Answer sheet for activities

Session 1

**Activity**

Can you list the medicines you know about that contain Paracetamol and what they are used for. Examples could include:

|  |  |
| --- | --- |
| **Medicine** | **What is the medicine used for?** |
| Paracetamol  | Treating mild to moderate pain, reducing fever  |
| Cold and Flu tablets | To relieve symptoms of cold and flu such as pain, fever, congested nose |
| Co-codamol | Severe pain |
| Co-dydramol | Severe pain |

**Activity**

Complete the table below with the correct route of administration for each form.

|  |  |
| --- | --- |
| **Form of Medicine** | **Route of administration** |
| Suppositories | Rectal |
| Tablets | Oral |
| Inhalers | Topical |
| Eye drops | Topical |

**Activity**

From what we have discussed so far, write down below what you think should appear on a medicine label.

|  |
| --- |
| **Medicine Label** |
| Name of the person |
| Name of the medicine |
| Form of the medicine |
| Strength (ex: how many mg in 1 tablet) |
| Quantity (ex: how many tablets in the box) |
| Direction for use (how much to take and when) |
| Date the medicine was dispensed |
| Name and address and usually phone number of the pharmacy |
| Warning labels |
| “Keep out of reach of children” |

**Activity**

If homely remedies are used in your care home, please think of 3 homely remedies that you keep and what they are used for? Examples below are homely remedies used in CEC care homes:

|  |  |
| --- | --- |
| Homely Remedy | Used for |
| Paracetamol | Pain |
| Peptac suspension | Heartburn and acid reflux |
| Simple linctus | Non-productive cough |
| Senna | Constipation |
| Loperamide | Diarrhoea  |

**What if....?**

One of your service users is having difficulty swallowing one of her tablets that she has been taking for a long time. She asks you to crush it and put it into her yoghurt so that it will “slip down more easily”. She says that one of the other care staff have done this for her previously.

|  |
| --- |
| Check care plan to see if it has been documented that the tablet can be crushed (there should be information from the pharmacist). If this is not documented, check with the GP and pharmacy if there is an alternative she can have and if not, whether it would be suitable to crush. It is important to ensure information has been sought from GP and/or pharmacy before attempting to crush any medication, as it can affect the medication adversely if the tablet is modified release or enteric coated. It can also affect staff adversely if they are exposed to drug particles when medication is crushed. |

Jot down below briefly what you would do in this situation and why.

Session 2

MAR chart activity:





**Medication Incidents Activity**

Consider the following examples of real medication incidents which have occurred and answer the questions.

**Right Person**

Four people received the wrong medication in a care home after the administration started in the first person’s room with the medication meant for the person next door, this continued down the corridor with everyone receiving their neighbours medicine until the person in the fourth room stated they did not recognise the medication and the incident was discovered.

What might have led to this incident occurring?

For instance: Being interrupted, pre-potting medication, not checking residents details (complacency), similar sounding names, pictures in front of MAR chart not updated, new staff member afraid to ask for help,

How could this have been prevented from happening?

Always check all details for each resident, finish administering medication to one resident completely before moving on the next, ensure pictures are up to date and accurate, ask resident to state their name, ask for help if unsure, if being interrupted by residents then ask other staff members for help, no excuse for other staff members to interrupt unless emergency.

**Right Medicine**

A person was given their liquid medication, the person thought it tasted odd and once investigated it turned out to be their calamine lotion instead of their Milk of Magnesia indigestion remedy.

What might have led to this incident occurring?

Not checking the label on the bottle, medication has run down the side so label can’t be read, rushed

How could this have been prevented from happening?

Check label before administering, if label cant be read then do not use, store oral medication and external medication separately,

**Right Dose**

A person received the wrong dose of levothyroxine after the pharmacy supplied a different strength. The dose was 100 micrograms. The pharmacy had previously supplied 25 microgram tablets with the instruction: Take FOUR tablets in the morning. This month the pharmacy supplied 100 microgram tablets with the instruction: Take ONE tablet in the morning. A care worker mistakenly gave 4 x 100microgram tablets.

What might have led to this incident occurring?

Most likely complacency, being used to give 4 tablets for a while and then the strength suddenly change.

How could this have been prevented from happening?

Communication, ensuring the person receiving the medication tell the rest of the staff about the change. Make sure to read all the information on the labels of medication at all time keeping in mind doses of medication can change and strength supplied can change.

**Right Time**

A person in their own home was prompted to take their medicine from their dosette box but they took them from the wrong side and managed to take all their night time tablets – simvastatin, diazepam, zopiclone and co-codamol - instead of their morning tablets – furosemide, aspirin and co-codamol.

