon available?						
L7	Is there a protocol for managing residents who refuse medication, when would the GP be informed?						1.2.3
L8	Is there a protocol for managing residents who have difficulty swallowing?						
L9	Is there a protocol such as a patch chart for managing patches that include site of application, removal and frequency of site rotation?						
L10	Are all medication monitoring tests e.g., U&E's, LFT's, lithium, carried out at appropriate time intervals?						1.9.1

L11	Do residents on warfarin have a current warfarin dose advice slip?						
L12	Is the warfarin dose information from the INR clinic regularly shared with the pharmacy?						
L13	Are staff aware of the type of side effects that may occur with any newly prescribed medication						1.9.2
L14	Does the home monitor the effects of medication and inform the GP if the residents condition changes?						1.14.1
L15	Are all residents body weights recorded at least monthly?						
L16	Do residents on nutritional supplements or where there are concerns about their weight, have their body weight recorded weekly?						
L17	Are residents who have been on nutritional supplements for 6 months reviewed by a dietitian?						
L18	Does a resident's sudden, significant weight loss trigger a medication review?						
L19	Does a clinically qualified medical professional review the medication for each resident at least annually?						1.8.3
L20	Is there a protocol for managing residents on PEG feeds? (including advice sought from the pharmacy on administering of medication)						

Section M - Medicines Incidents and Adverse Effects		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
M1	Does the home have a process for managing medication incidents such as adverse effects and near misses which includes? • How to report • Who to report too • What to record for the purposes of investigation? • How to investigate & how the results of the investigation will be acted upon & shared • How to feedback relevant information to the resident, their family and relevant authorities						1.5.3
M2	If a medication incident occurs are lessons learnt and circulated to all staff who administer medication?						
M3	Are all incidents that lead to a medical consultation actioned and the action recorded as needed?						
M4	Are all significant medication errors reported to CIW, Complex Care and the Local Authority?						1.6.2
M5	Are family members able to report concerns relating to medication?						1.6.10

Section N – Safety Alerts and Information		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
N1	Does the home receive and action safety alerts (e.g. MHRA/NPSA) with suitable records maintained and are the cascaded to all staff?						1.14.19
N2	Does the home have access to suitable reference material (e.g., paper BNF less than 12 months old, BNF app)?						1.14.19
N3	Is a PIL provided for each medicine and retained for reference by the home?						1.14.19
N4	Is advice sought from a pharmacist or GP if staff need clarification on a resident's medication?						

Section O - Equality and Diversity		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
O1	Does the home discuss with the resident or resident's representative the resident's wishes or beliefs to ensure they are followed and respected?						
O2	Does the home ensure that vegetarian / vegan residents do not receive medication containing animal products e.g. capsules containing gelatine?						
O3	Is there a process for ensuring that residents' medication intervals can be altered during religious festivals, such as when they are fasting?						

Section P - Covert Administration		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
P1	Is there a protocol in place for the covert administration of medication to residents, including consent forms and a best interest completed?						1.15.2
P2	Does the home ensure that Covert Administration is not used for residents that have capacity?						1.15.1
P3	Are all reasons for a resident's refusal to take medication explored before going down the covert route i.e. swallowing, hearing etc.?						1.15.1
P4	Does the home ensure that covert administration is only used after a capacity and a best interest assessment?						
P5	Does the protocol conform to the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007?						1.15.2
P6	Is the assessment of mental capacity recorded in the residents care records?						1.15.3
P7	Are all relevant signatures present on the consent form?						1.15.3
P8	Does the home discuss with the residents next of kin, friends or carers to help ensure that the residents previously expressed wishes, or beliefs are respected						1.15.3
P9	Does the covert form have an up-to-date list of all medication covered by the covert order?						1.15.3
P10	Is Information on how to covertly administer medication sought from the pharmacy and recorded on the form?						1.15.4

P11	Is a list of all the residents' medication available for the pharmacy to assess how to best to carry out covert administration for each medication i.e., in yogurt?						
P12	Does the home ensure that the need for covert administration is reviewed 6 monthly or after a medication change?						

Section Q - Homely Remedies	**Yes**	**No**	**N/A**	**Actions Needed and Comments**	**Sign & Date Actions Completed**	**SC1 Ref**

Q1	Has the policy been approved by the residents' GPs and pharmacists?						1.16.1
Q2	Does the policy name suitably skilled members of staff authorised to administer homely remedies?						
Q3	Are the medicines included on the policy appropriate i.e., GSL or P meds, for minor ailments?						
Q4	Has the list of medications been agreed with the GP/s?						
Q5	Is sufficient supporting information included in the policy to allow staff to administer safely? • Excluded patients • Name of medication and indication • Dose and administration frequency • Maximum daily dose • Max duration of treatment • Action to be taken where additional or further treatment is necessary						1.16.1
Q6	Does the home have records of the purchase & disposal of homely remedies?						
Q7	Are homely remedies stored in their original packaging, separately from the homes regular medication?						
Q8	Are the expiry dates of homely remedies checked monthly?						
Q9	Is administration of all non-prescribed medication recorded on a MAR chart?						1.16.1
Q10	Are homely remedies kept in their original packaging together with all information supplied i.e., PIL?						1.16.1

Q11	Do staff who would be expected to administer a Homely Remedy, sign the process to confirm they have the skills to administer homely remedies and acknowledge that they will be accountable for their actions?						1.16.2

Section R - Self-Medication	**Yes**	**No**	**N/A**	**Actions Needed and Comments**	**Sign & Date Actions Completed**	**SC1 Ref**

R1	Does the home have a policy for assessing if a resident has the capability to safely self-medicate?						1.13.2
R2	Is a risk assessment completed for self-medicating residents (including the safety of other residents),						1.13.1
R3	Is the level of any support needed recorded in the resident's care plan (e.g. reminders needed)?						
R4	Is an individual risk review carried out (at least) monthly to confirm continuing capability and to find out how much support a resident may need to carry on taking and looking after their medicines by themselves i.e., if an adjustment in the medication regime will help with self-medicating						1.13.2
R5	Are residents encouraged to self-medicate even with a limited number of their medication i.e., inhalers?						1.13.1
R6	Do self-medicating residents have secure but accessible storage for medication?						1.13.6
R7	Does the home record the supply of medication to self-medicating residents?						1.13.4
R8	Does the home record when staff have reminded self-medicating residents to take their medication?						1.13.6
R9	Do staff regularly check on storage, stock levels and expiry dates of medication kept by the resident?						
R10	Does the home ensure the residents do not self-medicate from compliance aids filled by their family?						
R11	Are residents able to easily access medication that requires special storage i.e. CDs, fridge items?						1.13.7