What problems might this cause for the person?

The person would likely become very drowsy and therefore be in risk of having a fall.

How can this be prevented from happening?

Initially monitor them to see how they are managing with their compliance device. If clear that the person is no longer managing, they probably need to be reassessed and care workers will have to administer medication to the person.

**Right Route**

A person was administered all morning medication which included a capsule called Spiriva (tiotropium bromide) which is intended to be used in an inhaler, not swallowed.

What would you do if you discovered this incident?

Get advice from health care professional (GP, pharmacist, NHS24)

How could this have been prevented from happening?

Store capsule for inhaler separately from oral medication, read all information on the label as information can be missed if rushed.

**Session 3**

**Activity**

Let’s consider the storage requirements for some medicines.

Complete the table below with the storage and expiry requirements. The first one has been done for you.

|  |  |  |
| --- | --- | --- |
| **Medicine** | **Stored where?** | **Discard after** |
| GTN tablets | Original container | 8 weeks |
| Insulin | Fridge before in use, once in use store at room temperature | Most preparations 4 weeks but some 6 weeks |
| Oramorph oral solution (10mg/5ml) | In CEC care homes in CD cupboard though not a legal requirement. | 90 days after opening |
| Antibiotic liquids | Some fridge, others room temperature so check the label | Check the label as some will be 7 days, other 10 or 14 days and some until expiry date printed on the bottle |

Side Effect activity

| MEDICINE | WHAT IT IS USED FOR | MOST COMMON SIDE EFFECTS |
| --- | --- | --- |
| Aspirin | Used to prevent clots forming to reduce the risk of heart attack or stroke | Stomach irritation, bruising, bleeding (esp. stomach)some asthmatics allergic |
| Diuretics (furosemide, bendroflumethiazide) | Used to reduce blood pressure or to remove excess fluid from the body | Low BP, dizziness, dehydration, confusion |
| Atenolol/Bisoprolol | Used to reduce blood pressure or to stabilise the heart | Cold fingers and toes, low BP, dizziness, slow heart rate, some asthmatics allergic |
| Amitriptyline | Used in high doses for depression and in low doses for pain | Dizziness, agitation, confusion, drowsiness, dry mouth, blurred vision |
| Salbutamol | Used in people with asthma/COPD for wheeze or shortness of breath | Tremor (esp. in hands), headache, palpitations |
| Steriod inhalers (Seretide, Clenil, Symbicort) | Used to prevent asthma or to reduce symptoms in people with COPD | Oral thrush, hoarseness |
| Lisinopril/ramipril  | Used to reduce blood pressure or to stabilise the heart | Low BP, dizziness, head ache, persistent dry cough, diarrhoea, vomiting |
| Tramadol | Used for pain relief | Nausea, vomiting, constipation, drowsiness, dizziness |
| Mirtazapine | Used for depression | Drowsiness, headache, dry mouth, increased appetite and weight gain |

Covert medication

**Activity**

A person in your care is refusing all his medication as he thinks you are trying to poison him. He has a heart condition which requires him to have medication every day and without this medication he will deteriorate very quickly. Discuss in groups what would you do in this scenario….

|  |
| --- |
| First try and have a conversation with the person to find out why he all of a sudden think you are trying to poison him. Does he have an infection, or has he got worsening dementia. If infection is ruled out try and speak to family for ideas, try a different member of staff to see if that helps. If you have tried everything you then need to speak to the GP and check if they would support staff in administering the medication covertly, ensuring the correct paperwork has been filled out and followed. |

**What if....?**

Imagine the following scenario:

Over the last week you’ve noticed that one of the people you care for seems regularly drowsier in the afternoons. On checking his medication administration record you notice that he has been having the maximum dose of his “as required” painkiller after lunch each day.

What would you look for on the label of the “as required” painkiller?

What would be your best course of action?

|  |
| --- |
| Check on the label if there are any warning label that explain the drowsiness. Also check the patient information leaflet for side effects. If confirmed that the medication could be the cause, ensure this is reported to the GP so they are aware when reviewing his medication. If it is unlikely to be the medication causing it, this should still be mentioned to the GP as there could be other things that then needs to be reviewed or examined. |

Session 4

**Activity**

Write down below three specific ways that you could suggest to a person to help prevent constipation, e.g. by suggesting they eat a piece of fruit at a regular time each day.

|  |
| --- |
| Examples could be: * drinking a glass of water before each meal
* replace white bread with wholegrain
* eating veg with every meal
* having a piece of fruit for dessert instead of puddings
* suggest a walk in the afternoon every day
 |